STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to provide an environment that promoted and resident dignity in 2 (Resident #60 and #71) of 3 residents reviewed for dignity, resulting in the potential of feelings of humiliation, embarrassment, and loss of self-worth, and a negative psychosocial outcome for the residents impacting their quality of life. Findings include: Resident #60: Review of current Care Plan for Resident #60, revised on [DATE], revealed the focus, .Risk of falls r/t (related to) COPD, HTN (high blood pressure), PVD (peripheral vascular disease) . with the intervention . Septic arthritis of right ankle .WBAT (weight bearing as tolerated) with RLE (right lower extremity with surgical boot .Ambulation with 1 PA (physical assist) . In an interview on [DATE] at 02:48 PM, Resident #60 reported the staff took a long time to come to assist him when he needed to use the restroom and he soiled himself and needed to have his clothes changed. Resident #60 was upset by this as he can use the bathroom and needed their help to get there because of his foot/ankle was broken. Resident #60 reported he was also receiving antibiotics by IV in his PICC line (Peripherally inserted central catheter (PICC) was a thin flexible tube that's inserted into a vein in the upper arm and threaded into a large vein near the heart). In an interview on [DATE] at 02:07 PM, Licensed Practical Nurse (LPN) T reported the call lights' were sent to pagers for the CNAs, there were screens which informed the staff of the call lights for any room in the building and could hop around the corner to assist. LPN T reported the staff try to answer the call light within 15 minutes at the most. The screens let staff know how long the call light had been activated. In an interview on [DATE] at 02:10 PM, Certified Nursing Assistant (CNA) NN reported the staff should have an immediate response to the call light sytem. CNA NN reported the call light system was for the residents to alert staff they needed assistance, it could be for several things, like water or ADL (activities of daily living) care. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 02:11 PM, Clinical Care Coordinator (CCC) F reported the expectation to answer within ,d+[DATE] minutes. The CNAs were alerted via the pager system. The call light system used to ensure patient needs were met when they arise. Resident #71: Review of an Admission Record revealed Resident #71 was a female with pertinent diagnoses which included cerebral palsy with spastic quadraplegia, depression, legal blindness, and moderate intellectual disabilities. Review of current Care Plan for Resident #71, revised on [DATE], revealed the focus, .I have a history of trauma .I have an alteration in my MOOD state r/t (related to) depression . with the intervention .Allow me to express my feelings, observe for any changes in my mood and my response to treatment, make a referrla to psych services/supportive therapy as needed .provide me reassurance when I am feeling anxious, depressed, tearful, or angry . In an interview on [DATE] at 12:04 PM, Family Member (FM) YY reported on Sunday ([DATE]) she was contacted by Licensed Practical Nurse (LPN) Q and he told me what he had said to her. LPN Q told her that he said to (Resident #71) that her sister died last night. FM YY reported she did not understand what made him randomly say that to her. Resident #71 reported, That was a cruel joke .He made me cry .Make me upset I think about it all the time .I had a hard time sleeping thinking about it This writer obseved Resident #71 attempt not to cry. FM YY reported we requested a couple months ago for her to see someone and now she had been traumatized again. In an interview on [DATE] 03:08 PM, Director of Nursing (DON) B reported she had receieved a phone call from LPN HHH informed Resident #71 was crying and upset as LPN Q had told her, her sister had passes away last night per Resident #71. DON B reported she spoke to LPN Q and he informed her they were bantering back and forth and with his odd sense of humor had told her sister had passed away, she didn't like that and told him it was not funny, she became angry and she wheeled back to her hallway. DON B informed LPN Q the allegation would need to be investigated, he asked if he should call FM YY and inform her of the incident and to apologize. DON B reported he contacted FM YY and apologized. In an interview on [DATE] at 03:39 PM, Licensed Practical Nurse (LPN) Q reported he blurted it out to Resident #71, he heard her sister passed and it was thoughtless bantered back and forth, darkest of humor blurted it out and said he reported he immediately said he was just joking, LPN Q reported (Resident #71) smiled and wheeled away. LPN Q reported shortly after he heard she was crying, upset, and prett worked up. LPN Q asked if I could give her a hug, as she was a [NAME], but she told me, No. LPN Q reported he was told later she had the brain function like a child and he did not realize that as he doesn't work with her. LPN Q reported he had crossed the line, and it was below the belt.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 2 (Resident #82 & #126) of 27 residents reviewed for accommodation of needs, resulting in the inability to call for staff assistance and the potential for unmet care needs. Findings include: Resident #82 Review of a Minimum Data Set (MDS) assessment for Resident #82, with a reference date of 9/10/24 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #82 was moderately cognitively imparied. Review of Resident #82's Care Plan revealed, .Focus: Due to my Parkinson's, I hold my arms close to my chest and hand closed and shake up and down my chest .I have an actual ADL (activities of daily living) deficit R/T (related to): Parkinson's .Resident is cognitively intact .Risk for falls R/T Parkinson's . Interventions: .Call light accessible. Date initiated: 12/07/2023 . During an observation on 10/09/24 at 09:54 AM in Resident #82's room, he was lying flat in his bed, and requested that this surveyor raise the head of the bed. Resident #82 reported that he did not know where his call light was located because he did not have good eye sight, and was not able to reach his table. Resident #82's eyes were closed, both arms were bent, hands were closed and laying on his chest. A soft touch call light pad was observed laying on the over the bed table approximately 3 feet out of Resident #82's reach. Resident #82 attempted to reach for the call light, but had limited movement in his right arm, and was shaking. In an interview on 10/09/24 at 10:02 AM, Registered Dietician (RD) K reported that she did not know if Resident #82 used a call light, but that she could raise the head of the bed for him. In an interview on 10/09/24 at 10:05 AM, Certified Nursing Assistant (CNA) II reported that Resident #82 does not use his call light because he cannot reach it, due to his arms being contracted (tightening of muscles and difficulty moving joints). CNA II reported that if the call light was placed closer to Resident #82, that he would be able to reach and activate it to call for assistance. 47659 Resident #126 Review of an Admission Record revealed Resident #126 was originally admitted to the facility on [DATE] with pertinent diagnoses which included history of falling. