STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235366	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Forest Hills	1095 Medical Park Dr Grand Rapids, MI 49506

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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. 47955 This citation pertains to intake MI00143238 Based on observation, interview, and record review the facility failed to maintain resident dignity in 1 (Resident #15) of 9 residents review for dignity resulting in feelings of frustration and anger. Findings include: Review of an Admission Record revealed Resident #15 had pertinent diagnoses which included: muscle weakness, dependence on wheelchair, morbid (severe) obesity. Review of a Minimum Data Set (MDS) assessment for Resident #15, with a reference date of 6/8/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #15 was cognitively intact. In an interview on 7/9/24 at 7:30 PM., Certified Nurse Assistant (CNA) D CNA I and CNA O reported that typical staffing is two CNAs for the B side. CNA D reported that her normal assignment was about 14 residents for the shift and that there were maybe 27 residents on B side. CNA D reported that there was not enough staff to do what the residents need us to do for them. In an interview on 7/10/24 at 10:45 AM., Resident #15 reported that she had sat in a wet and soiled brief on more than one occasion for one or two hours waiting for assistance for incontinent care and to have her brief changed. Resident #15 reported that she has had to wait for over an hour for her call light to be answered. Resident #15 reported that having to wait long time for her call light to be answered makes her angry. Resident #15 reported that she has taken notes on her cell phone of specific dates that she had to wait extended time for her call light to be answered. Resident #15 reported that on March 8, 2024, and April 18, 2024, she waited for 2 hours for her call light to be answered when she needed incontinent care for a bowel movement. Resident #15 reported that would be acceptable to wait 15 minutes to have incontinence care done but an hour or two was too long to wait. In an interview on 7/11/24 at 1:44 PM., Resident #15 reported that last night during night shift she had to wait over an hour for her call light to be answered. During an observation on 7/12/24 at 1:40 PM., Resident #15's call light was noted to be on. (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 - Few	In an interview on 7/12/24 at 1:50 PM., this surveyor entered Resident #15's room after knocking and with permission and Resident #15 reported that she had turned on her call light requesting assistance with incontinence care. Resident #15 reported that her call light had been on for about 10 minutes. During an observation on 7/12/24 at 1:54 PM., Resident #15's call light was answered, and care was provide as requested by Resident #15. Review of Kardex for Resident #15 revealed . toileting, incontinent .I prefer to wear a brief . bladder/bowel . brief use . I use bariatric disposable briefs. I will notify staff when I need to be changed . per my preference, I choose not to use a bed pan or toilet, I prefer to void and have BM (bowel movement) in my brief and call for staff assistance for changing . Review of Care plan for Resident #15 revealed .focus . I am continent but void in my brief and will tell staff when I need to be changed .initiated 5/23/24 .goal . I will be continent during waking hours and through review date .initiated 5/25/22 .interventions .brief use I use bariatric disposable briefs. I will notify staff when I need to be changed . initiated 5/25/2022 . In an interview on 7/16/24 at 11:22 AM., Resident #15 reported that last night she turned on her call light requesting incontinence care for a bowel movement at 12:15 AM and she waited over an hour for her call light to be answered. Resident #15 reported that the call light was answered at 1:20 AM. In an interview on 7/16/24 at 1:30 PM., Resident #15 reported that she was angry and frustrated when she had to wait over an hour for staff to answer her call light when she needs incontinence care.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake #MI00145579. Based on interview, and record review, the facility failed to prevent the misappropriation of resident medications in 1 of 3 residents (Resident #36) reviewed for abuse, resulting in loss of resident's diabetes medication, a delay in treatment of diabetes, and the potential for the resident to not reach their highest practical well-being. Findings include: Resident #36 Review of an Admission Record revealed Resident #36 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: type 2 diabetes (problem in the way the body regulates and uses sugar). Review of a Minimum Data Set (MDS) assessment for Resident #36, with a reference date of 3/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #15 was cognitively intact. Review of a Facility Reported Incident dated 5/9/24 at 5:53 PM revealed, .potential missing medication, Ozempic (improves blood sugar) .(Director of Nursing (DON) B) sent (Unit Manager (UM) W an email on 5/8/24 stating that (Resident #36) had not received his Ozempic and to look into this .the unit manager verified that the resident had not received the medication. The pharmacy was contacted, and the pharmacy stated that the medication was delivered on 05/01/2024, however we were unable to locate the medication. Immediately following being unable to find the medication, the unit manager reported to Nursing Home Administrator (NHA) and Medical Director that they are potentially missing a medication . Review of Resident #36's Medication Administration Record for April 2024 revealed, Ozempic (2mg/dose) subcutaneous solution pen-injector 8 mg/ml inject 2 mg subcutaneously (injection) one time a day every Tuesday for Type 2 Diabetes. Start Date 4/23/24, D/C (discontinue) date 4/30/24 . The record indicated that Resident #36 missed a dose on 4/23/24 and on 4/30/24. Review of Resident #36's Medication Administration Record for May 2024 revealed, Ozempic (2mg/dose) subcutaneous solution pen-injector 8 mg/ml inject 2 mg subcutaneously one time a day every Thursday for Type 2 Diabetes. Start Date 5/2/24, D/C (discontinue) date 5/13/24 . The record indicated that Resident #36 missed a dose on 5/2/24 and on 5/9/24. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/12/24 at 03:01 PM, Licensed Practical Nurse (LPN) R reported that on 5/1/24 at approximately 7:20 AM the pharmacy delivered a tote of medications to A hall. LPN R reported that she verified that all medications were received, prior to the pharmacy staff leaving. LPN R reported that she then removed the medications for A hall, and delivered the rest of the medications to B hall. LPN R reported that Resident #36's Ozempic was in the tote, but that she had forgotten to remove it with the rest of the A hall medications, prior to delivering it to B hall. LPN R reported that she left the tote in the B hall medication room and notified (third shift nurse) Registered Nurse (RN) MM that the pharmacy delivery had arrived. In an interview on 07/16/24 at 11:20 AM, RN MM reported that on 5/1/24 at 7:20 AM she was packed up and getting ready to leave for the day when LPN R brought over a tote from the pharmacy, and sat it on the desk. RN MM reported that she did not have time to put it all away, but that she quickly put the stat safe (back up) medications and the narcotic medications away before she left for the day. RN MM reported that she did not see Resident #36's Ozempic in the tote. In an interview on 07/12/24 at 12:41 PM, UM W reported that she had received an email from DON B requesting that she investigate why Resident #36 had not been receiving his Ozempic. UM W reported that the original prescription was written on 4/19/23, but the medication was not delivered until 5/1/24. UM W reported that during her investigation on 5/9/24, she had found a pharmacy tote in the B hall medication room, and Resident #36's box of Ozempic was in the tote, but the syringes containing the medication were gone. UM W reported that the empty box was labeled and dated, and matched the medication that was listed on the pharmacy delivery sheet. UM W reported that when nursing staff received a delivery from the pharmacy, they were supposed to verify with the delivery sheet and the pharmacy staff that each individual medication was received, before signing the delivery sheet. UM W reported that the delivery sheet from 5/1/24 was signed by LPN R. UM W reported that at first RN MM denied putting away the medications for B hall. UM W reported that she could see on the computer that RN MM had opened the stat safe medication cart on 5/1/24, and then when re-interviewed, RN MM admitted that she did put away the medications, but did not see Resident #36's Ozempic. During the interview with UM W a phone call was placed to the pharmacy, to verify that Resident #36's Ozempic was included in the shipment that the facility had received on 5/1/24. In an interview on 07/16/24 at 10:32 AM, LPN CCC reported that when she arrived for her shift on 5/1/24 around 7:00 AM, the door for the B hall medication room was propped open and remained propped open with a trash can until approximately noon that day, when maintenance staff brought a new key. LPN CCC reported that on 5/1/24 at approximately 7:30 AM, LPN R brought a pharmacy tote to B hall and sat it on the desk, and that RN MM put the medications away. In an interview on 07/16/24 at 10:51 AM, LPN G reported that in the late evening hours on 5/1/24 she was cleaning in the B hall medication room, and she found an empty box of Ozempic in the fridge. LPN G reported that when she determined that there were no syringes in the box, she tossed it into the pharmacy tote on the floor. LPN G reported that she did not know that it was Resident #36's, until later that week when UM W asked about the empty box of Ozempic that was found in the pharmacy tote. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/16/24 at 11:03 AM, DON B reported that she was in the facility on 5/1/24 and was not made aware of any concerns with the B hall medication room being propped open, and/or a missing key. DON B reported that when she was auditing medication administration records, she identified that Resident #36 had not been receiving his Ozempic. DON B reported that she was leaving for vacation and delegated UM W to investigate why the resident had missed multiple doses of the medication. In an interview on 07/16/24 at 01:03 PM, Environmental Service Manager (ESM) L reported that a couple of months ago he had to get extra keys made for the B hall medication room, because the previous unit manager had not turned her keys in. Review of a facility receipt dated 5/1/24 at 10:33 AM, indicated Keys for Nursing. In an interview on 07/17/24 at 10:00 AM, Resident #36 reported that he had missed several dose of his Ozempic shot, but that he had never authorized anyone else to use it. Review of the pharmacy's Consolidated Delivery Sheet dated 4/30/24, indicated that Resident #36's Ozempic was included in the delivery, and the medication was received by LPN R on 5/1/24.

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F 0658 Level of Harm - 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** 38384 This citation pertains to MI00145186 Based on observation, interview, and record review the facility failed to follow professional standards of practice for nursing for 1 of 18 residents (R404) reviewed for significant medication errors resulting in R404 receiving another resident's medications including opioids, experienced respiratory failure, and sent to the hospital for life-sustaining treatment. Findings include: R404 According to the Minimum Data Set (MDS), dated [DATE], R404 scored 15/15 (cognitively intact) on his BIMS (Brief Interview Mental Status). R7 According to the Minimum Data Set (MDS), dated [DATE], R7 scored 13 /15 (cognitively intact) on his BIMS (Brief Interview Mental Status). Review of R7's MAR/TAR dated 5/23/24 indicated at 8:00 AM, LPN WW indicated documented administration of: -Gabapentin 400 mg 1 capsule by mouth for neuropathy -methocarbamol 500 mg 2 tablets by mouth for muscle spasms/phantom pain -aspirin 81 mg by mouth for prophylaxis (preventative) -lotrel 5-20 mg 1 capsule by mouth for hypertension -Miralax17 grams by mouth for constipation -Apixaban (blood thinner) 5 mg 1 tablet by mouth for prophylaxis -hydromorphone HCL (dilaudid) 4 mg by mouth for chronic pain -levetiracetam 750 mg 2 tablets by mouth for seizure disorder -lidocaine External gel 4% topically for right shoulder pain (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Review of Licensed Practical Nurse (LPN) WW written statement by proxy of Nursing Home Administrator (NHA) A dated 5/23/24 at 1030 AM, indicated she had dispensed (prepped) and administered morning medications to R404 at approximately 7:30 AM. At approximately 7:45 AM LPN WW prepped R7's medications and handed the cup of medications to LPN XX and told him the room number. LPN WW stated she was unclear if she had given LPN XX the wrong room number or if he had heard her wrong but at approximately 8:35 AM R7 reported to her that he had not received his 8:00 AM medications. LPN WW informed R7 that he had received his medications, however, R7 continued to insist that he had not. LPN WW asked LPN XX if he had administered R7's to him and LPN XX stated, A bigger guy? LPN WW stated, No, that is not (R7). The medication error was reported to the former Unit Manager/Clinical Care Coordinator (UM/CCC) by both nurses, R404 had received R7's medications. Review of LPN XX written statement by proxy of NHA A dated 5/23/24 at approximately 11:45 AM, indicated he offered to run the medications for LPN WW. When LPN WW handed him the medications for R7 she told him These are for (R7's first name which was the same first name as R404) and when he asked for a room number. LPN XX stated when he entered the stated room, he spoke to a resident and asked if he was the man with the first name he was given. The resident responded to the name. LPN XX then informed R404 that he had his medications. During an interview on 7/11/24 at 3:35 PM, R404 stated, I was a resident at the facility in May (2024). I went to the room that was a lounge that morning, was given my medications by a lady, who said she was a nurse then I went back to my room. About 5 minutes later a man nurse came to my room and called out my first name. I said my first name. He did not ask me my last name. He said he had meds for me. I said I got my meds a short time ago by the lady nurse. He said the meds were mine. He said he had been a nurse for about [AGE] years and should know how to pass meds and that he knew they were my meds. He insisted he had my medications. I got tired of arguing with the nurse. He should have checked my ID. I still had the hospital bracelet on from the day before. I took the medications he insisted were mine. The next thing I knew I was in the hospital. I was told I was unresponsive. Review of LPN WW written statement by proxy of NHA A dated 5/23/24 at 2:27 PM, gave further clarification on the incident that happened earlier in the day involving R404 and other residents. LPN WW indicated she had prepped medications for three residents (R34, R353, and R49) with LPN XX administering them. LPN WW stated LPN XX had administered medications to the remainder of the residents on the 300 Hall. LPN WW stated all residents on the 400 Hall she had prepped medications and administered with LPN XX. During an interview on 7/10/24 at 3:38 PM, R7 stated, The facility overdosed the guy in the room across the hall from me a while back. The staff gave him my meds (medications). He was not my roommate. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/11/24 at 2:10 PM, LPN WW stated, I have been a nurse since 2002. I know the rights of medication (meds) administration. On May 23 rd (2024), I was passing meds with an agency nurse (LPN XX). We were working out of the same med cart. I gave (LPN XX) medications I had pulled to give to (R7) he gave the wrong person the wrong meds. Once (R7) came to the med cart and said he did not get his morning meds. (LPN XX) told me did not give the meds to (R7). I had been pulling meds that morning and (LPN XX) was giving them. I delegated the meds to (LPN XX). I knew I did wrong by pulling the medications and having the other LPN administer them. The meds were given by (LPN XX) around 8:30 AM. (R7) came to the med cart around 8:30 AM asking for his meds. I told him he already got them, and he argued with me. (LPN XX) said he gave the meds to a bigger guy (R404) and I told him that was not (R7). I gave (R404) his meds at 7:30 AM in the Garden Room. He was drowsy and laying across a bedside table. I had a hard time waking him, he took the meds, and went back to sleep. I left him there. He must have walked back to his room where (LPN XX) found him and gave him (R7's) meds. We went immediately to (Unit Manager (UM) VV) reporting the wrong meds had been given to the wrong person. I went back to passing meds at the same med cart. During an interview on 7/11/24 at 2:43 PM, LPN XX stated, I have been a nurse for [AGE] years. The first day I arrived, I was paired up (LPN WW) who was in her orientation process. We decided she would pull meds and I would pass them. (R404) was about the 4th resident we did this together. (LPN WW) would tell me the resident name and room number and I repeated it back to her and she would say yes. After the incident with (R404) we maybe did 5 more residents the same way. The Unit Manager told me to go sit with (R404) and do vital signs every 15 minutes. The second time VS were taken (R404) was slurring his speech and lethargic. The doctor came to the room, ordered Narcan, and it was administered. (R404) responded and then started to decline. A second Narcan was ordered and 911 was called. I do not know what the medications I gave him. I took the meds and went to what I thought was (R7's) room. (R404) responded when I went into the room. I did not pull the meds. I watched the MAR as (LPN WW) pulled meds and saw a first name but not a picture in the medical record. I watched the LPN pull a med out of the narcotic (controlled substance) drawer, but I did not look at what med it was or the name on the card. I do not know what meds were pulled. (R404) did not have on a wrist band, a name on the room door, or a picture in medical record. I know better than to administer medications the way I did. Review of R404's ED (Emergency Department) Provider Note dated 5/23/24, revealed, .Patient presented with unintentional medication overdose. Was given Dilaudid and Gabapentin. Was hypoxic (low level of oxygen in body tissues) and required Narcan (medication to treat narcotic overdose) in field. On arrival here, we did give him multiple doses of Narcan. Eventually started on Narcan drip. Was still sleepy. Noted to have hypercapnia (buildup of carbon dioxide in bloodstream). Did require hospitalization .Diagnosis: Acute hypercapnic respiratory failure . mistakenly given another patient's medication .At approximately 8:30 AM, he was given 4 mg of PO (by mouth) dilaudid and 800 mg Gabapentin that was intended for a different patient. Shortly thereafter he became unresponsive and desatted (blood oxygen levels dropped) to 70s Over the course of an hour (R404) became more somnolent (solemn state) and harder to arouse . gave him a total of 2 mg of Narcan .Toxicology was consulted in the emergency department. They recommended to start a Narcan drip Lab work was significant for a significant respiratory acidosis. The patient was evaluated by toxicology in the emergency department and recommended supportive measures and titratable Narcan in an effort to avoid intubation .Objective .in acute distress .cardiovascular rhythm irregular .Pulmonary . Tachypnea and accessory muscle usage present . (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Review of R404's Toxicology Consultation Note dated 5/23/24, revealed, Accidental narcotic ingestion . received total of 5 doses of Narcan and presently is on a Narcan drip .UA not known if the Narcan will be sufficient to return around his respiratory issues and he may require intubation . Review of facility policy, Medication Administration-General Guidelines dated 2/2019, revealed, Medications are administered as prescribed in accordance with good nursing principles and practices .The Five Rights . Right Resident, Right Drug . are applied for each medication being administered. A triple check of these five Right Rights is recommended at three steps in the process of preparation of a medication for administration . B. Administration .5) The person who prepares the dose for administration is the person who administers the dose. 6) Residents are identified before medication is administered. Methods of identification include: a. checking a photograph attached to the medical record b. checking an identification band c. asking the resident to verify his/her name d. verifying resident identification with other facility personnel . 12. Medications supplied for one resident are never administered to another resident .the nurse who administers the medication records the administration on the resident's MAR immediately after the medication is given .