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #126's Care Plan revealed, Focus Area: (Resident #126) Risk for falls r/t (related to) Recent UTI, vascular dementia with psychotic disturbance, HTN (hypertension-high blood pressure), Seizures, diastolic dysfunction, Hx (history) of CVA (Cerebrovascular accident -stroke), Hx of falls Date Initiated: 08/16/2024. Goal: Minimize risk for injury r/t falls. Date Initiated: 08/16/2024. Interventions: .Call light accessible. Date Initiated: 08/16/2024 . Review of a Minimum Data Set (MDS) assessment for Resident #126, with a reference date of 8/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated Resident #126 was moderately cognitively impaired. During an observation and interview on 10/08/24 at 9:28 AM, Resident #126 was lying in bed. When this writer entered Resident #126's room, Resident #126 asked for water and to have her brief changed. Resident #126 reported that she was very thirsty, felt like she had a wet brief, and had been waiting for someone to come help her. Resident #126 reported that she did not know where her call light was to call for staff assistance. It was noted that Resident #126's call light was at the end of Resident #126's bed and out of Resident #126's reach. During an observation and interview on 10/09/24 at 8:47 AM, Resident #126 was lying in her bed. When this writer entered Resident #126's room, Resident #126 reported that she was in pain and needed help right away. Resident #126 reported that she did not know where her call light was to call for staff assistance. It was noted that Resident #126's call light was lying on the floor under the bed and out of Resident #126's reach. During an interview on 10/09/24 at 8:56 AM, Certified Nursing Assistant (CNA) GG reported that Resident #126 did use her call light to request assistance from staff. Review of the facility's Call Light Policy last revised on 5/1/17 revealed, POLICY: Call lights will receive consistent and adequate response in order to best meet the individual needs of each resident. PROCEDURE: 1. Call lights will be placed within reach of the resident .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure accurate code status (a physician's order that determines the type of medical treatment a person will receive if their heart or breathing stop) was in place for 1 (Resident #62) of 27 residents reviewed for advanced directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time), resulting in the potential for a resident's preferences for medical care to not be followed by the facility, or other healthcare providers. Findings include: Review of an Admission Record revealed Resident #62 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe). Review of a Minimum Data Set (MDS) assessment for Resident #62, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] which indicated Resident #62 was cognitively intact. Review of Resident #62's Orders revealed that Resident #62's code status was CPR (cardiopulmonary resuscitation) which indicated that if Resident #62's heart or breathing stopped, that staff would initiate CPR. Date initiated: [DATE]. Review of Resident #62's Code Status form dated [DATE] revealed that Resident #62 had marked Do not resuscitate (DNR). The form was signed by Resident #62 and the facility's physician. It was noted that the form was missing two witness signatures. Review of Resident #62's Code status form dated [DATE] revealed that Resident #62 had marked Do not resuscitate. The form was signed by Resident #62, the facility's physician, and two witnesses. Review of Resident #62's Care Conference note dated [DATE] revealed, . Summary: . Code Status: CPR . During an interview on [DATE] at 10:04 AM, Social Worker (SW) H reported that she was responsible for reviewing and ensuring the accuracy of resident's advance directives when they were admitted to facility and at the resident's quarterly care conferences. SW H confirmed that she had participated in Resident #62's care conference on [DATE] and that the code status for Resident #62 was updated to CPR. SW H reported that she did not know why Resident #62's code status was updated to CPR when Resident #62 had signed a DNR order. SW H was not able to confirm what Resident #62's end of life wishes were. SW H confirmed that ensuring the accuracy of Resident #62's code status had been missed. During an interview on [DATE] at 11:18 AM, Resident #62 reported that she would want the facility to follow the orders of do not resuscitate (DNR) if her heart or breathing stopped. Resident #62 reported that she did not have the desire to receive CPR due to her age and health, and that she had never indicated to the facility that she wanted to change her code status to from DNR.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview, and record review, the facility failed to accurately complete Minimum Data Set (MDS) assessments in 1 (Resident #131) of 27 residents reviewed for accuracy of assessments, resulting in an inaccurate reflection of the resident's discharge status. Findings include: Resident #131 Review of an Admission Record revealed Resident #131 was originally admitted to the facility on [DATE], and discharged to (name of a different nursing home) on 7/26/24. Review of a MDS assessment for Resident #131 with a reference date of 7/26/24 revealed, Resident #131 discharged to a short-term general hospital on 7/26/24. This information was not consistent with the resident's admission record. Review of Resident #131's Progress Note dated 7/26/2024 at 09:13 AM revealed, D/c (discharge) instructions given to patient; he verbalized understanding. Resident dc with dc instructions and belongings via (another nursing home) transportation. In an interview on 10/10/24 at 02:03 PM, MDS Nurse L reported that Resident #131 discharged to a different nursing home on 7/26/24, and that the MDS assessment that was submitted upon discharge inaccurately indicated a discharge to the hospital.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to confirm the Pre-Admission Screening and Resident Review (PASARR) Level II determination request was sent to the Community Mental Health Services Program (CMHSP) for a Level II OBRA review and/or evaluation for 2 (Resident #49 and #26) of 3 residents, resulting in the potential for the residents to not receive or have delayed mental health services. Findings include: Review of OBRA - Specialized Nursing Homes dated 2023, revealed, .This review process begins with the completion of a screening form (Level I DCH-3877) usually by a nursing facility, hospital, or community agency/provider. If the responses to the questions on the form indicate the presence of a mental illness and/or an intellectual/developmental disability (or a related condition), the person is referred to the local community mental health services program (your local OBRA Coordinator) to assess if a comprehensive evaluation (Level II) is needed. This evaluation and the evaluator's recommendation are reviewed by the State OBRA office and a final determination is made as to whether the person is appropriate for nursing facility admission/stay and whether specialized services mental health care is required . https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/obra Resident #49: A review of R49's Admission Record, revealed R49 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included schizoaffective disorder, bipolar type and major depressive disorder. Review of R49's care plan dated 2/13/24, revealed, .I have an alteration in my MOOD state r/t (related to) Major depression disorder, schizoaffective disorder, Insomnia. I am currently prescribed psychotropic medication .Trauma History: Resident have a Trauma History of a car accident and a very stressful event/experience. Trauma triggers may include; loud noises/crashes and increased stress . with the intervention .Follow PASAR recommendations. Annual Record Review required by 11/3/24 .Revision on: 11/21/2023 . In an interview on 10/09/24 03:09 PM, Director of Social Services (DSS) Porsche reported she had not seen level II in the records, she was reaching out to the OBRA contact to request a level II for Resident #49. In an interview on 10/09/24 at 03:22 PM, SWD H reported the contact at the local community mental health agency reported he was not aware R49 was back in the nursing home. SWD H reported it appeared the last one done for R49 was in 2021. In an interview on 10/10/24 10:26 AM, SWD H reported she had heard back from the contact at the local community mental health agency and she was due November 2023 to have a Level II, 3878 Screening completed. Resident #26: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R26's Admission Record, revealed R26 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included bipolar disorder, anxiety, and depression. Review of R26's care plan dated 8/22/24, revealed, I have an alteration in my MOOD state r/t (related to) Vascular Dementia, Bipolar, Anxiety & Depression. I am currently prescribed psychotropic medication .I have a history of trauma; experienced a fire or explosion, physical assault, sexual assault, sudden violent death . with the intervention .Follow PASAR recommendations. Annual Assessment due by 5/23/24 . Revision on: 11/21/2023 . Review of PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR) Level I Screening dated 11/16/23, revealed, .Change in Condition .Section II: Screening Criteria: 1. (X)Yes .The person has a current diagnoses of (X) Mental Illness or ( ) Dementia .2. (X)Yes .The person has received treatment for(X) Mental Illness or ( ) Dementia .3. (X)Yes .The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days .DISTRIBUTION: If any answer to items 1 - 6 in SECTION II is Yes, send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 (Level II Screening) if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative . Review of Department of Health and Human Services letter dated 5/25/2023, revealed, .(County Community Mental Health Service) completed a PAS-OBRA Level II Evaluation on the above-named individual and made a recommendation on placement and services. Based on the information provided by this agency, the Stal of Michigan Department of Health and Human Services made the following: 1. DETERMINATION: Nursing Facility - Specialized Mental Health Services. The individual qualifies for the level of services provided by a nursing facility and requires specialized mental health/developmental disabilities services .2. RESULT OF THE DETERMINATION: The individual may be admitted to a nursing facility and may choose to receive specialized mental health/developmental disabilities services. The local community mental health services agency will discuss with the individual, the individual's legal representative and the nursing facility a plan for the provision of specialized services .3. REASON FOR THE DETERMINATION: The individual's physical, mental and psychosocial needs can be adequately met in a nursing facility .If the above-named individual remains in the nursing facility, a Level II Evaluation is needed by May 23, 2024 . In an interview 10/10/24 02:27 PM, Social Work Director (SWD) H SS reported a change of condition Level I evaluation was completed for R26 when it was determined she was assigned a guardian. The Level II was due in May, 2024.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981 Based on observation, interview and record review, the facility failed to implement a comprehensive, person-centered care plan for 1 (Resident #11) of 3 residents reviewed for pressure ulcer prevention, resulting in an incomplete reflection of the resident's care and monitoring needs for pressure ulcer preventative Findings include: Review of an Admission Record revealed Resident #11 was originally admitted to the facility on [DATE] with pertinent diagnoses which pressure ulcers stage 4. Review of Resident #11's Kardex (individualized-personalized resident care guide for staff use) with no date revealed: (Resident#11) I need my soft heel offloading boots on both of my feet at all times, remove for morning and evening care and for skin inspection . During an observation on 10/08/24 at 4:55 PM., on 0/09/24 at 12:30 PM., and on 10/09/24 at 2:10 PM Resident #11 was laying in his bed. It was noted Resident #11 was not wearing any sort of soft boot, nor were any soft boots noted in and or around Resident #11's room. Review of Physicians Orders dated 5/30/24 revealed: Order Summary: (Resident #11) Wound care to right heel: Cleanse site NS (normal saline), pat dry, apply foam border dressing to site. Ensure PRAFO (name brand-soft boots) boots are applied when in and out of bed During an observation on 10/10/24 at 9:19 AM., on 10/10/24 at 9:55 AM, and on 10/10/24 at 10:30 AM, Resident #11 was laying in his bed. It was noted Resident #11 was not wearing any sort of soft boot, nor were any soft boots noted in and or around Resident #11's room. During an observation on 10/10/24 at 10:50 AM., Registered Nurse (RN) V was completing wound dressing change for Resident #11's right heel. It was noted no offloading boots were on Resident #11. It was noted no soft boots around Resident #11's bed, or areas visible in his room. In an interview on 10/10/24 at 11:20 AM., RN V reported he was unsure where Resident #11's soft boots were. RN V looked around Resident #11's room, closet and drawers. No soft boots were found in Resident #11's room. RN V reported

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to revise a comprehensive care plan with new interventions after a fall in 1 (Resident #15) of 2 residents reviewed for falls resulting in an inaccurate reflection of the resident's care needs and the potential for unmet medical, physical, mental, and psychosocial needs. Findings include: Resident #15 Review of an Admission Record revealed Resident #15 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness. Review of Resident #15's Incident Report dated 7/4/24 revealed Incident description: Called to room by CENA (Certified Nursing Assistant).(Resident #15) was observed sitting on the floor with her legs bent at the knees and her lower legs alongside her buttocks, in front of her chair. Her tray table had also tipped over and she was sitting between the tray table and the chair, leaning to the left with her arm pressed and lower back pressed up against the tray table . notes: 30 minutes after incident (Resident #15) was taken by ambulance to be evaluated at (local hospital) .Other info: (Resident #15) was sitting in the recliner when another resident sat on the remote control for the recliner and resident chair moved to getting up and position and resident slid down on the floor. The tray table was caught by the moving recliner and knocked over so (Resident #15) was between the tray table and the chair . Review of Resident #15's Fall assessment dated [DATE] revealed, . Describe: (Resident #15) only fell b/c (because) another resident sat on her remote control to chair and it lifted her out of the chair .Summarize the impact of this problem/need on the resident. (Include complication, risk factors and root cause analysis) : . Root Cause Analysis: fall was related to another resident sitting on the remote control to the electric recliner and resident fell to the floor. Remote was not within resident's reach. Intervention: Family insisted to send to ED. IDT (Interdisciplinary team) Day 1: ED. IDT Day 2: hospitalized . IDT Day 3: hospitalized . During an interview on 10/10/24 at 10:37 