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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** 41424 Based on interview and record review, the facility failed to ensure a resident was consistently provided with showers/bathing for 2 of 7 residents (Resident #27 and Resident #406) reviewed for activities of daily living, resulting in unmet personal hygiene needs with the potential for isolation, psychosocial harm, skin breakdown, harboring infection, and decreased self-esteem. Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition.Personal hygiene affects patient's comfort, safety, and well-being. Hygiene care included cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities which as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation foster a positive self-image, promote healthy skin, and help prevent infection and disease . Resident #27: Review of an Admission Record revealed Resident #27 was a male with pertinent diagnoses which included dementia, abnormal posture, pain in right hip, pain in right hip, stroke, polyneuropathy (damage/disease affecting peripheral nerves on both sides of the body featuring weakness, numbness, and burning pain), dysphagia (damage to the brain responsible for production and comprehension of speech), dorsalgia (back pain), muscle weakness, unsteadiness on feet, lack of coordination, paralysis, cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language) and fracture of right hip. Review of current Care Plan for Resident #27, revised on 6/9/23, revealed the focus, .I have an ADL self care performance deficit r/t (related to) chronic pain, weakness, neuropathy, CVA (stroke), osteoarthritis (flexible tissue at the ends (cartilage) of bones wears down) . with the intervention .Bathing preference: shower in the morning .Shower-Wednesday and Saturday 1st shift . During an observation on 07/10/24 at 10:58 AM, Resident #27 appeared disheveled with his hair uncombed and mustache/beard needed trimmed and combed. He needed to be shaved on the side of his face and neck area. Resident #27's face appeared very greasy looking and when asked if anyone had washed his face, he was able to shake his head, No. During an observation on 07/16/24 at 09:34 AM, Resident #27 was observed lying in his bed with food on his face in his mustache and his beard all around his mouth area. His facial hair was not groomed and over grown. He did not have his neck shaved nor the side of his face. Resident #406: (continued on next page)

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Mission Point Nsg & Phy Rehab Ctr of Forest Hills	1095 Medical Park Dr Grand Rapids, MI 49506

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #406 was a female with pertinent diagnoses which included spinal stenosis (space inside the bones of the spine get too small), wedge compression fracture of fifth lumbar vertebra (spinal compression fracture that occurs when the front of a vertebra collapses, but the back does not), wedge compression fracture of first lumbar vertebra, fusion of spine (surgical procedure that permanently joins two or more vertebra together so there is no movement between them), muscle weakness, difficulty in walking, unsteadiness on feet, and lack of coordination. Review of current Care Plan for Resident #406, revised on 7/10/2018, revealed the focus, .I have an ADL self care performance deficit r/t lumbar surgery and fusion, fatigue, limited mobility, limited rom (range of motion), musculoskeletal impairment recent fall and history of falls, BLE (bilateral lower extremity) weakness, pain . with the intervention .Praise all efforts for self care .Shower 2 assist Wednesday and Saturday 7-3 . Review of a Minimum Data Set (MDS) assessment for Resident #406, with a reference date of 5/31/24 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated Resident #406 was cognitively intact. In an interview on 07/10/24 at 09:50 AM, Resident #406 reported she has not had a shower and not offered a shower or bed bath. Review of Minimum Data Set (MDS dated [DATE], revealed, .Section F: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? .Very important . Review of a Minimum Data Set (MDS) assessment for Resident #406, with a reference date of 5/31/24 revealed, .Section GG: E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes wahing of back and hair) .2. Substantial/maximal assistance .A. roll left and right: the ability to roll from lying on back to left and right side, and return to lying on back on the bed .01. Dependent .B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed .01. Dependent .C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support .01. Dependent . In an interview on 07/09/24 at 08:35 PM, Resident #406 reported she was unable to get up by herself and she had not been out of bed yet. Resident #406 reported she was unable to stand and had numbness in her feet. Resident #406 reported she had not received a shower, not a full bed bath since she had been at the facility. During an observation, Resident #406's hair was in an unkempt, knotted bun on the top of her head. In an interview on 07/12/24 at 10:39 AM, Resident #406 reported it had been approximately 4-6 weeks since her hair has been washed and she had not received a bath or a shower. Resident #406 reported when she was sent to the hospital they did not wash her hair while she was there as well. Resident #406 reported the staff could have taken her to the sink to wash her hair or laid her on the shower gurney to wash her up. In an interview on 07/12/24 at 03:15 PM, Resident #406 reported no staff had offered to provide her with a shower or bath and the most any had done was a quick wash with a wash cloth on her upper stomach area and down the tops of her arms. Resident #406 reported she had not been asked or provided a shower/bath since her initial admission a few months ago. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/10/24 at 10:53 AM, Certified Nursing Assistant (CNA) N reported she had 15 residents assigned to her on hallway II. There were three persons for Hoyer transfers. CNA N reported she tried to get the showers done for the residents on the hallway, depends on the day and what was happening on the hallway. CNA N reported the showers were documented in the medical record and on a skin monitoring form. She reported she tried to get everything done for the resident and still try to get out on time. CNA N reported most days there were 3 CNAs scheduled for the building. She reported she was by herself this week on the hallway. In an interview on 07/16/24 at 10:38 AM, Hospice Aide SS reported if the resident refused she would document in the medical record. When she completed a shower, she would inform the regular staff at the facility and the hospice RN case manager. When she does oral care, nail care she documents that in the medical record as well. She reported she also documented in the hospice system as well. If any changes to the resident, she would let the staff know and the RN case manager for hospice. In an interview on 07/16/24 at 11:12 AM, CNA FFF reported when a resident would refuse a shower/bath we would encourage them by asking again, offer a different time, approached by a different staff member. if the resident continued to refuse, we have to let the nurse know they refused. The skin monitoring sheets were placed in the kiosk and the shower/bath or refusal was documented in the medical record. In an interview on 07/16/24 at 11:37 AM, UM W reported the skin monitoring sheets were for her QA purpose, she reviews, makes sure the weekly skin sweep was in the medical record and then she shreds the document. In an interview on 07/16/24 11:42 AM DON reported the skin monitoring was not their process, the shower or bath was to be documented in the task section of the electronic medical record. If a resident refused, it was documented in the medical record as well as approached by the nurse to encourage the resident. Review of policy, Activities of Daily Living implemented 2/25/24, revealed, .Care and services will be provided for the following activities of daily living .1. Bathing, dressing, grooming, and oral care .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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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** 41424 This citation pertains to intake: MI00142051 Based on observation, interview and record review, the facility failed to provide consistent, meaningful and person-centered activities for 6 of 18 residents (Resident #11, #12, #17, #40, #406, and #34) reviewed for activities provided by the facility, resulting in the potential for loss of interaction, joy, self-esteem, growth, sense of well-being, autonomy, connectedness, identity, creativity, independence, pleasure, and comfort. Findings include: Review of The Boredom of Solitude published 4/21/23 by Psychology Today, [NAME] Danckert Ph.D., [NAME], Ph.D, revealed .Loneliness is a complex experience, one that can heighten our sense of vulnerability .which leads to elevated stress . and just like boredom, loneliness has been associated with poor mental health, challenges to cognitive function, and even cognitive decline in the elderly .perceived lack of meaning will color things as being boring. So, to solve loneliness, like solutions to boredom, we can't simply reach for any kind of interaction. We need things that are meaningful to us. Despite resident's cognitive status, their activity involvement was significantly related to better scores on care relationship, positive affect, restless tense behavior, social relations, and having something to do. [NAME] D, de [NAME] J, Willemse B, Twisk J, Pot AM. Activity involvement and quality of life of people at different stages of dementia in long term care facilities. Aging Ment Health. 2016;20(1):100-9. doi: 10.1080/13607863. 2015.1049116. Epub 2015 Jun 2. PMID: 26032736. Resident #11: Review of an Admission Record revealed Resident #11 was a male with pertinent diagnoses which included insomnia, dementia, major depressive disorder, stroke, and aphasia (loss of the ability to understand or express speech caused by brain damage, like with a stroke). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current Care Plan for Resident #11, revised on 1/18/23, revealed the focus, .I am here for a long term stay and will be offered activities daily . with the intervention .For 1:1 visits, I would enjoy: reminiscing, socializing (I was in the Navy and Army National Guard and enjoy talking about my service time), doing small woodworking projects, painting on canvas, going outdoors when the weather is good, and going for strolls in my wheelchair .I am of Catholic religious affiliation. I prefer not to practice .I do not like being in large groups with a lot of people talking. It confuses me .I enjoy having the daily chronicle delivered Monday - Friday. Please encourage me to attend groups of potential daily. I also needed reminders of when groups are and where .I have consent to attend community outings with activities .I have indicated that the following items are important to me: taking care of my personal belongings or things, having a shower, snacking between meals, choosing my own bedtime, having book/newspapers/magazines to read, listening to the music I like, being around pets, keeping up with the news, doing things with groups of people, doing my favorite activities, participating in religious services or practices, and going outdoors when the weather is good . like being around people, but in small groups. A lot of conversation confuses me, because I don't know if they are talking to me or someone else .I need the following equipment for leisure activities: I use my walker to navigate the building and courtyard. Please do not sit me with others in groups of potential leisure that want to do everything for me, it sometimes takes me a minute to figure things out, and if I need help I will ask a staff member .I want pet visits will be invited to special events at the facility and in the community .I would like the following groups: parties, socials, special music (jazz and musical music), special events, exercise and fitness groups, arts and crafts (painting and woodworking), movies, bingo, outdoor groups, outings, nail salon, reading groups, pet visits, exercise, and men's groups .I would love the following for independent leisure: I like to walk around the facility daily for exercise independently, socializing with others, watching television, going outside when the weather is good, and resting when I am feeling tired .Things that comfort me: being in a small quiet space by myself so that I can collect my thoughts, walking, and being outside . Review of medical record revealed the last Recreation Assessment completed for Resident #11 was 12/28/22. During an interview on 07/10/24 at 11:21 AM, Resident #11 reported he was in the Navy and then the National Guard. He had a medal on the wall and reported it was from powerlifting. He started powerlifting to give him something to do and it benefited him physically. Resident #11 reported he stays in his room most of the time and doesn't participate in activities much. He reported he would like activities where they would do woodworking, or building model cars and/or boats. When asked if he would participate in pottery, he reported that he would try it. He reported the facility doesn't bring him any books, magazines, or any activities he could do in his room. Resident #11 reported he really doesn't watch much TV. He reported he would like some outside activities like fishing as well. No Daily devotions were observed in the resident's room. Resident #12: Review of an Admission Record revealed Resident #12 was a female with pertinent diagnoses which included cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language), COPD, asthma, difficulty in walking, diabetes, and dysphagia (damage to the brain responsible for production and comprehension of speech). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current Care Plan for Resident #12 revised on 3/21/24, revealed the focus, .I am here for long term care and will be invited to participate in the activity program . with the intervention .I need the following equipment for leisure activities: my wheelchair. I also need reminders of when groups are and encouragement to attend groups . o I will be invited to special events at the facility and in the community .I would like to have the daily chronicle delivered M - F . I would like to participate in community outings . I would prefer the following groups: bingo, resident council, cooking/baking groups, special events, special music, parties, socials, and card groups . Things that comfort me: being in my room, being by myself, watching tv, and joking with staff . In an interview on 07/09/24 at 07:33 PM, Resident #12 was observed in her room lying in her bed. She reported the facility didn't have anyone for Bingo today. The residents waited and waited for someone to come and finally another resident ran the Bingo game. She reported she liked to color, play games, and play Bingo. Observations throughout the survey, Resident #12 was hardly in her room she went around the building socializing with others or participated in therapy. Resident #17: Review of an Admission Record revealed Resident #17 was a male with pertinent diagnoses which included polyosteoarthritis, diabetes, anemia, high blood pressure, anxiety, depression, asthma, and abnormalities of gait. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current Care Plan for Resident #17, revised on 7/10/2018, revealed the focus, .I am here for long term care and will be invited to participate in the activity program . with the intervention .For 1:1 visits, I would enjoy: socializing with staff or residents, listening to country/[NAME] music, playing board games like monopoly, having my mail delivered, therapeutic animal visits, assistance with my electronic devices, assistance with my bird feeders and other outside window decors, etc .I am Christian Reformed and want to practice independently. I would like to have bedside communion and to attend communion services .I do have consent to attend community outings with activities .I do not like: reading books, paint by number, being around people who are talking loudly, loud noise, or doing jigsaw puzzles .I have indicated that the following items are important to me: choosing what clothes to wear, taking care of my personal belongings or things, choosing my bathroom routine, having snacks available between meals, choosing my own bedtime, using the phone in private, having a place to lock my things to keep them safe, having reading material available, being around animals, keeping up with the news, doing things with groups of people, doing my favorite activities, going outside to get fresh air when the weather is good, and participating in religious services/practices at the facility. These items are available to me through daily routine preferences, 1:1 visits, independent leisure, and modified group-based activities .I like to play bingo, read the daily chronicle, go on outings with co-residents, garden (I used to have a huge flower garden), play board/card games (Monopoly, Sorry!, SlapJack, Uno, etc.), listen to music, talk on the phone to friends/family, being offered snacks from the food cart, collect coins, and watch tv/movies in my own leisurely time .I need the following equipment for leisure activities: wheelchair, hearing aides, and glasses. At times I may choose to not wear my glasses .I want pet visits .I will be invited to special events at the facility and in the community and will attend as desired .I would like to have the daily chronicle delivered to me Monday - Friday .I would prefer the following groups: bingo, bingoscize, arts and crafts, games, brainteasers, special events, therapeutic animal visits, outdoor, laugh club, men's group, arts/crafts, bingo store, resident council, movies/popcorn, current events, socials, cooking group, bingo store, dining discussions, word games, Wii Bowling (as a spectator), special music, parties, and socials .My life occupation was Electronical Engineer at Kirkhof Transformer. I also used to work as a bouncer and DJ .Things that comfort me: reading the daily chronicle in the morning, playing board games (such as monopoly, sorry!), arts and crafts activities (scratch pictures, abstract art), listening to music (Country, Western, [NAME], 70s-80s music), and socializing with family or staff . Review of medical record revealed the last Recreation Assessment completed for Resident #17 was 1/11/2021. In an interview on 7/10/24 at 11:37 AM, Resident #17 reported there were no activities staff after 4:00 PM and they had no activities on the weekends. He reported the facility had gotten rid of the activity aides and the director had left a few months ago because she could not do it all herself. The facility cannot afford more activity staff for after hours and weekends. Resident #40: Review of an Admission Record revealed Resident #40 was a female with pertinent diagnoses which included Alzheimer's disease, weakness, dementia, lack of coordination, muscle weakness, mild cognitive impairment, and repeated falls. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current Care Plan for Resident #40, revised on 7/10/2018, revealed the focus, .I am here for long term care and will be invited to participate in the activity program . with the intervention .Encourage me to try new groups of potential leisure .For 1:1 visits, I would enjoy: socializing, reminiscing, going outside, planting or taking care of plants, coloring supplies, magazines, cards, and going of a stroll in the facility .I am of Pentecostal religious affiliation and want to participate with religious activities at the facility. I enjoy attending communion services I do not have consent to go on community outings with activities .I do not like other residents barging into my room, others coming into my room uninvited, and being cold .I have indicated that the following items are important to me: choosing my own clothes, taking care of my personal belongings, choosing between a tub bath/shower/sponge bath/bed bath, choosing my own bedtime, having snacks between meals, having family and close friends involved in discussions about my care, listening the music I like, keeping up with the news, doing things with groups of people, participating independently, going outside when the weather is good, and participating in religious service and practices .I like spending time with my family, being in my room, and attending groups of potential leisure .I need the following equipment for leisure activities: my walker and encouragement to attend .I want pet visits .I will be invited to special events at the facility and in the community .I would like the daily chronicle delivered Monday - Friday .I would love the following for independent leisure: watching television, being in my room, socializing with others, snacking, going out with my family, people watching, and resting when I am feeling tired .I would prefer the following groups: games (bingos), arts and crafts, religious groups, outdoor activities, gardening, socialization, parties, socials, pet visits, and other groups that I choose .My life occupation was Nurses Aide .Things that comfort me: being in my room, being with my family, and doing my favorite activities . Review of medical record revealed the last Recreation Assessment completed for Resident #40 was 8/30/22. In an interview on 07/10/24 at 11:18 AM, Resident # 40 reported no one showed up to run Bingo so another resident ended up calling the numbers. She reported the activities staff left and the facility had not replaced her yet Resident #406: Review of an Admission Record revealed Resident #406 was a female with pertinent diagnoses which included spinal stenosis (space inside the bones of the spine get too small), wedge compression fracture of fifth lumbar vertebra (spinal compression fracture that occurs when the front of a vertebra collapses, but the back does not), wedge compression fracture of first lumbar vertebra, fusion of spine (surgical procedure that permanently joins two or more vertebra together so there is no movement between them), muscle weakness, difficulty in walking, unsteadiness on feet, and lack of coordination. Note: No mental health diagnoses currently in the electronic medical record. Review of current Care Plan for Resident #406, revealed no care plan for activities. Review of medical record for Resident #406 revealed no Recreation Assessment was completed by the Activities Department. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/10/24 on Hallway II, there were no activities that were posted on the scheduled activities on the corkboard by the nursing station were observed from 11:30 AM to 4:00 PM. Also noted no individualized activities throughout initial tour, unit observations, sampled resident observations, as well as individual non-sampled residents in their rooms/hallways were observed throughout the day. During an observation on 7/11/24 on Hallway II, there were no activities that were posted on the scheduled activities on the corkboard by the nursing station were observed from 10:0 AM to 2:00 PM. Also noted no individualized activities throughout initial tour, unit observations, sampled resident observations, as well as individual non-sampled residents in their rooms/hallways were observed throughout the day. The scheduled 7/12/24 activities at 2:30 PM, Courtyard/Ice Cream Social was canceled and no other activity put in place. The weather during the survey was 7/10/24: 76 degrees, 7/11/24: 83 degrees, 7/12/24: 84 degrees, 7/16/24: 80 degrees, and 7/17/84: 81 degrees. No outside activities took place during the survey. Also noted no individualized activities throughout initial tour, unit observations, sampled resident observations, as well as individual non-sampled residents in their rooms/hallways were observed throughout the day. Review of the activity calendars for May, June, and July 2024, revealed no outings scheduled. No activities after 4:00 PM and no scheduled activities on Saturdays. In an interview on 07/16/24 at 10:13 AM, Certified Nursing Assistant (CNA) P reported she had been filling in, while on light duty, as an activities aide. She reported she does not have attendance sheets and any activities she does with the residents she would go into the electronic medical record and document in the appropriate task section. CNA P reported she does not have any prior experience in activities as she worked as a CNA at the facility prior to being placed on light duty. In an interview on 07/17/24 at 10:27 AM, revealed, the facility not had an Activities Director since mid-May 2024. Administrator A reported the facility had been using a light duty certified nursing assistant (CNA) to complete activities for the residents. 38384 During an interview on 7/9/24 at 7:45 PM, Dietary Aide (DA) F stated, I worked in Activities for a while. The facility fired all the activities aides and kept the Activity Director. The facility had to do budget cutbacks and Activities got hit the hardest. The residents do not always have activities going on. It's sad because the residents like their activities. 47955 Resident #34 Review of an Admission Record revealed Resident #34 had pertinent diagnoses which included: dementia and major depressive disorder. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Minimum Data Set (MDS) assessment for Resident #34, with a reference date of 4/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #34 was moderately cognitively impaired. In an interview on 7/9/24 at 9:06 PM., Resident #34 stated .this place is a joke, as far as wanting something to do, we sit around and watch TV, they do not engage us in activities, and I never get one to one activity . Resident #34 reported that today's activities included communion, trivia, a sing a long, and bingo. Resident #34 reported that she asked to be reminded in time for bingo and when she was walking in the hallway to bingo the nurse told her bingo was over and she missed it. In an interview on 7/10/24 at 9:11 AM., Resident #34 reported that she was not going to any activities today, the TV in her room would be her activity today. Review of activity scheduled for 7/10/24 revealed .10:30 exercise, 1:30 pod cast, 2:30 Roku movie . Review of activity schedule for 7/11/24 revealed .10:30 Mad Libs, 1:30 bean bag toss, and 2:30 nail salon. In an interview on 7/11/24 at 10:16 AM., Unit Manager (UM) G reported that activities were provided by a certified nurse assistant (CNA) that was on light duty who is currently on vacation and not in the building this week. There were no other staff in the activity department. UM G reported that Resident #34 sleeps late and misses the first couple of activities scheduled in the day. UM G reported that Resident #34 spends time watching TV in her room, she likes to get her nails done, and she likes anything to do with dogs and/or one to one activity. UM G reported that the activity department was lacking with staff. Review of Recreation assessment dated [DATE] for Resident #34 revealed .activity pursuit patterns and preferences included reading/writing, spiritual/religious, trips/shopping, helping others, intergenerational, social/parties, pet visits, family/friends, baking/cooking, walking/wheeling outdoors, TV/movies, gardening/plants, talking/conversing . Review of care plan for Resident #34 revealed . will be invited to participate in the activity program .will participate independent leisure activities .I want pet visits . initiated 10/7/22 .I will be invited to special events . initiated 1/18/23 .I would prefer the following groups: .may be interested in playing bingo .initiated 10/7/22 with revision on 7/19/23 . going outside when the weather is nice . initiated on 10/7/22, revised on 3/29/24 . (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy, Activities implemented 1/1/24, revealed, .It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community .2. Activities will be designed with the intent to: a. Enhance the resident ' s sense of well-being, belonging, and usefulness .b. Create opportunities for each resident to have a meaningful life .c. Promote or enhance physical activity .d. Promote or enhance cognition .e. Promote or enhance emotional health .f. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence .g. Reflect resident ' s interests and age . h. Reflect cultural and religious interests of the residents .i. Reflect choices of the residents .8. Activities may include individual, small and large group activities as well as: a. Indoor and Outdoor Activities .b. Activities away from the facility .c. Religious Programs .d. Exercise Programs .e. Community Activities .f. Social Activities .g. In-Room Activities .h. Individualized Activities .i. Educational Programs .

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 41424 This citation pertains to intake: MI00142051 Based on observations, interview and record review, the facility failed to employ an Activity Director with the required qualifications resulting in the potential for unmet met psychosocial needs, feelings of boredom and a lack of person-centered activities. This citation has the potential to impact all 54 who reside in the facility. Findings include: In an interview on 07/16/24 at 10:13 AM, Certified Nursing Assistant (CNA) P reported she had been filling in, while on light duty, as an activities aide. She reported she does not have attendance sheets and any activities she does with the residents she would go into the electronic medical record and document in the appropriate task section. CNA P reported she does not have any prior experience in activities as she worked as a CNA at the facility prior to being placed on light duty. In an interview on 07/17/24 at 10:27 AM, revealed, the facility not had an Activities Director since mid-May 2024. Administrator A reported the facility had been using a light duty certified nursing assistant (CNA) to complete activities for the residents.