AM, Clinical Care Coordinator (CCC) G reported that the facility's IDT team met after each resident fall to review the fall and ensure that a new intervention was in place to attempt to prevent further falls. CCC G reported that he thought the facility had updated Resident #15's care plan to ensure that her chair remote was tucked into her recliner when she was sitting in the recliner. CCC G reviewed Resident #15's care plan with this writer and reported that the facility did not have the care plan intervention added to Resident #15's chart. During an interview on 10/10/24 at 3:05 PM, CCCD reported that the facility did not initiate any fall interventions or update the care plan for Resident #15 after her fall on 7/4/24 because Resident #15's family had insisted that she was sent to the hospital after her fall, and Resident #15 was admitted to the hospital for a few days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 Four Mile NW Grand Rapids, MI 49544	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to ensure dependent residents received assistance with activities of daily living (ADL), specifically personal hygiene and getting out of bed were provided for 2 (Resident #19 & #20) of 4 residents reviewed for ADL care, resulting in unmet care needs and the potential for avoidable declines in overall health and wellness. Findings include: Resident #19 Review of an Admission Record revealed Resident #19 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: parkinsons (a disorder of the central nervous system (brain and spinal cord) that causes difficulty with movement.) Review of a Minimum Data Set (MDS) assessment for Resident #19, with a reference date of 8/8/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #19 was cognitively intact. Review of Resident #19's Care Plan revealed, Focus: .At risk for urinary/bowel incontinence r/t (related to) parkinson's .I have actual ADL (activities of daily living) deficit r/t parkinson's .Interventions: .non ambulatory, bed bath/shower: Monday & Thursday 1st shift, Transfer 1 PA (person assist) .Bed mobility 1 PA . During an observation and interview on 10/08/24 at 11:55 AM in Resident #19's room, the resident was lying flat in his bed, his pants were visibly wet and there was a strong odor of urine. Resident #19 reported that when he asks staff for assistance, they tell him that they will be right back, but they never do. During an observation and interview on 10/10/24 at 11:36 AM in Resident #19's room, the resident was lying flat in his bed, with a sheet wrapped around the bottom half of his body, and there was a strong odor of urine in the room. Resident #19 reported that he preferred a shower vs. bed bath, but had not gotten a shower yet this week, and that he likely would not get it that day either. In an interview on 10/10/24 at 12:03 PM, Certified Nursing Assistant (CNA) AA reported that at times Resident #19 would decline assistance, but that she had not gotten a chance to check in with him yet that day. CNA AA reported that she started her shift at 6:30 AM and tried to get into Resident #19's room before noon, but that she had no time that day. CNA AA reported that Resident #19 toileted himself, but was also incontinent. CNA AA reported that Resident #19 was supposed to get a shower that morning. During a subsequent observation and interview on 10/10/24 at 01:42 PM in Resident #19's room, the resident was lying in bed and there was still a strong odor of urine. Resident #19 reported that he had not received any assistance yet that day and stated, .my requests have been put in, and that's usually all that happens .it would be nice to get some attention and get cleaned up. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #19's Shower Task indicated that he had received 3 showers since 9/12/24. Resident #20 Review of an Admission Record revealed Resident #20 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: paraplegic (inability to move lower body), myasthenia gravis (skeletal muscle weakness) and osteomyelitis (bone infection) of the lower spine. Review of a Minimum Data Set (MDS) assessment for Resident #20, with a reference date of 8/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #20 was cognitively intact. Review of Resident #20's Care Plan revealed, Focus: Skin Management - At risk for additional skin breakdown .hx (history) of Stage 4 sacral ulcer, hx of Stage 4 pressure ulcer right medial foot .MASD (moisture associated skin damage) buttocks to my intergluteal cleft .Interventions: .assist me with floating my heels .Please help me get turned and repositioned while in bed or in my wheelchair as needed .Focus: I have actual ADL deficit .Interventions: .non-ambulatory .bed mobility 2 PA . During an observation and interview on 10/08/24 at 12:01 PM in Resident #20's room, the resident was lying in his bed. Resident #20 reported that he would like to get up into his chair everyday, but that there is not enough staff to help him. Resident #20 reported that when he presses his call light, the staff shut it off and say that they will be right back, but don't come back. Resident #20 reported that he would like to get out and/or see what they have going on in activities, but its such a big ordeal to get him in and out of bed, that he rather not even try. During an observation and interview on 10/10/24 at 11:47 AM Resident #20 was lying in his bed, positioned on his left side with a pillow tucked under his right side, wearing a facility gown. Resident #20 reported that he was up in his chair the day before for a couple hours, and when he wanted to lay back down, there was no one available, but that eventually staff from another hall came to help. Resident #20 reported that he could not stand to sit in his chair for more than a couple hours, because his bottom hurt. Resident #20 reported that he had not had any cares provided yet that day, and that he had been in the same position since the day before. Resident #20 reported that he didn't think the wounds on his back side would ever heal, because he did not get proper wound care, and/or repositioning. Resident #20 reported that his room was always the last room that staff come to when they do their rounds, and sometimes they don't come at all. In an interview on 10/10/24 at 12:03 PM, CNA AA reported that she had not gotten a chance to check on Resident #20 yet that day. CNA AA reported that the resident had wounds on his back side, he should be repositioned every 2 hours, and that she usually asked the nurse to assist with turning so that his wound dressing can be changed if needed. In an interview on 10/10/24 at 12:11 PM, Clinical Care Coordinator (CCC) G reported that Resident #19 and #20 are roommates, and both require assistance with ADL care, or at least rounding every 2 hours. CCC G reported that Resident #19 is incontinent, self-transfers to the toilet, but is not able to effectively clean himself. CCC G reported that Resident #20 required assistance with repositioning due to his history of a Stage 4 pressure ulcers and MASD. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/10/24 at 01:02 PM in Resident #20's room, CNA AA was preparing to provide cares and get the resident out of bed and into his wheelchair. At 1:16 PM Licensed Practical Nurse (LPN) P entered the room to assist with turning and incontinence care. There was a foul odor when Resident #20 was rolled onto his side. Resident #20's soaker pad, underneath him was observed soiled with brown and red liquid substance, the bottom sheet was soiled, and his incontinence brief had blue lines, indicating that it was wet.

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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 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 Based on observation, interview and record review, the facility failed to implement interventions to prevent skin breakdown for residents at risk for pressure ulcers, for 1 (Resident #20) of 5 residents reviewed for pressure ulcers, resulting in the potential for the development of an avoidable pressure ulcer, infection, and overall deterioration in health status. Findings include: Resident #20 Review of an Admission Record revealed Resident #20 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: paraplegic (inability to move lower body), myasthenia gravis (skeletal muscle weakness) and osteomyelitis (bone infection) of the lower spine. Review of a Minimum Data Set (MDS) assessment for Resident #20, with a reference date of 8/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #20 was cognitively intact. Review of Resident #20's Braden Assessment (used to predict risk of pressure ulcers) dated 9/12/24 indicated that the resident was at moderate risk. Review of Resident #20's Care Plan revealed, Focus: Skin Management - At risk for additional skin breakdown .hx (history) of Stage 4 sacral ulcer, hx of Stage 4 pressure ulcer right medial foot .MASD (moisture associated skin damage) buttocks to my intergluteal cleft .Interventions: .assist me with floating my heels .Please help me get turned and repositioned while in bed or in my wheelchair as needed .Focus: I have actual ADL deficit .Interventions: .non-ambulatory .bed mobility 2 PA . During an observation and interview on 10/10/24 at 11:47 AM Resident #20 was lying in his bed, positioned on his left side with a pillow tucked under his right side, and wearing a facility gown. Resident #20 reported that he was up in his chair the day before for a couple of hours, and when he wanted to lay back down, there was no one available, but that eventually staff from another hall came to help. Resident #20 reported that he can't stand to sit in his chair for more than a couple hours, because his bottom hurts. Resident #20 reported that he had not had any cares provided yet that day, and that he had been in the same position since the day before. Resident #20 reported that he didn't think the wounds on his back side would ever heal, because he did not get proper wound care, and/or repositioning. Resident #20 reported that his room is always the last room that staff come to when they do their rounds, and sometimes they don't come at all. In an interview on 10/10/24 at 12:03 PM, CNA AA reported that she had not gotten a chance to check on Resident #20 yet that day. CNA AA reported that the resident had wounds on his back side, he should be repositioned every 2 hours. In an interview on 10/10/24 at 12:11 PM, Clinical Care Coordinator (CCC) G reported that Resident #20 required assistance with repositioning due to his history of a Stage 4 pressure ulcer and MASD. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/10/24 at 01:02 PM in Resident #20's room, CNA AA was preparing to provide cares and get the resident out of bed and into his wheelchair. At 1:16 PM Licensed Practical Nurse (LPN) P entered the room to assist with turning and incontinence care. There was a foul odor when Resident #20 was rolled onto his side. Resident #20's soaker pad, underneath him was observed soiled with brown and red liquid substance, the bottom sheet was soiled, and his incontinence brief had blue lines, indicating that it was wet. There was a large dressing covering the majority of Resident #20's middle buttocks, that was not completely adhered on the very bottom. There were multiple areas on the residents lower buttocks and upper thighs that were open and weeping blood. In a subsequent interview on 10/10/24 at 1:35 PM, CNA AA reported that the brief and pad was saturated due to the wound draining. In an interview on 10/10/24 at 01:40 PM, LPN P reported that the foul odor was typical for Resident #20, and that the incontinence brief and pad were wet from the incontinence cream that gets applied when staff provide cares, and from the other open areas on his buttocks and thighs. In a subsequent interview on 10/10/24 at 01:55 PM, CCC G reported that with Resident #20's history of Stage 4 pressure wound and significant MASD, the odor and drainage reported during the resident's incontinence care was concerning. Review of Resident #20's Wound Note dated 10/9/24 at 10:03 AM indicated, MASD located on intergluteal cleft, measuring 10.2 cm x 6.3 cm, bleeding, with light drainage.

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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. 47659 This citation pertains to intake MI00146660. Based on observation, interview, and record review, the facility failed to provide sufficient staff to meet resident needs for 6 (Resident #19, Resident #20, Resident #71, Resident #333, Resident #51, and Resident #60) of 3 residents and residents from the confidential group interview reviewed for staffing, from a total sample of 27 residents, resulting in long call light wait times and resident care needs not being consistently met with the potential for unmet care needs for all residents residing in the facility. Findings include: During an interview on 10/10/24 at 1:00 PM, Scheduler RR reported that she was responsible for scheduling nurses and certified nursing assistants (CNA's) in the facility based on the acuity and needs of the residents. Scheduler RR reported that she had received workload concerns from the facility staff all the time. Scheduler RR reported that she had received the most complaints about staffing on the facility's 200 and 500 hall, which seemed to have the heaviest workload for staff. This writer informed Scheduler RR of the observations of residents on the 200 hall that had not received any morning care by 12:30 PM. Scheduler RR reported that she felt that the residents needs not being met timely on the 200 hall was not a staffing issue, but an issue with one particular CNA. Scheduler RR reported that there was one CNA that was very precise with care, and did everything the right way and took more time with each resident than she should. This writer queried on how much time Scheduler RR felt was appropriate for a CNA to spend with each resident, and Scheduler RR reported that she was not able to report how much time she felt was appropriate. Scheduler RR reported that she was not a clinical staff member, so she did not know what kind of care assistance each resident on the 200 hall required, or an estimated time that should be allotted for staff assignments. Scheduler RR reported that she had never gone to the hall to observe cares and assignments for staff, and that this would be something that nursing management would need to do. Scheduler RR reported that she would never consider moving the CNA to another hall with residents that required less care because the residents on the 200 hall loved her because she did a good job. Scheduler RR confirmed that the CNA that she felt took too long had also voiced concerns to her about not being able to manage the workload on the hall. Scheduler RR reported that she did not have the pull to adjust the schedule to accommodate the halls that had a heavier work load with more staff, and that was up to nursing management. 41027 Resident #19 Review of a Minimum Data Set (MDS) assessment for Resident #19, with a reference date of 8/8/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #19 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	Review of Resident #19's Care Plan revealed, Focus: .At risk for urinary/bowel incontinence r/t (related to) parkinson's .I have actual ADL (activities of daily living) deficit r/t parkinson's (a disorder of the central nervous system (brain and spinal cord) that causes difficulty with movement.) .Interventions: .non ambulatory, bed bath/shower: Monday & Thursday 1st shift, Transfer 1 PA (person assist) .Bed mobility 1 PA . During an observation and interview on 10/08/24 at 11:55 AM in Resident #19's room, the resident was lying flat in his bed, his pants were visibly wet and there was a strong odor of urine. Resident #19 reported that when he asks staff for assistance, they tell him that they will be right back, but they never do. Resident #19 reported that he wasn't going to ask for assistance anymore, unless it was an emergency because all the good staff don't work in the facility anymore, and there's not enough of the other staff. Resident #19 reported that he would not be getting out of bed either, because there was never anyone available when he wanted to lay back down. During an observation and interview on 10/10/24 at 11:36 AM in Resident #19's room, the resident was lying flat in his bed, with a sheet wrapped around the bottom half of his body, and there was a strong odor of urine in the room. Resident #19 reported that he preferred a shower vs. bed bath, but had not gotten a shower yet this week, and that he likely would not get it that day either. In an interview on 10/10/24 at 12:03 PM, Certified Nursing Assistant (CNA) AA reported that at times Resident #19 would decline assistance, but that she had not gotten a chance to check in with him yet that day. CNA AA reported that she started her shift at 6:30 AM and tried to get into Resident #19's room before noon, but that she had no time that day. CNA AA reported that Resident #19 was supposed to have gotten a shower that morning. During a subsequent observation and interview on 10/10/24 at 01:42 PM in Resident #19's room, the resident was lying in bed and there was still a strong odor of urine. Resident #19 reported that he had not received any assistance yet that day and stated, .my requests have been put in, and that's usually all that happens .it would be nice to get some attention and get cleaned up. Review of Resident #19's Shower Task indicated that he had received 3 showers since 9/12/24. Resident #20 Review of a Minimum Data Set (MDS) assessment for Resident #20, with a reference date of 8/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #20 was cognitively intact. Review of Resident #20's Care Plan revealed, Focus: Skin Management - At risk for additional skin breakdown .hx (history) of Stage 4 sacral ulcer, hx of Stage 4 pressure ulcer right medial foot .MASD (moisture associated skin damage) buttocks to my intergluteal cleft .Interventions: .assist me with floating my heels .Please help me get turned and repositioned while in bed or in my wheelchair as needed .Focus: I have actual ADL deficit .Interventions: .non-ambulatory .bed mobility 2 PA . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/08/24 at 12:01 PM in Resident #20's room, the resident was lying in his bed. Resident #20 reported that he would like to get up into his chair everyday, but that there is not enough staff to help him. Resident #20 reported that when he presses his call light, the staff shut it off and say that they will be right back, but don't come back. Resident #20 reported that staff talk about being short handed, and that he hears them talking in the hall about who has enough time to do things, or which resident's that they still need get to. Resident #20 reported that occasionally staff will offer him to get out of bed, but then make it sound like its going to be a difficult task, so he doesn't always ask. Resident #20 reported that he would like to get out and/or see what they have going on in activities, but its such a big ordeal to get him in and out of bed, that he rather not even try. During an observation on 10/08/24 at 02:49 PM Resident #20 was observed in his wheelchair in his room. During an observation and interview on 10/10/24 at 11:47 AM Resident #20 was lying in his bed, positioned on his left side with a pillow tucked under his right side, wearing a facility gown. Resident #20 reported that he was up in his chair the day before for a couple of hours, and when he wanted to lay back down, there was no one available, but that eventually staff from another hall came to help. Resident #20 reported that he had not had any cares provided yet that day, and that he had been in the same position since the day before. Resident #20 reported that his room is always the last room that staff come to when they do their rounds, and sometimes they don't come at all. In an interview on 10/10/24 at 12:03 PM, CNA AA reported that she had not gotten a chance to check on Resident #20 yet that day. CNA AA reported that there were 3 aides on the hall that day, and she still did not have time to get to every resident, every 2 hours. In an interview on 10/10/24 at 12:11 PM, Clinical Care Coordinator (CCC) G reported that there was sufficient staff that day, and that Resident #19 and #20 both should have been rounded on and provided cares 2-3 times since 6:30 AM that day. During an observation on 10/10/24 at 01:02 PM in Resident #20's room, CNA AA was preparing to provide cares and get the resident out of bed and into his wheelchair. At 1:16 PM Licensed Practical Nurse (LPN) P entered the room to assist with turning and incontinence care. There was a foul odor when Resident #20 was rolled onto his side. Resident #20's soaker pad, underneath him was observed soiled with brown and red liquid substance, the bottom sheet was soiled, and his incontinence brief had blue lines, indicating that it was wet. 41424 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a confidential interview for resident council on 10/10/24 at 11:08 AM, Thirteen residents reported the call light wait times were long, and the facility was short staffed especially on nights and weekends. Nurses were having to cover two hallways and report they can't get to the resident's requests for assistance. Medications were being delivered late because of the staffing issue. Four residents reported they had to wait for someone to take them to the restroom and were concerned about soiling themselves. Residents reported they were told to go to the bathroom in their briefs. One resident reported that was degrading to soil their brief on purpose and they were not a child. It was reported there were times the call light wasn't answered for approximately an hour. Multiple residents reported the staff shut off the call light and say they will come back and then they don't come back to assist the resident. Resident #71: Review of an Admission Record revealed Resident #71 was a female with pertinent diagnoses which included cerebral palsy with spastic quadriplegia, depression, legal blindness, and moderate intellectual disabilities. In an interview on 10/9/24 at 12:12 PM, Family Member (FM) YY reported the staff were not doing rounds every two hours as they were supposed to do, Resident #71 had redness and a rash due to not being taken to the restroom and not being changed. Resident #71 reported second shift was not very good at toileting or changing her every two hours. Resident #333: During an observation on 10/08/24 at 11:52 AM, Resident #333 was observed seated in her wheelchair. In an interview, Resident #333 reported she required staff assistance to get into bed and she had to wait until 12:30 -1:00 AM before staff came and assisted her to bed. She reported she had turned on her call light and was told that she didn't need to turn it on again. Resident #333 reported she thought her call light had been turned off or it was not working since no one had come to assist her to bed. Resident #51: Review of an Admission Record revealed Resident #51 was a female with pertinent diagnoses which included ulcer of right lower extremity, lymphedema, kidney disease, chronic pain, deep vein thrombosis (blood clot) and migraine. In an interview on 10/09/24 at 08:50 AM, Resident #51 reported the facility did have short staffing, sad that staff had to work by themselves on this unit. Resident #51 reported on the weekends the facility was short staffed all three shifts. Resident #51 reported she had an injury to her ankle one Sunday as the CNA was rushing to get me ready for church and she was the only one, that should never happen that she had to be by herself. We were rushing and she was helping me get dressed for church and get out of here on time to go to church. My ride was here and we were rushing to get the entrance and my foot got caught in the wheelchair and my ankle was hurt. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 Four Mile NW Grand Rapids, MI 49544	

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Physician's Note dated 9/30/24 at 1:37 PM, revealed, .ASSESSMENT/PLAN: Right ankle pain -patient noted injury one week ago where ankle was caught in her wheelchair. Suspected to be sprain at that time. Patient noting continued pain with ambulation and movement. Will order x-ray to r/o (rule out) acute process or occult fracture -encourage supportive care, rest and elevation .-continue pain regimen as seen below .-monitor for improvement . Resident #60: Review of an Admission Record revealed Resident #60 was a male with pertinent diagnoses which included stroke, cognitive communication deficit, pain in right ankle and joints of right foot, cellulitis of right lower limb, and muscle weakness. Review of current Care Plan for Resident #60, revised on 9/5/24, revealed the focus, .Risk of falls r/t (related to) COPD, HTN (high blood pressure), PVD (peripheral vascular disease) . with the intervention .Septic arthritis of right ankle .WBAT (weight bearing as tolerated) with RLE (right lower extremity with surgical boot . Ambulation with 1 PA (physical assist) . Review of Physician's Note dated 10/8/24 at 3:28 PM, .Continue to assist with ADLs as needed and provide a safe environment . In an interview on 10/08/24 at 02:48 PM, Resident #60 reported the staff took a long time to come to assist him when he needed to use the restroom and he soiled himself and needed to have his clothes changed. Resident #60 was upset by this as he can use the bathroom and needed their help to get there because of his foot/ankle was broken. Resident #60 reported he was also receiving antibiotics by IV in his PICC line (Peripherally inserted central catheter (PICC) was a thin flexible tube that's inserted into a vein in the upper arm and threaded into a large vein near the heart). In an interview on 10/10/24 at 02:07 PM, Licensed Practical Nurse (LPN) T reported the call lights' were sent to pagers for the CNAs, there were screens which informed the staff of the call lights for any room in the building and could hop around the corner to assist. LPN T reported the staff try to answer the call light within 15 minutes at the most. The screens let staff know how long the call light had been activated. In an interview on 10/10/24 at 02:10 PM, Certified Nursing Assistant (CNA) NN reported the staff should have an immediate response to the call light system. CNA NN reported the call light system was for the residents to alert staff they needed assistance, it could be for several things, like water or ADL (activities of daily living) care. In an interview on 10/10/24 at 02:11 PM, Clinical Care Coordinator (CCC) F reported the expectation to answer within 10-15 minutes. The CNAs were alerted via the pager system. The call light system used to ensure patient needs were met when they arise.