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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. 41424 This citation pertains to intake: MI00145580 Based on record review and interview, the facility failed to ensure residents recieved care in accordance with residents needs in 2 of 18 residents (Resident #27 and Resident #406) review for quality of care, resulting in Resident #27 not receiving appropriate assessment and treatment for a injury of unknown origin, and Resident #406 not attending follow up appts with surgeon following spinal fusion surgery. Findings include: Resident #27: Review of an Admission Record revealed Resident #27 was a male with pertinent diagnoses which included dementia, abnormal posture (added 5/25/24), pain in right hip (added 6/25/24), pain in right knee (added 6/18/24), stroke, polyneuropathy (damage/disease affecting peripheral nerves on both sides of the body featuring weakness, numbness, and burning pain), dysphagia (damage to the brain responsible for production and comprehension of speech), dorsalgia (back pain), muscle weakness, unsteadiness on feet, lack of coordination, paralysis, cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language) and fracture of right hip. Review of current Care Plan for Resident #27, revised on 3/9/23, revealed the focus, .I am at an increased risk for falls r/t (related to) orthostatic hypotension, muscle weakness, polyneuropathy, open area to left foot . with the intervention .Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance .Enable bar on right side of bed .Ensure that I am wearing non-skid footwear .I need a specialty wheelchair: Regr with pummel cushion and right-side lateral support, and left side arm rest to help reduce my risk for falls. A Device Assessment will be documented per policy to ensure proper use of such equipment (5/21/24) .PT/OT wheelchair /room evaluation .Reduce my risk for falling by cleaning up spills or clutter from my floor, provide glare-free lighting, accessible working call light, bed set at height deemed appropriate by PT/OT/Nurse (as applicable), my personal items within reach .Review information on past falls and attempt to determine cause of falls. Record possible root cause(s) and remove any potential causes as applicable .Staff to check and change resident and offer assistance to use toilet if awake .Fall Interventions: Offer to assist resident to get up in wheelchair for all meals. Bed against wall, enabler bar and fall mat to left side of bed (6/5/24) . Review of Nursing Progress Note dated 5/11/2024 at 7:00 PM, revealed, .Event occurred on 05/11/2024 at 6:50 PM. Resident fell out of wheelchair trying to propel self out of room into the hallway . Review of Nursing Progress Note dated 5/11/2024 at 11:19 PM, revealed, .Resident returned from (Local Hospital) ER department via stretcher by (Transport services). Head CT negative. Left eyebrow laceration glued together and covered with a bandaide. No new orders written, monitor laceration site for s/sx of infection . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Practitioner Progress Note dated 5/14/24 at 10:29 AM, revealed, .Pt is 67 y/o male with PMH significant for dementia, hx of CVA, anxiety, depression, HTN, HLD, hx of substance abuse and hemiparesis of L side. Pt is seen today by provider to follow up post ED visit for fall over the weekend. Nursing reports that patient fell out of his wheelchair trying to propel himself down the hallway. He did end up hitting his head and was evaluated in the ED. Pt did sustain a laceration to his left eye brow without need for sutures and head CT was negative for acute changes. Pt reports that he is feeling scared after the fall. He denies any pain or injuries as a result of the fall. I fell out of my wheelchair. He denies headache, neck pain, vision changes, or pain anywhere else. He continues to express that he feels scared as a result of the fall . Review of Nursing: Antigravity Team Note dated 5/15/2024 at 1:24 PM, revealed, .Root Cause(s) of Fall: IDT met and discussed residents most recent fall. Per resident's medical record the resident experienced a fall in the doorway of his room going into the hallway. Resident was unable to express what had happened however interview of staff notes that the resident will frequently use items in his environment to assist with propelling his w/c and it is felt that the resident had used the doorframe of his bedroom in an attempt to pull himself into the hallway ultimately pulling himself out of his w/c. Resident had on proper footwear, the call-light had not been activated due to the resident being in the doorway and the call-light being located on the bed. Assessment of the resident's w/c notes a standard w/c with a standard cushion. Review of resident's diagnoses note a diagnosis of embolic stroke with residual left sided weakness .New Interventions: - seating and positioning eval with noted addition of pummel cushion, right-side lateral support, left side arm rest . Review of Secure Conversation dated 6/14/24, revealed, .HI (first name of NP), resident has been complaining of pain on his right leg. No swelling or injury . Response: .Okay, thank you, please utilize prn (as needed) pain medicine. This is chronic . Review of Medication Administration Note dated 6/18/24 at 08:27 AM, .Give 2 tablets by mouth every 6 hours as needed for PRN (as needed) for pain .Resident requested for Right leg pain . Review of Medication Administration Note dated 6/18/24 at 12:53 PM, .Give 2 tablets by mouth every 6 hours as needed for PRN (as needed) for pain .PRN Administration was Ineffective . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Nursing Progress Note dated 6/18/24 at 9:10 PM, revealed, .Resident was slapping his right leg with his hand and yelling out throughout the morning. This nurse spoke with NP (nurse practitioner) in building and requested Right knee x-ray d/t (due to) resident nodding his head to feeling new and sharp pain in right thigh. X-ray resulted with -FINDINGS: Multiple views of the right knee show normal alignment without acute fractures or dislocations .Med staff notified of results and order Voltaren gel to Right knee TID (three times a day) for pain management. This nurse requested something different d/t (due to) resident rubbing leg constantly and being observed rubbing his face throughout the day. Med staff wished to continue with order. Resident declined lunch and dinner. Resident also declined any pain meds d/t him stating, they make me sleepy. This nurse spoke with med staff regarding his most recent return from hospital with no order for his Lyrica that he has been on in the past. Resident allowed this nurse to administer PRN Tylenol this morning with difficulty, with minimal effect. Resident allowed this nurse to apply Lidocaine patches to knee and thigh area of Right leg. This nurse assessed resident after dinner d/t CNA stating resident declined to eat dinner as well. Resident was observed Diaphoretic (sweating heavily), clammy, VS (vital signs) obtained with temp via forehead of 102.6, BP 161/84 P 108 O2 97% RA. Resident was able to be calmed down with reassurance by med staff. This nurse called on call med staff .spoke with her regarding the above and encouraged Voltaren gel be applied and then light weight pants so resident wouldn't touch his leg then his eye/face area. This nurse stated that resident is observed to be in pain r/t facial grimacing and moaning when med staff attempted to reposition him. Med staff ordered UA with C&S, Motrin and encourage ice packs as he allows. This nurse passed on the above to the oncoming nurse. Med staff stated, if he has any change in LOC (level of consciousness), increased pain or becomes non-verbal to call again and speak with on call . In an interview on 07/10/24 at 11:06 AM, Registered Nurse (RN) EE reported Resident #27 had a fall with a fracture of his right hip. Review of Incident Summary dated 6/25/24 at 5:20 PM, revealed, .NHA (Nursing Home Administrator) was notified at approximately 4:37pm that a resident has an intertrochanteric fracture (the area of the body where the hip and thigh meet) of unknown origin in his right hip. Resident was having complaints of pain, an x-ray was ordered, and a fracture was identified. Resident being sent out for further evaluation . Review of interview conducted by facility, revealed, .Spoke to (LPN TT) on 7/1/24 at approximately 1530. Per (LPN TT) she had been working with (CNA N) CENA on Tuesday 6/18/24 and (CNA N) reported that resident (Resident #27) had begun to complain of increased pain around the Thursday/Friday timeframe the week before and that he was experiencing even more pain today (6/18/24). Per (LPN TT), (CNA N) spoke to (NP YY) NP about this resident and (NP YY) assessed and ordered a knee x-ray and other pain interventions. When (LPN TT) was asked if the resident had had any abnormal occurrences or behaviors prior to this day (LPN TT) stated that she did not recall any but she did note that he began smacking his leg more and verbally complaining of increased pain on 6/18/24 . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 07/16/24 at 09:42 AM, Licensed Practical Nurse (LPN) TT reported Resident #27 had increased pain the last 4-5 days prior to 6/18/24, I went in there and he was hitting his leg. When she asked him about his pain, he indicated his leg hurt from his knee to his hip. LPN TT reported she reported the increase in pain to the nurse practitioner and the CNA reported to her as well. LPN TT reported she felt bad as he had a fractured hip and pain for a week and half at least and the staff were performing cares on him, turning him and attempting to get him up while he had a fractured hip. LPN TT reported he was getting aggressive with his behaviors with staff due to his increased pain. In an interview on 07/12/24 at 10:59 AM, CNA N reported she noticed his pain was more than his normal and reported to the nurse and reported it to the nurse practitioner too that from his knee to his hip was hurting him. CNA N reported she worked with the resident frequently and was familiar with him and she reported she could tell without asking him that he had increased pain by his response to the cares. CNA N reported she wanted him to be comfortable and his pain was not under control. CNA N reported now he had scheduled pain medications and the pain seem to be under better control. CNA N reported they just started the scheduled pain medications on Wednesday (7/10/24). Review of interview conducted by facility, revealed, .Spoke to (CNA N) on 6/28/24 at approximately 1430. Per (CNA N), (Resident #27) has a history of hitting his leg so this behavior was not abnormal for him however a couple of days before the x-ray was taken she had reported to the nurse that touching the residents leg resulted in him expressing a lot of pain. The following day (CNA N) reports that the resident continued to express the same thing however on this day the resident was insistent that he wanted to get up in his chair and they utilized the sit-to-stand to assist with the transfer and this was completed without concern. Per (CNA N), when she returned to work on Tuesday the resident was noted to be grinding his teeth and his facial expressions appeared as if the resident was experiencing increased pain. (CNA N) stated that she notified the NP, (NP YY), of her concern however the resident would not talk to her so (CNA N) asked the resident questions in the presence of (NP YY). (CNA N) asked the resident if his hip hurt and the resident nodded yes, she then asked if his knee hurt and he nodded yes and per (CNA N) she verified with (Resident #27) that he hurt from his hip to his knee and he nodded yes. Further interview of (CNA N) asking if there were any abnormal behaviors or occurrences since resident had returned from the hospital on 6/5/24 resulted in (CNA N) reporting that she had noted that the residents right foot kept dropping off the foot pedal which is new for this resident . Review of Practitioner Progress Notes dated 6/18/24 at 12:39 PM, revealed, .Pt is seen today by provider at the request of nursing. Nursing reports acute on chronic right knee and hip pain. Nursing reports chronic pain to his right thigh with worsening over the last day or so .Upon assessment, pt states that he is having right knee pain. He describes the right knee pain as new and sharp. He reports pain with palpation and movement. He denies recent injury, fall or hearing a popping noise recently. Nursing and nursing aide denies event of injury occurring . In an interview on 07/17/24 at 08:22 AM, Nurse Practitioner (NP) YY reported when she examined Resident #27 she did not perform palpation or assessment of the right hip area as he was seated in his broda chair. NP YY reported she had only performed range of motion on his right knee. When queried if the NP had staff lie the resident down in his bed for a more thorough examination she reported she did not have staff lie him down. NP YY reported she prescribed a lidocaine patch as well as re-prescribed Lyrica for Resident #25. Note: the medication was discontinued at the hospital and not re-prescribed when he returned from the hospital on 6/5/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of interview during investigation revealed, .Spoke to (RN EE) RN on 7/1/24 at approximately 1715 (5:15 PM) via phone .Per (RN EE) she can only recall that staff have been reporting that the resident is noting to be more resistant to turning and that he is grabbing at their arms, being belligerent and agitated when care is being provided and that this started a couple of weeks ago. Resident has been more receptive to taking his medication when (RN EE) notifies him that his pain medications are in with the other medications, and this has been a change in the residents behaviors over the last 2 weeks as well . Review of Nursing Progress Note dated 6/23/24 at 10:15 AM, revealed, .This nurse was notified in shift-to-shift nurse report @0920 a.m. that resident's right knee is very red, warm to the touch and swollen. This writer called the on-call provider number and spoke with (Nurse Practitioner name) NP. Reviewed residents' history and recent right knee xray results as negative. New order received and noted for a uric acid level to be drawn in the a.m. tomorrow, 6/24/24, and administer prn Ibuprofen . Review of eMar - Medication Administration Note dated 6/23/24 at 10:15 AM, revealed, .Behaviors noted r/t (related to) pain . Review of Practitioner Progress Note dated 6/24/24 at 12:48 PM, revealed, .Chief complaint: R knee pain duration unknown .HPI: Pt says his right knee has been painful for 6 months. Worse with movement. Staff reported knee is red, warm and swollen. No fever. No hx gout. Uric acid level was drawn.Review of Systems: was not completed Poor historian .Musculoskeletal: Poor Strength, keep R knee flexed. Tender to palpation. no effusion. not red or warm. He wouldn't let me straighten the knee. no edema or calf tenderness . Diagnosis: M25. 561 - Pain in right knee: I don't see deformity or effusion. Cont. Ibuprofen and voltaren gel and observe for now. consider xray and CBC/WSR. Uric acid pending (ordered by on call provider) . Review of Practitioner Progress Notes dated 6/25/24 at 12:04 PM, revealed, .Chief complaint: Ongoing pain . HPI: Pt is 67 y/o male with PMH significant for dementia, hx of CVA, anxiety, depression, HTN, HLD, hx of substance abuse and hemiparesis of L side. Pt is seen today by provider to f/u to right knee and right hip pain. Uric acid ordered by on call provider resulted as normal at 4. 3. Nursing states that pain continues but ibuprofen does help his pain. Time spent reviewing with IDT. Pt is awaiting sign on to hospice, family is working on ppwk for this transition of care. Right knee xray revealed mild osteo arthritis. Suspect arthritis of right hip as well .Musculoskeletal: Poor Strength, No gross deformities, pain with palpation of right hip .M25. 561 - Pain in right knee: -continue prn ibuprofen and Voltaren gel .New diagnoses: M25. 551 - Pain in right hip .Plan: -suspect osteoarthritis of R hip, obtain xray of hip to r/o fx or dislocation. Low suspicion -continue prn ibuprofen -Add voltaren gel to right hip . Review of Nursing Progress Note dated 6/25/24 at 4:45 PM, revealed, .Resident had been experiencing pain since 6/14/24. Multiple assessments and diagnostic testing completed and 6/25/24 order for right x-ray ordered and noted to be positive .Immediate intervention implemented: Res transfer status changed to total lift, family requested to hospice . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Practitioner Progress Note dated 6/26/24 at 11:49 AM, revealed, Pt is seen today by provider to f/u (follow up) to positive hips xray. Pt has been experiencing increased pain to right leg, hip xray completed on 6/25/24 resulting as positive for fx (fracture) .He does endorse pain to right hip .Procedure: Hip RT (right) 2v (views): Findings: Intertrochanteric fracture is demonstrated on the right. Some displacement is seen. No dislocation is noted .Impression: Mildly displaced intertrochanteric fracture on the right .Plan: pt not a surgical candidate, goal to optimize pain and comfort . In an interview on 07/16/24 at 11:08 AM, CNA FFF reported she went to help another CNA with Resident #25. CNA FFF reported the other CNA informed her to be careful as he was in a lot of pain and to go easy on him when they turn him and move him. CNA FFF reported Resident #25 told CNA GGG he was still in pain, and to tell the nurse he had to go to the hospital as the pain was unbearable. CNA FFF reported she believed CNA GGG reported the pain and Resident #25's request to go the hospital but she was not sure what happened after as she was on the other hallway. This writer attempted to contact CNA GGG but was unable to reach them. Review of interview conducted by facility, revealed, .Per (CNA GGG) she could recall working with (CNA FFF) and providing care for (Resident #27) and he was grabbing at her arm and expressing increased pain with movement. (CNA GGG) believed that this increase in behavior and verbalization of pain had occurred around the June 20th timeframe. Per (CNA GGG) when she had asked the resident to rate his pain from 1-10 he stated it was a 20 and he was expressing that he was wanting to go to the hospital. (CNA GGG) stated that it was at this time that she noted that the residents hip was kind of swollen and she reported this to (RN AA), the nurse with the long dark hair. (CNA GGG) stated that she could recall (RN AA) stating that she was aware and working on getting an x-ray . Review of the provided schedule for 6/20/24 revealed, CNA GGG, CNA FFF, and RN AA worked that day. In an interview 07/17/24 at 10:14 AM, UM W reported LPN TT was walking up the hallway and she appeared upset, she was upset the provider did not want to do an xray on Resident #27's upper leg/hip as she did not feel it was clinically necessary. UM W reported she went to speak to the provider and NP YY reported to her she felt there was nothing to clinically support that she had examined him and did not see anything that would warrant further unnecessary testing. UM W reported the NP indicated him slapping his leg was not unusual for him. UM W reported when she went to examine Resident #27, who was in bed at this time, she attempted to straighten his leg a little bit and he said No and started slapping his leg. UM W reported she had maybe lifted it a couple of inches. UM W reported she did not observe the NP perform her examination on Resident #27. In an interview on 07/17/24 at 10:20 AM, Unit Manager (UM) W reported pain assessments were completed on every shift in the medication administration record (MAR). UM W reviewed the documented pain levels in mid-June 2024 for Resident #27's and his pain levels were documented in the range of 4-5 on a scale from 0-10 with 10 being the worst. UM W reported when she went to assess Resident #27 originally, she was barely able to lift his right leg up 2 inches and Resident #25 yelled No and appeared to be in extreme pain. UM W reported with the expression of his pain she observed the documentation of a range of 4-5 appeared to not be correct unless he was not moved at all when assessed and he had had pain medication administered. Resident #406: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #406 was a female with pertinent diagnoses which included spinal stenosis (space inside the bones of the spine get too small), wedge compression fracture of fifth lumbar vertebra (spinal compression fracture that occurs when the front of a vertebra collapses, but the back does not), wedge compression fracture of first lumbar vertebra, fusion of spine (surgical procedure that permanently joins two or more vertebra together so there is no movement between them), muscle weakness, difficulty in walking, unsteadiness on feet, and lack of coordination. Review of Care Conference Summary dated 5/28/2024 at 2:59 PM, revealed, .Summary of Discussion: Initial care conference held to discuss admission, goals, and discharge planning. Resident admits into subacute rehabilitation post hospitalization at (Local Hospital) r/t spinal stenosis (L4-5) and compression fracture of L5. Resident is s/p orthopedic surgery and TOC states to follow up with OAM in 2 weeks . In an interview on 07/17/24 at 10:00 AM, Health Information Coordinator (HIC) M reported urogynecologist indicated they do not need to see Resident #406 with no explanation to this writer. HIC M was queried whether Resident #406 was scheduled to see a gastroenterologist and HIC M reported she was unsure and she would need to take a look and reported she was not scheduled to see the gastroenterologist. When queried whether Resident #406 was scheduled to see the spinal surgeon, HIC M reported she had contacted them on Monday (July 15, 2024) and today but had not returned a phone call back to her. When queried when the resident returned from the hospital, it was reported she returned on 7/2/24 and had been back in facility for approximately 2 weeks. When queried if it was HIC Ms responsibility to follow up on scheduling appointments for residents, she stated, Sure. When queried if Resident #406 had seen the spinal surgeon since her admission, HIC M reported she would have to refer to her notes and when she looked she did not have a note in reference to the appointment. When asked if she had scheduled an appointment for Resident #406 to see the spinal surgeon on 6/8/24 per the discharge instructions from the hospital she reported she did not schedule the appointment. In an interview on 07/17/24 at 12:01 PM, Therapy Director (TD) PP reported there was no order for changes to the spinal precautions and the staff should be following the precautions until otherwise changed by the spinal surgeon. The spinal surgeon would be the provider who would discontinue the precautions for Resident #406. In an interview on 07/17/24 at 12:17 PM, Director of Nursing (DON) B reported the HIC M would be the staff member to follow up and initiate the scheduling of appointments with the spinal surgeon and other discharge appointments.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake #MI00142938. Based on observation, interview and record review, the facility failed to provide care to prevent the development, consistent with professional standards of practice in 1 of 3 residents (Resident #405) reviewed for pressure injuries, resulting in the development of pressure ulcers on bilateral heels, and the potential for infection and overall deterioration in health status for all residents at risk for deterioration in skin integrity. Findings include: Resident #405 Review of an Admission Record revealed Resident #405 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: weakness, difficulty walking and prediabetes (higher than normal blood sugar levels). Review of a Minimum Data Set (MDS) assessment for Resident #405, with a reference date of 2/8/24 revealed that the resident was at risk for pressure ulcers, and had zero unhealed ulcers. Review of Resident #405's Hospital Records indicated that the resident had admitted on [DATE] for sepsis, and was found to have pressure wounds present both heels. Wound images reviewed revealed a large black blister covering the left heel and a smaller reddish/purple blister on the right heel. Review of Resident #405's Practitioner Note dated 2/21/24 revealed, .seen today by provider to evaluate reported heel pain. Rehab director reported that patient has been doing well with therapy, walking, and standing up until yesterday. She complained of pain to bilateral heels that interfered with her ability to stand and take steps. Pain was reported in bilateral heels. Pain reported on 2/20/24 was supposedly 10/10 and reported pain during therapy today is 6/10. Upon assessment She reports pain to both heels and reports that nothing makes it better. She states this as increasing over the last few days. Upon examination, there is blood blister present to left heel and excessive dryness to bilateral feet. There is no evidence of pressure injury to right heel .New diagnoses: Pressure induced deep tissue damage . Review of Resident #405's Physical Therapy Treatment Notes revealed a decline in participation related to complaints of bilateral foot pain. In an interview on 07/17/24 at 11:17 AM, Licensed Practical Nurse (LPN) Q reported that Resident #405 did not move herself when in bed or in her chair, but that she could stand with assistance. LPN Q reported that the resident frequently complained of being wet and soiled. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/17/24 at 11:55 AM, Director of Nursing (DON) B reported that Resident #405 did not have any wounds upon admission, per the skin assessment. DON B reported that a pressure wound on the left heel was first noted in the practitioners visit note on 2/21/24. DON B reported that the residents care plan included only general pressure interventions, and was not updated to reflect the resident's individual status. DON B reviewed the resident's order for unna boots (a compression dressing specifically to manage lower leg venous wounds, and not indicated for pressure wounds on the heels), and reported that it did not make sense for pressure ulcer treatment. Review of Resident #405's Admission Skin assessment dated [DATE] at 4:21 AM, indicated that all skin was intact, and there were no specific body locations listed in the assessment. Review of Resident #405's Weekly Skin Sweep dated 2/10/24 indicated no skin conditions, and intact skin. Review of Resident #405's Weekly Skin Sweep dated 2/19/24 indicated an open stage 2 pressure ulcer on the left buttock, measuring 2.6 cm x 2.1 cm. There was no documentation related to heels. Review of Resident #405's most recent Braden Assessment (risk level for pressure injuries) dated 2/10/24 indicated that the resident was at low risk for developing pressure injuries. Review of Resident #405's Care Plan revealed, .at risk for impaired skin integrity .dated initiated 2/3/34, revision on 2/9/24 .Interventions: .Assist me to moisturize my skin as needed, Assist me to position body with pillows/support devices, protect bony prominences .Assist me to turn &/or reposition .Assist/encourage me to elevate my heels off the bed . There was no documentation related to the identified pressure wounds. Review of Resident #405's Physician Orders/Treatment Administration Record revealed, Float heels off surfaces at all times every shift-Start Date 02/02/2024. There were 8 of 42 opportunities missed to document this treatment was in place. Review of Resident #405's Physician Orders/Treatment Administration Record revealed, Sacrum (tailbone): Cleanse with NS (normal saline), skin prep (protectant) all around. Apply foam dressing. every night shift every 3 day(s) -Start Date 02/02/2024 This wound was not documented on an assessment until 2/19/24. Review of Resident #405's Physician Orders/Treatment Administration Record revealed,skin prep to bilateral heals every day every night shift for pressure injury -Start Date 02/22/2024 .patient to where (sic) unna boots while in bed. every shift for pressure injury-Start Date 02/21/2024.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 This citation pertains to MI00145581. Based on interview and record review, the facility failed to prevent the elopement and ensure the safety in 1 of 2 residents (Resident #305) reviewed for elopements, resulting in an Immediate Jeopardy when on 6/13/2024 at approximately 8:34 PM, Resident #305, who was cognitively impaired exited the facility by facility staff when he was mistaken for a visitor and traveled on foot along a busy road with a speed limit of 40 miles per hour looking for his sister. Resident #305 was found by community members who returned him to facility staff who were searching for him and they brought him back to the facility. This deficient practice placed Resident #305 and other residents identified as at risk for elopement at risk for serious harm, injury, and/or death. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R305 admitted to the facility on [DATE] with diagnoses of mild cognitive impairment and psychomotor agitation (unintentional and purposeless motions and restlessness sometimes accompanied by emotional distress). Brief Interview for Mental Status (BIMS) reflected a score of 5 out of 15 which indicated R305 was severely cognitively impaired (00 to 07 is severe cognitive impairment). Review of the Elopement and Wandering Residents Policy with an Implementation Date of 3/2008 and a Review/Revision Date of 5/2024 revealed Policy Explanation and Compliance Guidelines: 5. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 6. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering: a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay. Review of Agency Licensed Practical Nurse (LPN) II's progress noted dated 6/13/2024 after R305's elopement revealed, At 8:48pm the writer was alerted by staff that the resident mentioned was not in his room and had been let outside of the building around 30 minutes prior. He was seen going north bound in the parking lot towards Forest Hill Ave. The elopement protocol was initiated and the writer vocalized to the staff that she was going to start heading north and go east down Forest Hill Ave while the other staff headed west in search of said resident. Meanwhile the remaining staff accounted for all other residents in the building and did and all clear to ensure that (R305) was the only one unaccounted for. While heading eastbound on forest hill ave the writer spotted the resident on the corner of [NAME] Dr SE and Forest Hill Ave with two individuals. The writer approached the group and identified herself. The individuals stated that he was confused and tried to enter their home. He was able to call his sister from the male's cell phone and the two parties agreed to meet at Forest Hills Food at 9pm. They were heading there when I approached them. The writer thanked them for their help and both the writer and resident returned to the facility. Once at the facility the writer accessed the resident for injuries and pain. The resident denied any pain and reported being hot and tired. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an observation on 7/11/2024 at 4:15 PM, noted the route that R305 took was from the parking lot at the facility going north and uphill to main road which was a busy road with a speed limit of 40 mph. R305 then headed East to where the sidewalk ended approximately 0.25 miles down. R305 walked down to the road approximately 0.6 miles away from the facility unsupervised until community members found him. During an interview on 7/12/2024 at 11:48 AM, Licensed Practical Nurse (LPN) DD stated that on 6/13/2024 she stayed over to complete Relias training (educational training) since she was still in orientation. LPN DD said that she clocked out at 8:34 PM and was getting ready to go out the door when staff sitting at the nurse's station asked her to let 2 gentlemen out of the facility. She stated that she knew one was a resident who was going out to smoke and the other one she didn't know (R305) and assumed he was okay to let out since staff told her to let him out. During an interview on 7/12/2024 at 10:58 AM, Certified Nursing Assistant (CNA) D stated that she came in on 6/13/2024 around 7 PM and around 8:15/8:30 PM, R305 approached her at the nurses' station and asked her to call his sister because he wanted to know if she was coming in later that night. CNA D said she called R305's sister and his sister said she wasn't coming in that night and would be in the next morning. CNA D stated that R305 walked back to his room and that was the last time she saw him. Then, approximately 15 to 20 minutes later a code search was implemented for R305. During an interview on 7/12/2024 at 2:39 PM, CNA BB stated on 6/13/2024 she was doing her Relias training at the nurses' station when R305 went up to her and said he needed to go to the hospital. CNA BB said she thought R305 was a visitor and was going to see family at the hospital. She noticed at that time that LPN DD was leaving and asked if she was leaving and then saw R305 go out with her. During an interview on 7/12/2024 at 3:10 PM, CNA E stated on 6/13/2024 she was doing her Relias training at the nurses' station Relias with CNA BB when she saw LPN DD and a man (R305) leaving with her. CNA E said that she didn't know he was a resident until 30 minutes later when she found out he was a resident and was missing. CNA E stated that R305 was missing for 20 to 30 minutes before anyone realized he was missing. Review of the Admission/Readmission assessment dated [DATE] under Section D. Safety/Fall Risk revealed that R305 had a history of falls and fell in the last month prior to admission at the facility. Under Section E. Elopement Risk Assessment showed that R305 didn't have any elopement attempts at previous residence, didn't have a history of wandering at previous residence and didn't have 1 or more attempts to elope in the last 90 days. Under 6. Behavioral Symptoms, a. Intrudes into other resident rooms. Has delusions, such as need to go out and [NAME] the lawn; Expressions of confusion, Fear, Disorientation; Short attention span; Excessive motor activity; Wanders was checked yes. Under 7. Other Diagnosis Affecting Cognitive Status or Memory, a. Dementia, Depression, Anxiety, Delusional Disorder, mental Illness, Closed Head Injury, Other was checked yes. Under 9. Elopement Risk a. Is the Resident At Risk for Elopement? was checked no. Review of the Elopement Risk assessment dated [DATE] after R305 eloped under 1. History of Wandering and/or Elopement revealed d. Resident has made one (1) or more attempts to elope from either previous or current residence in the last 90 days was checked yes. Under 9. Elopement Risk a. Based upon the assessment above, the resident is determined to be at risk for elopement? was checked yes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Inpatient Bedside Nurse Warm Handover to Subacute Nurse form that is completed by the nurse for all new admissions prior to admission from discharging facility revealed a section at the bottom titled safety risks. During an interview on 7/12/2024 at 10:04 AM, Registered Nurse (RN) T stated that prior to admission a report is received from the hospital and they fill out the Inpatient Bedside Nurse Warm Handover to Subacute Nurse form to make sure all information is captured prior to admission. RN T said that elopement risk wasn't brought up with R305 from the hospital and hasn't been brought up since she has worked at the facility or with any new admits prior to R305 eloping. During an interview on 7/12/2024 at 2:36 PM, Director of Nursing B stated that she wasn't sure if she could find the Inpatient Bedside Nurse Warm Handover to Subacute Nurse form for R305. DON B also stated that they had wander guards available in the facility prior to 6/13/2024 if they needed to put one on a resident. Review of Practitioner Progress notes dated 6/14/2024 completed by Nurse Practitioner (NP) YY revealed, Patient is seen today by provider following admission to facility. Medications, labs, nursing notes, and plan of care reviewed with patient and nursing. Extensive time spent reviewing patient and plan of care with IDT and nursing. Pt arrived to facility on 6/13/24 and shortly there after eloped from the facility. Pt was found and returned to the facility unharmed. Review of hospital paperwork showed elopement behaviors upon initial arrival to hospital, suspected to be d/t change (due to) of environment, but did not continue throughout hospital stay. During an interview on 7/16/2024 at 9:49 AM, NP YY stated that the day after R305 eloped they had a IDT (interdisciplinary team) and the team was looking into R305's elopement and someone found information about his elopement behaviors at the hospital. NP YY said that elopement risk wasn't on the referral from the hospital since it happened initially at the hospital and not afterwards otherwise, they would have discussed the change of environment at the facility and put interventions into place. During an interview on 7/12/2024 at 2:36 PM, Nursing Home Administrator (NHA) A stated that Social Worker Advocate (SWA) C was the only one in the facility that has access to EPIC (hospital electronic medical record). NHA A stated that SWA C was able to find R305's hospital notes in EPIC regarding his elopement behaviors at the hospital. During an interview on 7/16/2024 at 10:03 A, SWA C stated that she found R305's hospital notes through EPIC the day after R305's elopement since they were discussing R305 at IDT and she started digging into his notes and found that he had elopement behaviors. SWA C said that she looks at EPIC with discharge planning and for her profession only. SWA C stated that the facility has an admissions team off site that gives information to nursing and should be doing a thorough review prior to admitting a resident. On 7/12/2024 at 9:18 AM, NHA A was notified of an Immediate Jeopardy that began on 6/13/2024 when R305 exited the facility when he was mistaken for a visitor. On 7/12/2024, this surveyor verified the facility completed the following to remove the Immediate Jeopardy. The Abatement was accepted on 7/12/2024 at 4:04 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. R305 was placed on a 1:1 supervision upon return to the facility. - 6/13/24 2. Employee placed on administrative leave. - 6/13/24. Upon return from administrative leave, this staff member was provided 1:1 education on the elopements and wandering residents policy. 3. All newly admitted residents that have a guardian or activated DPOA were identified as being at risk for this deficient practice. - 6/13/24 4. All resident's elopement risk assessments reviewed and any identified elopement risks residents that were currently residing in the facility were reviewed to ensure appropriate interventions were in place. - 6/13/24 5. External door checks were completed by the Administrator. - 6/13/24 6. All-staff re-education was initiated. - 6/13/24 7. On 6/13/24, education was completed to all-staff on elopement and wandering residents policy was initiated; any facility staff member and agency staff member who did not receive education by 6/13/24 will receive education prior to the start of their next shift. All facility staff and agency staff who were present at the time of the incident were immediately educated. As of 6/13/24, all facility staff and agency staff have completed the necessary required education. Education is completed for all new hires prior to their next shift. 8. Administrator/designee audited daily door alarms checks as of 6/13/2024 to ensure proper functioning of the egress and wander guard system. The audits have been conducted weekly for four weeks and then monthly for two months. 9. Elopement drill has been completed on 06/26/2024 and 06/17/2024. 10. Director of Nursing/designee audited new admission elopement risk assessments as of 6/13/2024 to ensure proper interventions have been placed if a resident triggers as an elopement risk and to verify a wander guard is in place for the first 7-days if the resident has a legal decision maker. The audit has been conducted weekly for four weeks and then monthly for two months. During an interview on 7/12/2024 at 1:56 PM, NHA A stated that door alarm checks are supposed to be done daily by maintenance and someone is delegated on weekends/holidays. While reviewing the daily door alarm checks it was noticed that several days were missed and not checked and NHA A said that he audits the door alarm checks weekly and knows there are holes on the sheets. NHA A stated that someone is delegated on weekends and holidays to do door alarm checks, usually a housekeeper who failed to do it and maintenance failed to check and make sure he handed it down to the housekeeper. NHA A was unable to find sheets for the missing days in the maintenance office. Although the immediate jeopardy was removed on 7/12/2024, the facility remained out of compliance with a scope of isolated and severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to daily door alarm checks not being completed and sustained compliance had not yet been verified by the state agency.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 This citation pertains to intake MI00143238 and intake MI00142051 Based on observation, interview, and record review the facility failed to ensure sufficient staffing to meet the needs of 5 (Resident #2, Resident #15, Resident #17, Resident #304, and Resident #406) of 18 residents and 12 resident council meeting members reviewed for staffing, resulting in the potential for residents to not maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #2 Review of an Admission Record revealed Resident #2 had pertinent diagnoses which included: acquired absence of the right leg above the knee, acquired absence of the left leg above the knee, and paraplegia. Review of a Minimum Data Set (MDS) assessment for Resident #2, with a reference date of 6/14/2024 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #2 was cognitively intact. In an interview on 7/9/24 at 7:18 PM., Resident #2 reported that it could take an hour or more for the staff to answer his call light. In an interview on 7/16/24 at 11:32 AM., Resident #2 reported that yesterday he did not get his shower. Resident #2 reported that the CNA came to him and told him she was not going to be able to get his shower done because they were short staffed. Resident #2 reported that he did use his call light to remind the staff it was his shower day and that it took an hour or hour and a half for the staff to respond to his call light. Resident #15 Review of an Admission Record revealed Resident #15 had pertinent diagnoses which included: muscle weakness, dependence on wheelchair, morbid (severe) obesity. Review of a Minimum Data Set (MDS) assessment for Resident #15, with a reference date of 6/8/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #15 was cognitively intact. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/10/24 at 10:45 AM., Resident #15 reported that she had sat in a wet and soiled brief on more than one occasion for one or two hours waiting for assistance for incontinent care and to have her brief changed. Resident #15 reported that she has had to wait for over an hour for her call light to be answered. Resident #15 reported that having to wait long time for her call light to be answered makes her angry. Resident #15 reported that she has taken notes on her cell phone of specific dates that she had to wait extended time for her call light to be answered. Resident #15 reported that on March 8, 2024, and April 18, 2024, she waited for 2 hours for her call light to be answered when she needed incontinent care for a bowel movement. Resident #15 reported that would be acceptable to wait 15 minutes to have incontinence care done but an hour or two was too long to wait. In an interview on 7/11/24 at 1:44 PM., Resident #15 reported that last night during night shift she had to wait over an hour for her call light to be answered. During an observation on 7/12/24 at 1:40 PM., Resident #15's call light was noted to be on. In an interview on 7/12/24 at 1:50 PM., this surveyor entered Resident #15's room after knocking and with permission and Resident #15 reported that she had turned on her call light requesting assistance with incontinence care. Resident #15 reported that her call light had been on for about 10 minutes. During an observation on 7/12/24 at 1:54 PM., Resident #15's call light was answered, and care was provide as requested by Resident #15. In an interview on 7/16/24 at 11:22 AM., Resident #15 reported that last night she turned on her call light requesting incontinence care for a bowel movement at 12:15 AM and she waited over an hour for her call light to be answered. Resident #15 reported that the call light was answered at 1:20 AM. Resident #17 Review of an Admission Record revealed Resident #17 had pertinent diagnoses which included: muscle weakness, lack of coordination, shortness of breath, and morbid (severe) obesity. Review of a Minimum Data Set (MDS) assessment for Resident #17, with a reference date of 4/25/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #17 was cognitively intact. During a resident council meeting on 7/11/24 at 1:30 in the main dining room with 12 residents that attended, it was reported by Resident #15 that call light wait times have been up to and over an hour before the light was answered. Resident #17 reported that call light wait times have taken up to and over an hour on the night shift for staff to respond. Review of Resident Council Minutes dated 1/24/24 revealed .nursing staff don't always come right back on second and third shift . (call light) waits are long especially if there is a split assignment . Review of Resident Council Minutes dated 2/28/24 revealed . call light times can be long . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident Council Minutes dated 3/27/24 revealed . call lights . sometimes it takes a while for them to answer depending on who is working .third shift is horrible, after 11 pm you can never get someone .hit and miss depending on the shift and if there is a split .3rd shift after 11 pm is hard to get someone, they are always sitting at the desk and on their phones .Ratio of staff addressed to administration with response that administration is working on ratios, four new staff joined the team today . Review of Resident Council Minutes dated 4/24/24 revealed . call lights not being answered . hit or miss 10-12 pm . Review of Resident Council Minutes dated 5/22/24 revealed .call lights are getting faster . In an interview on 7/9/24 at 7:30 PM., Certified Nurse Assistant (CNA) D CNA I and CNA O reported that typical staffing is two CNAs for the B side. CNA D reported that her normal assignment was about 14 residents for the shift and that there were maybe 27 residents on B side. CNA D reported that there was not enough staff to do what the residents need us to do for them. In an interview on 7/12/24 at 10:41 AM., Director of Nursing (DON) B reported that nurses work 12-hour shift and CNAs work both 8 hour and 12-hour shifts. DON B reported that there are never less than 2 nurses scheduled for a shift day or night shift and that there should be 4 CNAs on day and second shift and 3 CNAs on night shift. DON B reported that she staffed as she saw needed. DON B reported that the residents on the 100 and 200 halls were long term care (LTC) residents with less acute needs than the residents on the rehab unit the 300 and 400 halls. DON B reported that the census fluctuated, and acuity levels of the residents changed, and the staffing would reflect those changes. In an interview on 7/12/24 at 10:50 AM., Scheduler (S) J reported that yesterday 7/11/24 there was an unfilled role for CNA. S J reported that a CNA from night shift was mandated to stay over 4 hours. S J reported that she was unable to find a replacement CNA for the 11 am to 3 pm time. S J reported that there was no coverage by a CNA during that time. S J reported that nursing managers assisted with meals and resident care. In an interview on 7/12/24 at 10:55 AM., DON B reported that she assisted with turning dependent residents on the B side unit during the time of 11 am and 3 pm on 7/11/24 because there were only 3 CNAs working at the time. DON B reported that her expectation when there was not sufficient staff on the floor was that the nurse managers would work on the floor in the roles that were needed. Review of a word document provided by DON B that included all residents residing in the facility transfer status as of the date of 7/17/24 revealed the facility had a census of 53 residents and of those residents 28 resident required the assistance of 2 staff member to transfer. During a resident council meeting on 7/11/24 at 1:30 PM., a resident that attended reported that mail was not being delivered on Saturdays. During an observation a bundle of mail was noted outside of the nursing home administrator's (NHA) office. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/11/24 at 3:29 PM., Regional Activity Director (RAD) BBB reported that the activity director should distribute the resident's mail and that the social services advocate should distribute mail as well. In an interview on 7/11/24 at 3:36 PM., Social Services Advocate (SSA) C reported that the mail goes to the NHA A who then shares it with the Business Office Manager (BOM) AAA. In an interview on 7/11/24 at 3:41 PM., BOM AAA reported that she distributed the mail to residents Monday through Friday. BOM AAA reported that during the weekend the mail was held until Monday because there was on one in the activity department that was here to distribute the mail on Saturday. In an interview on 7/12/24 at 3:45 PM., NHA A reported that mail was distributed on Saturdays by a dietary aide that was scheduled to work in the kitchen every weekend. During a resident council meeting on 7/11/24 at 1:30 PM., several residents that attended reported that there were no outing activities scheduled. A resident that attendance reported that there was no activity director at this time, and there was no one who could drive the bus for outings. In an observation and interview on 7/11/24 at 3:29 PM., RAD BBB was noted to be conducting an activity in the activity room. RAD BBB' reported that she was helping until the new director started in the position. RAD BBB reported that she was here one day last week and 4 days this week. RAD BBB reported that she helped with completing recreational assessments for new admission residents if there was no one to complete them. RAD BBB reported that there were no activity aides, and there was a CNA who was on light duty that helped to provide scheduled activities. RAD BBB reported that this light duty CNA was not working this week. 48637 Resident #304 (R304) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R304 admitted to the facility on [DATE] with diagnoses of anxiety, depression, and dementia. Brief Interview for Mental Status (BIMS) reflected a score of 14 out of 15 which indicated R304 was cognitively intact (13 to 15 cognitively intact). During an interview on 7/09/2024 at 8:17 PM, R304 stated that she was left in urine for about an hour that day. She was teary eyed while talking about it and said it didn't make her feel good. R304 said that she asked to get up several times and it took them about an hour to get to her up. R304 stated that she knows lying in urine isn't good for her skin and she was worried about developing pressure ulcers on her bottom. 38384 During an interview on 7/9/24 at 7:45 PM, Dietary Aide (DA) F stated, I worked in Activities for a while. The facility fired all the activities aides and kept the Activity Director. The facility had to do budget cutbacks and Activities got hit the hardest. The residents do not always have activities going on. It's sad because the residents like their activities. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/10/24 at 10:53 AM, Certified Nursing Assistant (CNA) N reported she had 15 residents assigned to her on hallway II. There were three persons for hoyer transfers. CNA N reported she tried to get the showers done for the residents on the hallway, depends on the day and what was happening on the hallway. CNA N reported the showers were documented in the medical record and on a skin monitoring form. She reported she tried to get everything done for the resident and still try to get out on time. CNA N reported most days there were 3 CNAs scheduled for the building. She reported she was by herself this week on the hallway. In an interview on 07/11/24 at 01:19 PM, Cerfified Nursing Assistant (CNA) FF reported she had worked last night to help out and as nobody came in to work. CNA FF reported she had Rooms: 20-37. CNA FF reported the lunch come first to the back hallway (hallway III) and by the time that gets done, she comes over here (hallway II) for the lunch. The building was split between the three of them as the other CNA who worked last night could only stay so long over and she had to go home. In an interview on 07/11/24 at 01:46 PM, Unit Manager (UM) W reported she had informed the staffing person first thing this morning there was only 3 aides on today. She reported she had informed the Administrator A at approximately 10:30 AM as the overnight CNA would be leaving at 11:00 AM and the floor would be left at 3 CNAs for a census of 54 residents. UM W reported the facility did not use agency staff for the CNAs only for the nurses. In an interview on 07/11/24 at 01:51 PM, Certified Nursing Assistant (CNA) V reported she had the front half of hallway II and the whole other hallway (hallway I). Note: Rooms 1-19 single occupancy rooms. In an interview on 07/16/24 at 02:19 PM, Unit Manager (UM) W reported the acuity on the other side (rehab and long term care) we had talked to some of the nurses about the lack of documentation in the medical records. With the amount of admissions and discharges it was hard for the nurses. UM W reported she thought the nurses want to do a good job, she thought but it was just hard to do with all that had to be done. UM W reported the agency nurses seem to just be passing medications, there was no staff development person to educate staff and it would be good to have a staff development person as it was hard to educate all the staff and to babysit staff to ensure the staff were doing what they were supposed to do. UM W reported the staffing was determined by the numbers and no on the acuity of the units. Review of Facility assessment dated [DATE], revealed, .Resident Acuity Affecting Nurse Aides: 32 residents provided assistance with dressing, 42 residents provided assistance with bathing, 11 residents provided assistance with eating, 45 residents provided assistance with toileting, and 16 residents provided assistance with mobility . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Fundamentals of Nursing ([NAME] and [NAME]) 8th edition revealed: Burnout is the condition that occurs when perceived demands outweigh perceived resources ([NAME] et al., 2013a). It is a state of physical and mental exhaustion that often affects health care providers because of the nature of their work environment. Over time, giving of oneself in often intense caring environments sometimes results in emotional exhaustion, leaving a nurse feeling irritable, restless, and unable to focus and engage with patients ([NAME] et al., 2013b) .Compassion fatigue impacts the health and wellness of nurses and the quality of care provided to patients .When a nurse experiences ongoing stressful patient relationships, he or she often disengages ([NAME] et al., 2011) .It is not uncommon for nurses who are experiencing compassion fatigue to become angry or cynical and have difficulty relating with patients and co-workers (Young et al., 2011). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 1671-1672). Elsevier Health Sciences. Kindle Edition.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47955 Based on interview and record review the facility failed to ensure the nursing staff was evaluated for appropriate competencies and skill sets resulting in the potential for residents of the facility to be unable to maintain the highest practicable physical, mental, and psychosocial well-being and the potential for decreased resident safety for all residents who resided in the facility. Findings include: In an interview on 7/12/24 at 10:41 AM., Director of Nursing (DON) B reported that she had provided a competency fair for nursing employees last month and that it was poorly attended. DON B reported that she did not make the competency fair attendance mandatory. DON B reported that a staff development role did not exist, and the responsibilities of that role fell to the director of nursing. Review of untitled spreadsheet document on 7/17/24 provided by DON B revealed columns that included employee names, position, department date, hire date, initial competency, annual competency 2023 and annual competency 2024. The untiled document included a total of 50 employee names, all from the nursing department. The final column that was titled annual competency 2024 had recorded 12 of 50 competencies completed on 6/5/2024. The final column that was titled annual competency 2024 had recorded overdue, due on a date prior to review date, or was blank for 38 of 50 employees. In an interview on 7/16/24 at 1:57 PM., this surveyor asked DON B if the untitled spreadsheet she provide for staff competencies was interpreted that the blank boxes in the annual competency 2024 column indicated that the competency evaluations were incomplete and DON B reported that the interpretation of the blank boxes in the annual competency 2024 column did indicate that the competencies were not complete. In an interview on 7/17/24 at 9:26 AM., Nursing Home Administrator (NHA) A reported that competencies and performance reviews were to be completed annually. NHA A reported that human resources individual provided a list to department head via email with expected completion dates and the expectation was that department heads completed the performance evaluations and annual competency reviews. NHA A reported that nursing staff competency evaluations were noted to be overdue, missing, and incomplete. In an interview on 7/17/24 at 9:23 AM., NHA A reported that the new hire competency evaluations were to be completed on day 2 of new hire orientation. NHA A reported that new hire orientation day 2 was to be done in person at the facility. NHA A reported that day 2 orientation was not being completed as expected by the facility staff and new hire competency evaluations were not being completed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 47955 Based on interview and record review the facility failed to ensure 12 hours of in-service education was completed in 5 reviewed certified nurse assistants (CNA) (CNA H, CNA I, CNA O, CNA P and CNA ZZ) of 5 resulting in the potential for performance concerns and decreased resident safety for all residents who resided in the facility. Findings include: Review of Education Spreadsheet 2024 provided by Director of Nursing (DON) B revealed categories of education included abuse, compliance, infection control, QAPI (quality assurance, performance improvement), resident rights, and communication, total of 44 nursing department employees, the date that each education was assigned, and the completion date for each employee. The Education Spreadsheet 2024 revealed no recorded completion date for 10 employees under abuse, no recorded completion date for 15 employees under compliance, no recorded date of completion for 12 employees under infection control, no recorded completion date for 23 employees under QAPI, no recorded completion date for 18 employees under resident rights, and no recorded completion date for 13 employees under communication. Review of Course Completion History dated 7/12/24 provided by DON B revealed 5 Certified Nurse Assistants (CNA) of 5 (CNA H, CNA I, CNA O CNA P, CNA ZZ) had not completed the assigned required training categories. CNA H had not completed any trainings as assigned. CNA I completed 4 of 6 assigned required trainings. CNA O had completed 1 of 6 assigned required trainings. CNA P completed 2 of 5 assigned required trainings. CNA ZZ had not completed any trainings as assigned. In an interview on 7/16/24 at 1:56 PM., DON B reported that CNA 12-hour in-services that were assigned were not completed. In an interview on 7/17/24 at 9:21 AM., DON B reported that annual training was assigned upon hire and then yearly. DON B reported that there was no staff member in the role of staff development, and no one was tracking CNA 12-hour in-service completion. In an interview on 7/17/24 at 9:23 AM., Nursing Home Administrator (NHA) A reported that the facility assigned training was computer based and included training/topics that would count towards CNA 12-hour in-service requirements. NHA A reported that these trainings were to be completed by the facility on day 2 of new hire orientation and then assigned yearly. NHA A reported that day 2 orientation was not being completed as expected by the facility staff and the trainings were not being completed by newly hired CNAs. In an interview on 7/17/24 at 9:30 AM., DON B reported that an email was sent to employees when a training was assigned and available to be completed. DON B reported that she had received emails notifying her that she had trainings to complete. In an interview on 7/17/24 at 10:03 AM., CNA X reported that she has not done any required in-services that were assigned, and she was notified by email that she had courses to complete. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 7/17/24 at 12:16 PM., CNA ZZ reported that she has not done any required trainings that were assigned, and she was notified by email that she had courses to complete.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 This citation pertains to Intake MI00145186 Based on interview, and record review, the facility failed to ensure residents were free from significant medication errors in 1 of 1 resident (R404) reviewed for medication administration resulting in an Immediate Jeopardy when, beginning on 5/23/2024 at approximately 7:46 AM, R404 was administered another residents medications and was found unresponsive. Resident #404 was hospitalized in the ICU (Intensive Care Unit - provides care and life support for acutely ill/injured patients) on BiPAP (Bilevel Positive Airway Pressure - a device that helps with breathing) with a Narcan drip (a medication used to treat an opioid overdose) and the likelihood of further life-threatening deterioration in his medical condition. Findings include: Review of facility policy, Medication Administration-General Guidelines dated June 2019, revealed, Medications are administered as prescribed in accordance with good nursing principles and practices .The Five Rights (Right Resident, Right Drug, Right Dose, Right Route, and Right Time) are applied for each medication being administered .12. Medications supplied for one resident are never administered to another resident . Review of Licensed Practical Nurse (LPN) WW written statement by proxy of Nursing Home Administrator (NHA) A dated 5/23/24 at 1030 AM, indicated she had dispensed (prepped) and administered morning medications to R404 at approximately 7:30 AM. The resident had been in the Garden room and was noted to be tired with his head on a tray table. At approximately 7:45 AM LPN WW prepped R7's medications and handed the cup of medications to LPN XX and told him the room number. LPN WW stated she was unclear if she had given LPN XX the wrong room number or if he had heard her wrong but at approximately 8:35 AM R7 reported to her that he had not received his 8:00 AM medications. LPN WW informed R7 that he had received his medications, however, R7 continued to insist that he had not. LPN WW asked LPN XX if he had administered R7's to him and LPN XX stated, A bigger guy? LPN WW stated, No, that is not (R7). The medication error was reported to the former Unit Manager/Clinical Care Coordinator (UM/CCC) VV who gave direction to complete an incident report with exact times and to notify the Medical Director (MD). Nurse Practitioner (NP responded with orders to monitor R404's vital signs (VS) every 6 hours x (for) 24 hours. Review of LPN XX written statement by proxy of NHA A dated 5/23/24 at approximately 11:45 AM, indicated he offered to run the medications for LPN WW. When LPN WW handed him the medications for R7 she told him These are for (R7's first name which was the same first name as R404) and when he asked for a room number, LPN WW responded room [ROOM NUMBER]. LPN XX stated when he entered room [ROOM NUMBER], he spoke to a resident and asked if he was the man with the first name he was given. The resident responded to the name. The LPN then informed R404 that he had his medications, and the resident did not dispute taking them. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of LPN WW written statement by proxy of NHA A dated 5/23/24 at 2:27 PM, gave further clarification on the incident that happened earlier in the day involving R404 and other residents. LPN WW indicated she had prepped medications for three residents with LPN XX administering them. LPN WW stated LPN XX had administered medications to the remainder of the residents on the 300 Hall. LPN WW stated all residents on the 400 Hall she had prepped medications and administered with LPN XX. LPN WW then stated immediately upon identifying the medication error of R404, she and LPN XX the facility stopped having her prepping medications and LPN XX administering them. Review of LPN XX written statement by proxy of NHA A dated 5/29/24 4:01 PM indicated the LPN did not remember if R404 had already received his medications and that he had not given the resident his medications twice. The LPN verified he had shown LPN WW which resident he had given R7's to. Review of LPN WW written statement by proxy of NHA A dated 5/29/24 at 4:06 PM, indicated she verified only LPN XX had administered medications once to R404 She also stated she and LPN XX did walk to R404's room in order to show her which resident he gave medications to. R404 According to the Minimum Data Set (MDS), dated [DATE], R404 scored 15/15 (cognitively intact) on his BIMS (Brief Interview Mental Status). Review of R404's Medication Administration Record/Treatment Administration Record (MAR/TAR) dated 5/23/24 at 8:00 AM indicated Licensed Practical Nurse (LPN) WW documented administration of: -allopurinol 100 mg 1 tablet by mouth for gout -glipizide ER (extended release) 10 mg 1 tablet by mouth -lisinopril-hydrochlorothiazide 10-12.5 mg 1 tablet by mouth for hypertension -multivitamin men 50+ 1 tablet by mouth for supplement -apixaban (blood thinner) 5 mg by mouth for Afib -metformin HCL 1000 mg 1 tablet my mouth for diabetes This indicated Resident #404 had received his ordered morning medications. R7 According to the Minimum Data Set (MDS), dated [DATE], R7 scored 13 /15 (cognitively intact) on his BIMS (Brief Interview Mental Status). Review of R7's MAR/TAR dated 5/23/24 indicated at 8:00 AM, LPN WW indicated documented administration of: -Gabapentin 400 mg 1 capsule by mouth for neuropathy (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-methocarbamol 500 mg 2 tablets by mouth for muscle spasms/phantom pain -aspirin 81 mg by mouth for prophylaxis (preventative) -lotrel 5-20 mg 1 capsule by mouth for hypertension -Miralax17 grams by mouth for constipation -Apixaban (blood thinner) 5 mg 1 tablet by mouth for prophylaxis -hydromorphone HCL (dilaudid) 4 mg by mouth for chronic pain -levetiracetam 750 mg 2 tablets by mouth for seizure disorder -lidocaine External gel 4% topically for right shoulder pain Review of facility medication administration audit received 7/12/24 at 11:27 AM, indicated on 5/23/24 LPN WW signed out medications with LPN XX having administered them: -7:36 AM to resident in room [ROOM NUMBER] bed 1 -7:41 AM to resident in room [ROOM NUMBER] bed 1 -7:46 AM to R7 (incident involving R404 received the medication not R7) -7:52 AM to resident in room [ROOM NUMBER] bed 1 During an interview on 7/10/24 at 3:38 PM, R7 stated, The facility overdosed the guy in the room across the hall from me a while back. The staff gave him my meds (medications). He was not my roommate. They (nurses/facility) were worried about their own asses and not the man they overdosed. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/11/24 at 2:10 PM, LPN WW stated, I worked at the facility for a little over a month by 5/23/24. I kinda sorta had orientation when I started. It consisted of a walk-through of the facility. There was no orientation on policy. I have been a nurse since 2002. I know the rights of medication (meds) administration. On May 23 rd (2024), I was passing meds with an agency nurse (LPN XX). We were working out of the same med cart. I gave (LPN XX) medications I had pulled to give to (R7). I do not know if I gave the LPN the wrong room number or he heard me wrong, but he gave the wrong person the wrong meds. Once (R7) came to the med cart and said he did not get his morning meds, (LPN XX) and I went looking for the resident that got (R7's) medications. (LPN XX) told me did not give the meds to (R7). I had been pulling meds that morning and (LPN XX) was giving them. I was working behind because the med pass was heavy and falling behind. I delegated the meds to (LPN XX) because I was getting behind, I was a newer nurse to the facility. (LPN XX) just started to work that morning. (LPN XX) was learning the residents and so was I. When a nurse pulls up the MAR it tells you the resident's room number and gives their picture. There was also a printed sheet with resident room numbers. I knew I did wrong by pulling the medications and having the other LPN administer them. The meds were given by (LPN XX) around 8:30 AM. (R7) came to the med cart around 8:30 AM asking for his meds. I told him he already got them, and he argued with me. (LPN XX) said he gave the meds to a bigger guy (R404) and I told him that was not (R7). I gave (R404) his meds at 7:30 AM in the Garden Room. He was drowsy and laying across a bedside table. I had a hard time waking him, he took the meds, and went back to sleep. I left him there. (R404) was not in a wheelchair. He must have walked back to his room where (LPN XX) found him and gave him (R7's) meds. When (R404) was found in his room later that morning by (LPN XX and I. He was sitting in a chair. He was alert and (LPN XX) verified he had given (R7's) medication to (R404). We went immediately to (Unit Manager (UM) VV) reporting the wrong meds had been given to the wrong person. I went back to passing meds at the same med cart. The DON (Director of Nursing) came to see me about 20-30 minutes later and sent me home. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/11/24 at 2:43 PM, LPN XX stated, I am an agency LPN. I have been a nurse for [AGE] years. May 23 rd (2024) was my first day at the facility. I did not get any orientation. The first day I arrived, I was paired up (LPN WW) who was in her orientation process. We decided she would pull meds and I would pass them. (R404) was about the 4th resident we did this together. (LPN WW) would tell me the resident name and room number and I repeated it back to her and she would say yes. After the incident with (R404) we maybe did 5 more residents the same way. (R7) came up to the med cart saying he had not gotten his meds yet that morning. (LPN WW) told him we had given him his meds already. I told her that I had not given medications to (R7). (LPN WW and I found (R404) and she told me he was the wrong resident. We told the Unit Manager right away that we had a med error. The Unit Manager told us to call the doctor who told us to monitor (R404) and do vital signs (VS) every 4 hours. I got a first set a VS on (R404) who was stable. We went back to the med cart and on to the next resident where she passed meds and I watched. The Unit Manager told me to go sit with (R404) and do vital signs every 15 minutes. The second time VS were taken (R404) was slurring his speech and lethargic. I told a CNA (certified nursing assistant) to get the Unit Manager. The doctor came to the room, ordered Narcan, and it was administered. (R404) responded and then started to decline. A second Narcan was ordered and 911 was called. (R404) came around but was confused. EMS (Emergency Medical Services) arrived and gave oxygen. The resident's POX (oxygen level) was in the high 80s. 87-90. I do not know what the medications I gave him. I know the 5 Rights of Medication Administration. I did the best of my ability May 23 rd. I took the meds and went to what I though was (R7's) room. (R404) responded when and went into the room. I did not pull the meds. I watched the MAR as (LPN WW) pulled meds and saw a first name but not a picture in the medical record. I watched the LPN pull a med out of the narcotic (controlled substance) drawer, but I did not look at what med it was or the name on the card. I do not know what meds were pulled. I was told by the Unit Manager the facility normally does have names on room doors or wrist bands. He did not have on a wrist band, a name on the room door, or a picture in medical record. I know better than to administer medications the way I did. A nurse new to a facility should never orient with a nurse that is on orientation too. Ever. During an interview on 7/11/24 at 3:35 PM, R404 stated, I was a resident at the facility in May (2024). I went to the room that was a lounge that morning, was given my medications by a lady, who said she was a nurse then I went back to my room. About 5 minutes later a man nurse came to my room and called out my first name. I said my first name. He did not ask me my last name. He said he had meds for me. I said I got my meds a short time ago by the lady nurse. He said the meds were mine. He said he had been a nurse for about [AGE] years and should know how to pass meds and that he knew they were my meds. He insisted he had my medications. I got tired of arguing with the nurse. He should have checked my ID. I still had the hospital bracelet on from the day before. I took the medications he insisted were mine. The next thing I knew I was in the hospital. I was told I was unresponsive. I was given something to work against the meds. I remember I thought I was in some kind of fantasy world because of the wrong meds. I groped the nurse and that was not me. I apologized to the nurse. Once I got out of the ER (emergency room) and they put me in ICU (intensive care unit). Then I was sent back to the nursing home for two weeks and finally went home. I originally went to the nursing home because I had Afib. And was sent to rehab at the nursing home. During an interview on 7/12/24 at 9:00 AM, NHA A stated, I do not know all of the medications that (R404) was given. I did not know (R404) got a muscle relaxer that was meant for (R7). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/12/24 at 9:15 AM, Director of Nursing (DON) B stated, I do the staff training. (LPN WW) worked here for almost a month when the incident happened. She had a couple of mentors. I never saw her orientation check list. I do not know what the mentors documented on it about her. She needed more time to learn the flow of the building and. It was not the intention to have (LPN XX) pass medications with her. It was his first day. He was to be doing treatments and new admissions if any came in. He did not have an orientation check list. Agency are on their own when come to work at the facility. Review of R404's Practitioner Progress Note dated 5/23/24 at 1:54 PM, revealed, .called to see new resident urgently this morning due to hypoxia and altered mental status .had inadvertently been given the medication of a different resident. These included dilaudid, Gabapentin, and Keppra (muscle relaxant) .breathing more shallow, less responsive, and diaphoretic (sweating) .was not able to speak .gave Narcan 4 mg nasally . pulse weakened .given second dose of Narcan .lungs with crackles and decreased breath sounds lower half . heart irregular .EMS arrived .transported to ED . Review of R404's ED (Emergency Department) Provider Note dated 5/23/24, revealed, .Patient presented with unintentional medication overdose. Was given Dilaudid and Gabapentin. Was hypoxic (low level of oxygen in body tissues) and required Narcan (medication to treat narcotic overdose) in field. On arrival here, we did give him multiple doses of Narcan. Eventually started on Narcan drip. Was still sleepy. Noted to have hypercapnia (buildup of carbon dioxide in bloodstream). Did require hospitalization .Diagnosis: Acute hypercapnic respiratory failure . mistakenly given another patient's medication .At approximately 8:30 AM, he was given 4 mg of PO (by mouth) dilaudid and 800 mg Gabapentin that was intended for a different patient. Shortly thereafter he became unresponsive and desatted (blood oxygen levels dropped) to 70s Over the course of an hour (R404) became more somnolent (solemn state) and harder to arouse . gave him a total of 2 mg of Narcan .Toxicology was consulted in the emergency department. They recommended to start a Narcan drip .started the drip at 0.4 milligrams/hour, but incrementally increased the dose .ordered a VBG (venous blood gas test) which showed pH of 7.08 (7.32-7.42) pCO2 132 (38-52), bicarb 36.5 (22-32). He was started on BiPAP FiO2 40%. A second VBG approximately 40 minutes later showed minimal improvement. He was transferred to the intensive care unit for further management .Based on last blood pressure taken in the ED of (!) 191/176 .admitted to hospital for acute hypoxic respiratory failure and chest pain. Cardiology believed chest pain was likely type 2 MI (myocardial infarction (heart attack)) .05/23/24 1646 (4:46 PM) INSERT ARTERIAL LINE .CRITICAL CARE ARTERIAL BLOOD GAS - Abnormal; requiring BiPAP -pH, Arterial 7.19 (7.35 -7.45) -pCO2, Arterial 88.1 (35.0-45.0) -Bicarbonate, Arterial 32.7 (20.0-28.0) -Base Excess, 4.5 (2.0 - 2.0) (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Assumed care from previous physician care at 1:00 pm .Blood gas showed he is significantly acidotic with CO2 retention .Toxicology was consulted .quickly transitioned over to BiPAP and patient was frequently stimulated to try to maintain respirations .required near constant stimulation to keep him awake however and is at high risk for intubation .admitted to the intensive care unit on Narcan drip and BiPAP with close respiratory monitoring, but remains at high risk for decompensation .Critical care time was required due to the life threatening nature of this patient's condition .Heparin gtt (IV drip) started .Lines: Art, PIV .Airways: BiPAP .SUBJECTIVE: Upon presentation to the emergency department the patient was hemodynamically stable but requiring 4 L nasal cannula to maintain appropriate saturations which eventually escalated to BiPAP. The patient received 5 doses of Narcan and subsequently placed on a Narcan drip with some improvement in his mentation. Lab work was significant for a significant respiratory acidosis. The patient was evaluated by toxicology in the emergency department and recommended supportive measures and titratable Narcan in an effort to avoid intubation .Objective .in acute distress .cardiovascular rhythm irregular . Pulmonary .Tachypnea and accessory muscle usage present . Review of R404's Hospital Toxicology Consultation Note dated 5/23/24, revealed, Accidental narcotic ingestion .received total of 5 doses of Narcan and presently is on a Narcan drip .UA not known if the Narcan will be sufficient to return around his respiratory issues and he may require intubation. He remains poorly responsive and requires stimulation to continue participation with the BiPAP. The Narcan may be of little benefit at this point but it will not hurt the patient to increase the dose if attempting to prevent intubation. Care otherwise remains supportive symptomatic. Ingestion includes Neurontin (Gabapentin) and Dilaudid (hydromorphone) .he has severe hypercapnia with a pCO2 of 121 and pH of 7.1. He presently is on BiPAP and a Narcan drip . On 7/11/24, NHA A was notified of the Immediate Jeopardy that began on 5/23/24 due to the facility failing to prevent a serious medication error for Resident #404 requiring hospitalization and admission to the intesive care unit. On 7/11/24, this surveyor verified the facility completed the following to remove the Immediate Jeopardy: 1. Newly hired nurses to only be assigned to follow facility nurses as of 05/23/2024. 2. Medication Administration Guidelines policy was reviewed by the administrator and Director of Nursing and deemed appropriate on 05/23/2024. 3. Medication Administration - General Guideline to be followed at each medication pass. 4. On 5/23/24, daily schedules were reviewed by the DON and scheduler to ensure appropriate nurse orientation practice is occurring. 5. On 5/23/24, education was completed to nurses on medication administration-general guidelines was initiated; any facility staff member and agency staff member who did not receive education by 5/23/24 will receive education prior to the start of their next shift. All facility staff and agency staff who were present at the time of the incident were immediately educated. As of 5/23/24, all facility staff and agency staff have completed the necessary required education. Education is completed for all new hires prior to their first shift. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Medication administration audits began the week of 05/23/2024 and were completed weekly x 2 weeks then monthly x 2 months to ensure the Medication Administration Guidelines were being completed. 7. Beginning on 05/23/2024, DON completed daily schedule audits when there was a nurse on orientation to ensure that they are scheduled with a facility nurse - ongoing 8. NHA/designee began to complete resident identifiers audits starting 05/23/2024 to ensure there was a picture uploaded to PCC (electronic medical records) and room is identified with the resident name once weekly x 2 weeks then monthly x 2 months. 9. Results of audits have been reviewed with the QAA committee on May 30th and June 20th to ensure compliance and any further recommendations. During an observation on 7/9/24 at 7:55PM, Resident #15 was observed to have plastic cup with medications left at her bedside. Review of the medical record revealed Resident #15 had a medication administration review on 6/22/2013 that indicated she was unsafe to self-administer medicaitons. This required additional training for nursing on the medication administration policy. 10. Additional education provided on the Medication Administration - General Guidelines policy (2023) to 8 out of 21 licensed nurses, including licensed agency nurses on 07/12/2024. All licensed nurses including agency nurses will have education on the Medication Administration - General Guidelines policy completed prior to the beginning of their next shift. Although the immediate jeopardy was removed on 7/12/24, the facility remained out of compliance at a scope of isolated and severity of actual harm that is not Immediate Jeopardy because education had not yet been completed and sustained compliance had not yet been verified by the State Agency.