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Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38905 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, or serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents who consume food from the kitchen. Findings include: During an initial tour of the kitchen, at 9:31 AM on 10/8/24, an open bottle of lemon juice was found stored on a dry storage shelf with spices and seasonings. Observation of the bottle found that roughly 20% of the contents was left. The contents were observed milky and discolored and further observation of the manufacturer's label found that the item states Refrigerate After Opening. The bottle was shown to Dietary Manager (DM) EEE and was discarded at this time. According to the 2017 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less. During a tour of the kitchen, at 9:36 AM on 10/8/24, it was observed that four full pans were found stacked and stored wet on the clean pots and pans storage rack. When asked if there was a drying rack that staff would use, DM EEE stated that staff should let the pots and pans fully dry on the rack by the three-compartment sink. According to the 2017 FDA Food Code section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD . During a tour of the meal service, starting at 11:32 AM on 10/8/24, it was observed that [NAME] FFF was found to be plating residents meals wearing gloves and having artificial fingernails roughly an inch in length. After plating numerous resident meals, some of [NAME] FFF nails were found to have broken through her gloves and were observed protruding through the finger tips. The surveyor watched as more than a dozen plates were plated while [NAME] FFF had her nails coming out of her gloves. During this time, it was also observed that the handle of the mechanical scoop used for Mac and Cheese and the tongs for the green beans, occasionally fell into the product between plating and stayed in the dishes until each product was needed on another plate. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During meal service, at 12:25 PM on 10/8/24, it was observed that [NAME] GGG stepped in to start serving food on the line. During this service it was observed that cook GGG had plated green beans and realized that the resident's meal ticket would need a different vegetable, discarded the green beans back into the steam table and continued plating the resident's tray as needed. According to the 2017 FDA Food Code section 2-302.11 Maintenance of Fingernails (A) FOOD EMPLOYEES shall keep their fingernails trimmed, filed, and maintained so the edges and surfaces are cleanable and not rough. (B) Unless wearing intact gloves in good repair, a FOOD EMPLOYEE may not wear fingernail polish or artificial fingernails when working with exposed FOOD. According to the 2017 FDA Food Code section 3-304.12 In-Use Utensils, Between-Use Storage. During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (A) Except as specified under (B) of this section, in the FOOD with their handles above the top of the FOOD and the container . According to the 2017 FDA Food Code section 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 -3-306.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 This citation pertains to intake MI00146660. Based on interview and record review, the failed to ensure documentation of resident medical records were completed for 2 (Resident #17 and #43) residents, of total sample of 27, reviewed for comprehensive and accurate medical records, resulting in an inaccurate reflection of the resident's medical treatments administered resulting in the potential for providers to not have an accurate picture of resident status and condition. Findings include: Resident #17 Review of an Admission Record revealed Resident #17 was originally admitted to the facility on [DATE] with pertinent diagnoses which included hypertension (high blood pressure). Review of Residents Treatment Administration Record (TAR) revealed, Orders: Cleanse right heel with normal saline, pat dry, apply foam dressing. Change every 3 days and PRN (as needed). One time a day every 3 day(s). Start Date: [DATE]. It was noted that on [DATE], and [DATE] and [DATE], there was missing documentation that the treatment had been completed or missed. Order: Cleanse sacral wound with soap and water, pat dry, fill wound with iodosorb (gel used to treat pressure ulcers) and cover with dry dressing. Change daily and PRN. In the morning. Start date [DATE]. It was noted that on [DATE] there was missing documentation to indicate that the treatment had been completed or missed. Order: Left shin cleanse with soap and water, pat dry, apply foam dressing. Change every 3 days and PRN. in the morning every 3 day(s) for wound care. Start date: [DATE]. It was noted that on [DATE] there was missing documentation to indicate that the treatment had been completed or missed. During an interview on [DATE] at 10:57 AM, Clinical Care Coordinator (CCC) G reported that he was responsible for reviewing documentation of Nursing staff and ensuring they completed documentation. CCC G reported that he checked the electronic health record (EHR) system daily for reports of missing documentation, and would follow up with staff that had not completed the documentation. This writer reviewed Resident #17's TAR with CCC G and queried about the missing documentation of Resident #17's treatments in September and [DATE]. CCC G reported that he was unaware that Resident #17 had multiple missing documentation for treatments in September and October. CCC G confirmed that he had not reached out to the staff members responsible for the missing documentation of Resident #17's treatments in September and [DATE]. Resident #43 Review of an Admission Record revealed Resident #43 was originally admitted to the facility on [DATE] with pertinent diagnoses which included alzheimer's disease. Review of Resident #43's EHR revealed no documentation of care tasks completed by CNA's from 11:30 PM- 6:00 AM on [DATE] through [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:56 AM, CNA GG reported that CNA's were required to document care tasks for every resident each shift. CNA GG reported that some of the required documentation for every resident included the resident's toileting status and if the resident had a bowel movement on their shift. During an interview on [DATE] at 8:48 AM, CCC D reported that the facility's CCC's would monitor the facility's EHR daily to ensure that staff were completing all required documentation on residents. CCC D showed this writer the outstanding charting report in the EHR that was utilized for the CCC's to monitor outstanding documentation. It was noted that toilet use was a required task monitored in this report. This writer queried about Resident #43's toilet use documentation, and why there was not any documentation available from 11:30 PM through 6:00 AM on [DATE] to [DATE]. CCC D reported that the charting for the toilet use task was to be completed by exception. CCC D could not report why the toilet use task order was noted to be completed every shift if the facility only required this task to be charted by exception. CCC D could not explain why the facility would receive outstanding reports for this task if it was not required to be documented for each shift. CCC D reported that she was not able to explain why Resident #43 did not have any CNA tasks documentation in her EHR from 11:30 PM through 6:00 AM on [DATE] to [DATE]. During an interview on [DATE] at 10:57 AM, CCC G reported that the CCC's were responsible for reviewing the outstanding documentation of CNA tasks. CCC G reviewed Resident #43's toilet use task with this writer and reported that CNA's were expected to document under the toilet use task every shift. CCC G was not able to report why Resident #43 did not have any CNA tasks documentation in her EHR from 11:30 PM through 6:00 AM on [DATE] to [DATE]. During an interview on [DATE] at 12:43 PM, CNA LL reported that she was the CNA responsible for caring for Resident #43 from 11:30 PM through 6:00 AM on [DATE] to [DATE]. CNA LL reported that she had not completed any documentation on Resident #43 because she did not have access to the facility's EHR system, so she was not able to document on any residents that she had provided care for that night. CNA LL reported that she had reached out to scheduler RR to gain access to the EHR. During an interview on [DATE] at 1:00 PM, Scheduler RR confirmed that she was notified by CNA LL on [DATE] that she did not have access to the facility's EHR to document resident cares. Scheduler RR reported that CNA LL had not worked since July, so her password had expired. Scheduler RR reported that she had to contact another facility staff member to assist CNA LL with gaining access to the EHR, which she got on [DATE]. Scheduler RR confirmed that CNA LL worked on [DATE], [DATE], and [DATE] without access to the facility's EHR to document on all of the residents that she had cared for. During an interview on [DATE] at 2:09 PM, CCC G reported that he was not aware that CNA LL had worked three shifts without access to document on any of the residents that she had cared for. During an interview on [DATE] at 3:05 PM, CCC D reported that she was not aware that that CNA LL had worked three shifts without access to document on any of the residents that she had cared for. Review of the Facility's Medical Record Documentation dated [DATE] revealed, PURPOSE: To assure care provided is accurately described in the medical record. POLICY: Licensed staff will document care provided in the medical record which shall include the name and credentials of additional licensed personal when dual signatures are not available in the electronic medical record .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981 Based on observation, interview, and record review, the facility failed to implement infection control practices for proper hand hygiene, maintain clean resident wheelchairs for 2 (Resident #79, #40) of 2 residents, and sanitize resident shared equipment creating unsanitary conditions for commonly touched/utilized items reviewed for infection control practices resulting in the potential for the spread of infection, cross-contamination, and disease transmission for all residents residing in the facility. Findings include: In an observation on 10/08/24 at 10:30 AM., noted a sit to stand lift the base (where residents plant their feet while being raised from a seated to a standing position for transfers to and from chairs, beds, toilets. etc) was heavily soiled with dust, debris and food crumbs. During an observation on 10/09/24 at 4:04 PM., Licensed Practical Nurse (LPN) U was observed exiting a resident room after assisting Certified Nurse Aide (CNA) Z. LPN U exited the resident room without using hand sanitizer which was noted on the wall in the resident room. LPN U approached her medication cart, and began documenting/charting on a laptop. LPN U did not use hand sanitizer before touching the laptop, or after she finished documenting. LPN U then noticed a call light on and proceeded to go answer the call light, simultaneously both CNA Z and LPN U had recognized the call light on. LPN U did not use hand sanitizer before entering the room. CNA Z used hand sanitizer prior to entering the room which was a personal sized hand sanitizer attached to her uniform scrub top and noted to be an acceptable alcohol base hand sanitizer. CNA Z tended to the resident, and LPN U was not needed to assist. LPN U then exited the resident room, without using hand sanitizer at any time, then returned to her medication cart. LPN U pulled her medication cart keys out of her pocket, unlocking the medication cart. LPN U then logged back into the laptop to begin checking for medications to be set up and administered. LPN U at no time used hand sanitizer before starting to pull medications from the medication drawer. In an interview on 10/09/24 at 4:20 PM. LPN U reported she did not follow proper hand hygiene techniques by failing to use hand sanitizer and/or washing her hands before and after exiting resident rooms. LPN U reported it is standard of practice and policy at the facility to wash in/wash out meaning either use hand sanitizer or wash hands before and after entering/exiting rooms, touching surfaces, and setting up medications. LPN 'U reported she did not realize she did not use hand sanitizer that was readily available on the units, in resident rooms and on her medication cart. In an observation on 10/10/24 11:24 AM., noted a sit to stand lift the base was heavily soiled with dust, debris and food crumbs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/10/24 at 12:10 PM., CNA P reported staff are suppose to wipe down all resident shared equipment between uses. CNA P reported a times the sanitizing wipes are not always readily available attached to the lifts, and shared equipment. CNA P reported the reason the food and crumbs are located on the base of the sit to stands is due to residents being lifted after meals and food crumbs falls onto the base of the lifts, and then the residents step on it the crumbs, they become stuck on. CNA P reported there are no hand held small broom/dust pans, or small hand vacuums to easily sweep up/vacuum the food, dust and debris on the bases and the rim prevents it from just falling off on its own. CNA P reported all staff should notice any item and shared equipment, commonly touched high surface areas that need to be clean, and are responsible to either clean it, or ask for housekeeping to assist with cleaning the equipment, item or area. 41424 During an observation on 10/08/24 at 10:25 AM, this writer observed a bariatric wheelchair in the hallway between room [ROOM NUMBER]-511, there was a thick black pad, the frame of the chair was dirty with dirt and debris, the right arm rest was torn away on the right outer side, the left arm rest was tearing away on the right inside. The sit to stand in the hallway between 511 and 509, the foot rest area had dirt and debris on it and the left arm of the U which surrounded the front of the resident had a brown stain smeared on it. Resident #79: During an observation on 10/08/24 at 10:55 AM, this writer was standing in the hallway and spoke to Resident #79 he had dirt and debris built up on his wheelchair spokes. Resident #40: During an observation on 10/08/24 at 11:10 AM, Resident #40 had a flap on the back of her wheelchair and it was turned up. In the flap was dirt and debris inside the fold. During an observation on 10/08/24 at 10:38 AM, observed Certified Nursing Assistant (CNA) PP come out of a resident's room with a the hoyer, placed it along the all in the hallway, and did not wipe it down with sanitizing wipes. observed no wipes on the machine to wipe it down. The other CNA who assisted left the room and headed the other way down the hallway and did not sanitize the hoyer. In an interview on 10/10/24 at 02:10 PM, CNA DD reported the hoyer and/or sit to stands were to be disinfected after use because of the potential for contamination and shared infections/germs with another resident. Review of policy, Cleaning and Disinfection of Resident Care Items and Equipment revised October 2009, revealed, .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard Cleaning/Disinfecting Durable Medical Equipment: 3. Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident .