STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235396	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Silverbell Estates	1255 W Silverbell Rd Orion, MI 48359

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00138031, MI00138863, MI00140340, and MI00141846. Based on observation, interview, and record review, the facility failed to document administration of schedule II (2) controlled substances (drugs that have high potential for abuse and/or addiction) according to professional standards of practice for nine (R502, R504, R509, R511, R512, R513, R514, R515, and R516) of 12 residents reviewed for medications. Findings include: On 4/3/24 at 1:03 PM, an observation of the Oak Unit medication cart was conducted with Licensed Practical Nurse (LPN) 'B' and the following observations were made: R509 LPN 'B' was asked to present R509's Morphine Sulfate Solution (a controlled liquid medication used to treat pain). The amount of medication in the bottle was compared with the amount documented on R509's Medication Monitoring/Control Record (a form used to document medication removed from the supply in order to keep an accurate record of the medication). The amount of medication in the bottle was 27 milliliters (ml). The last entry documented on the control record was dated 4/3/24 at 6:00 AM and noted there was 21. 75 ml remaining after 0.25 ml was given (removed) which equaled a 5.25 ml discrepancy between what was documented as given and what was actually in the bottle of medication. When queried about the discrepancy, LPN 'B' stated, It [NAME] out when we get to the bottom of the bottle. LPN 'B' reported she counted each controlled substance with the outgoing nurse from the midnight shift, but did not report the discrepancy to anyone. Further review of R509's control record revealed 30 ml was delivered and received on 3/29/24. There was no nurse's signature to indicate who received the medication from the pharmacy Further review of R509's clinical record revealed R509 was admitted into the facility on [DATE] with diagnoses that included: Multiple Sclerosis. R509 signed onto hospice on 2/29/24. R516 (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN 'B' was asked to present R516's Acetaminophen with Codeine tablets (a controlled medication used to treat pain). There were zero tablets observed in the blister pack. The last entry on the control record was dated 4/2/24 at 2:00 AM and the amount remaining was noted as one. When queried about the discrepancy between the amount of medication remaining in the blister pack and the amount documented on the control record, LPN 'B' reported she gave the medication that morning, but did not document that she pulled the tablet from the supply. LPN 'B' stated, I was just about to go back and document it. LPN 'B' reported she gave the medication at 9:00 AM, four hours earlier. A review of R516's clinical record revealed R516 was admitted into the facility on [DATE] with diagnoses that included: history of stroke. R511 LPN 'B' was asked to present R511's Norco (Hydrocodone-Acetaminophen) tablets from the medication cart. There were 12 tablets observed in the blister pack (a sheet of medications where each individual tablet can be punched out of the back of the sheet through a foil seal). The last entry documented on the control record for R511's Norco was dated 4/2/24 at 8:01 PM and noted there were 13 tablets remaining after one was given on that date. When queried about the discrepancy between the physical amount of tablets in the blister pack and the amount documented on the control record, LPN 'B' reported she removed one tablet earlier in the morning and administered it to R511, but did not document that she pulled the tablet from the supply. LPN 'B' reported she did not have time to sign out the medication on the control record. At that time, LPN 'B' grabbed a pen and wrote that she removed one tablet at 9:14 AM (approximately four hours earlier) and that there were 12 tablets remaining. A review of R511's clinical record revealed R511 was admitted into the facility on [DATE] with a diagnosis of fusion of spine. R512 LPN 'B' was asked to present R512's Percocet (oxycodone-acetaminophen) tablets from the medication cart. There were 20 tablets observed in the blister pack. The last entry documented on the control record for R512's Percocet was dated 4/3/24 at 2:00 AM and noted there were 21 tablets remaining after one was given at that time. When queried about the discrepancy, LPN 'B' stated, I just gave him one but didn't have time to document it. Further review of R512's control record for Percocet revealed on 3/31/24, 30 tablets were dispensed by the pharmacy. The control record indicated on 4/1/23, LPN 'D' received 30 tablets of Percocet from the pharmacy for R512. It was documented by LPN 'D' that one tablet was removed from the supply, but there was no documentation that indicated the date or time the medication was given. A review of R512's clinical record revealed R512 was admitted into the facility on [DATE] and readmitted on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). At that time, an interview was conducted with LPN 'B'. When queried about whether she documented any controlled medications that she pulled from the supply, LPN 'B' reported she did not because she did not have time to do and planned to do it later. When queried about the protocol for administering controlled substances, LPN 'B' did not offer a response. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/3/24 at 1:25 PM, an observation of the [NAME] Unit medication cart was conducted with Licensed Practical Nurse (LPN) 'C' and the following observations were made: R513 LPN 'C' was asked to present R513's Norco tablets from the medication cart. There were 21 tablets observed in the blister pack. The last entry on the control record was dated 4/3/24 at 12:00 PM, documented by LPN 'C', and indicated there were 23 tablets remaining after one tablet was given at the documented time. When queried about the discrepancy, LPN 'C' reported the count was off when she counted with the outgoing nurse from the midnight shift. When queried about why LPN 'C' continued to document the incorrect number of remaining tablets at 12:00 PM if a discrepancy was discovered that morning, LPN 'C did not offer a response. On 4/3/24 at 2:06 PM, a review of R513's MAR for April 2024 revealed no documentation that R513's Norco that was pulled from the supply at 12:00 PM was administered to the resident (as evidenced by no signature from the nurse to indicate the medication was given). A review of R513's clinical record revealed R513 was admitted into the facility on [DATE] with a diagnosis of COPD. R514 LPN 'C' was asked to present R514's Hydrocodone-acetaminophen tablets from the medication cart. There were three tablets remaining in the blister pack. The last entry documented on the control record was dated 4/3/24 at 5:00 AM and it was noted that four tablets were remaining at that time. When queried about the discrepancy, LPN 'C' reported she gave R514 one tablet during her shift but did not sign it out on the control record yet. LPN 'C' explained that she did not document on the control record until the resident took the medication and did not document at the time the medication was removed from the supply. On 4/3/24 at 1:50 PM, a review of R514's MAR for April 2024 revealed R514 was scheduled to receive one dose of the Hydrocodone-acetaminophen 5-325 mg at 2:00 PM. There was no documentation on the MAR that indicated LPN 'C' administered the medication as she reported during her interview. Further review of R514's clinical record revealed R514 was admitted into the facility on [DATE] with a diagnosis of seizures. R515 LPN 'C' was asked to present R515's Hydrocodone-acetaminophen (Norco) tablets from the medication cart. There were 15 tablets observed in the blister pack. The last entry on the control record was dated 4/3/24 at 5:00 AM and noted there were 16 tablets remaining in the supply. When queried about the discrepancy, LPN 'C' reported she gave the medication, but did not document it. On 4/3/24 at 2:03 PM, a review of R515's MAR for April 2024 revealed R515 was scheduled to receive a dose of Hydrocodone-acetaminophen 7.5-325 mg (Norco) at 12:00 PM. There was no documentation on the MAR that indicated LPN 'C' administered Norco to R515, as evidenced by no signature. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of R515's clinical record revealed R515 was admitted into the facility on [DATE] and readmitted on [DATE] with a diagnosis of neurocognitive disorder with lewy bodies. On 4/3/24 at 1:50 PM, an interview was conducted with the Director of Nursing (DON). When queried about the process for administration of controlled substances, the DON reported when a controlled medication was pulled from the supply, the nurse signed the narcotic book (Control Record) and documented the exact time the medication was pulled, how many was pulled, and what the remaining amount was. Then, the nurse administered the medication to the resident, ensured they took it, and signed it out on the MAR to indicate the resident took the medication. 30675 R502 Review of the clinical record revealed R502 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included: acute kidney failure, acute pancreatitis without necrosis or infection, spinal stenosis, and sprain of ligaments of cervical spine. According to the Minimum Data Set (MDS) assessment dated [DATE], R502 had intact cognition and received opioid medication for three of the seven days during this assessment reference period. Review of the physician orders, Medication Administration Records (MARs), controlled substance records, and progress notes revealed multiple missing documentation without explanation of the missed scheduled, and/or as needed (PRN) Percocet (narcotic pain medication) administrations. On 9/19/23 at 9:57 AM, the order was changed from Percocet Oral Tablet 5-325 MG to Percocet Oral Tablet 7.5-325 MG Give 1 tablet by mouth every 8 hours as needed for pain. The MAR documented R502 was administered the above prn Percocet order five times on: 9/14 at 9:09 AM 9/14 at 5:12 PM 9/15 at 9:20 AM 9/15 at 5:18 PM 9/16 at 1:18 AM The controlled substance record revealed the following 13 discrepancies of the Percocet medication being documented as removed, but not documented as administered on the corresponding MAR on: 9/14/23 at 11:00 PM 9/16 at 8:00 AM 9/16 at 4:00 PM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/17 at 8:00 AM 9/17 at 4:00 PM 9/18 had a line through the entire entry 5:00 AM with 20 Percocet tablets on hand and one given with 19 remaining. The next documented entry was on 9/18 at 8:00 AM which identified there were 19 tablets on hand with one tablet removed and a total of 18 tablets remaining. The bottom portion of this control record to document Record of Waste and Spoilage was left blank and there was no additional documentation in the clinical record to explain the control record discrepancy. 9/20 at 12:35 PM 9/20 at 5:00 PM 9/20 at 8:00 PM 9/21 at 2:00 AM 9/21 at 8:14 AM 9/21 at 1:06 PM 9/21 at 5:35 PM On 9/26/23, the resident was prescribed Percocet Oral Tablet 7.5-325 MG give 1 tablet by mouth every 4 hours for pain (scheduled at 12:00 AM; 4:00 AM; 6:00 AM; 12:00 PM; 4:00 PM; 8:00 PM). The controlled substance record for the scheduled Percocet revealed on 10/18/23, the nurse documented the scheduled Percocet on the record of waste and spoilage under DESCRIBE IN DETAIL that read, Spilled water on med. Although two signatures were required per facility process, this was only signed by one nurse. The section for signature #2 was left blank. R504 Review of R504's closed clinical record revealed the resident was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included: encounter for other orthopedic aftercare, periprosthetic fracture around internal prosthetic left hip joint, difficulty in walking, osteoarthritis, bilateral primary osteoarthritis of hip, and malignant neoplasm of vulva. According to the MDS assessment dated [DATE], R504 had intact cognition and received opioid medication. Review of the physician orders, Medication Administration Records (MARs), controlled substance records, and progress notes revealed multiple missing documentation without explanation of the missed scheduled, and/or as needed (PRN) Percocet (narcotic pain medication) administrations, including medication documented as being given days beyond the resident's discharge from the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note entry on 12/15/23 at 5:49 PM documented, .EMS (Emergency Medical Services) arrived unplanned. Patient called because she states her F/C (Foley Catheter) hurts .EMS is taking patient to [name of local hospital] per patient request . However upon review of the MARs, there were multiple medications documented as administered (via a check mark) to R504, despite the resident being discharged from the facility on 12/15/23 before 6:00 PM. These medications included: Calcium Carbonate Oral Tablet Give 500 MG by mouth one time a day for other (to be administered via MAR at 8:00 PM). Melatonin Oral Tablet 3 MG Give 1 tablet by mouth at bedtime for insomnia (to be administered via MAR at 9:00 PM). Oxybutynin Chloride Oral Tablet Give 10 MG by mouth one time a day for bladder spasms (to be administered via MAR at 8:00 PM). Lovenox Injection Solution Prefilled Syringe 30 MG/0.3 ML (Milliliters) subcutaneously every 12 hours for other (to be administered via MAR at 9:00 AM & 9:00 PM). Additionally, review of R504's prescription which had been ordered on 12/12/23 for Norco (Hydrocodone-Acetaminophen - a narcotic pain medication) 7.5-325 MG instructed nursing staff to Give 1 tablet by mouth every 4 hours as needed for pain Discontinue Norco 5/325 when 7.5 arrives. The MAR documented the first administration of the Norco 7.5-325 MG was given on 12/13/23 at 5:00 AM. The order for Norco 5-325 MG had not been discontinued until 12/23/23 (8 days following R504's hospitalization and 10 days after the resident had received their first dose of the Norco 7.5-325 MG). On 4/3/24 at 2:30 PM, an interview was conducted with the Director of Nursing. When asked about the concern regarding medication being documented as given, despite the resident being discharged , the DON reported they were not able to offer any explanation but would have to investigate further. There was no additional documentation provided by the end of the survey. The DON was asked about the earlier request to provide the controlled substance records for R504 and reported they were currently working on trying to locate that documentation. There was no documentation provided by the end of the survey.

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F 0686 Level of Harm - 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** 41415 This citation pertains to intake(s): MI00140190 & MI00140245. Based on interview and record review the facility failed to ensure accurate wound assessments, timely implementation of treatment for identified wounds, coordination of care and wound services and ensure a collaborative approach for wound healing was completed with the dietician for two (R's 501 & 506) of three residents reviewed for pressure wounds, resulting in R506 to have developed an infected unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) buttocks/sacral wound (after debridement identified as a Stage III- full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissues and rolled wound edges are often present- buttock/sacral wound) that required the resident to be transferred and admitted to the hospital due to sepsis from an infected buttock/sacral ulcer. Findings include: R506 Review of a complaint submitted to the State Agency (SA) documented the concern of the facility to have failed to prevent pressure ulcers which became infected. Review of the medical record revealed R506 was admitted to the facility on [DATE] with a readmitted [DATE] and diagnoses that included: hemiplegia and hemiparesis affecting right dominant side, dementia, and senile degeneration of the brain. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12 and required staff assistance for all activities of daily. Further review of the medical record revealed R506 had an appointed legal guardian in place. Review of a Braden Scale for Predicting Pressure Sore Risk dated 3/22/23, documented a score of 18 which indicated At Risk. Review of the July 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented the following order Wound Prevention: Apply triad paste daily every day shift for skin . Start Date 6/18/23. Review of a Skin Observation dated 7/8/23 at 1:18 PM, documented in part . Does the Resident have any NEW Skin Issues Observed . Yes . Left gluteal fold- skin tear . Left thigh (rear)- dime size skin tear . Review of the medical record revealed no documentation of the physician to have been notified of the identified skin impairments and no new treatment implemented. Review of Nursing note by the Director of Nursing (DON) dated 7/11/23 at 11:30 AM, documented in part . Resident has NEW skin issue(s) observed. 1 . unstageable, Left buttock - stage III pressure . sacral/coccyx region . resident noncompliant of [NAME] <sic> hygiene repositioning and brief changing . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a care plan titled . The resident has potential for impairment to skin integrity . documented . Resident's unwillingness to offload once he is up in his w/c (wheelchair) for the day, can be resistive to check and change . Review of the medical record revealed one incident documented on 3/17/23 of the resident to have been noncompliant with care prior to the identification of the sacral/coccyx wound. Review of the medical record revealed no documentation of treatment implemented for the . unstageable, Left buttock Stage III pressure . sacral/coccyx region . identified on 7/11/23, until more than a week later on 7/19/23. Review of the July 2023 MAR and TAR documented the following order in part, . cleanse left buttock and coccyx with dankins, apply calcium alginate and medi honey and cover with ABD pad. Document any refusals every evening shift every Wed (Wednesday) for skin healing . Start Date- 07/19/2023 . This order was implemented more than a week after the initial identification of the sacral/coccyx wound. Review of the wound consultations revealed the following: On 7/14/23 at 10:49 AM, documented in part . being seen for wound to buttock . Functional Assessment: Total Dependence . Pressure injury of deep tissue of sacral region . Acute moist area with eschar in gluteal fold of sacrum. Unable to perform full assessment. Resident refuses to leave wheelchair . Dietician to participate to optimize nutrition. Report changes to provider. Pressure injury to left buttock, stage2 (Partial-thickness loss of sin with exposed dermis, presenting as a shallow open ulcer) . Unable to perform full assessment. Resident refuses to leave wheelchair 2 open area left buttock. Dressing has small amount of serosanguinous drainage . Pressure injury to the right buttock, stage 2. Active Acute open area right buttock with small open area. Unable to measure size due to resident refusing exam . On 7/18/23 at 4:16 PM, documented in part . Pressure injury of deep tissue of sacral region Active Acute resident sitting in wheelchair - declined exam Monitor wound . Report changes to provider . Pressure injury of left buttock, stage 2 Active Acute resident sitting in wheelchair - declined exam. Monitor wound care . Report changes to provider . Pressure injury of right buttock, stage 2 Active Acute resident sitting in wheelchair - decline exam Monitor Wound care . Dietician to participate to optimize nutrition. Report changes to provider . On 7/21/23 at 10:18 AM, documented in part . being seen for wound to buttock . Pressure injury of deep tissue of sacral region Stable. Chronic Area in gluteal fold moist. Approximate size 2 x 2 x 0.125 inches. Base of wound dark in color . Report changes to provider. Pressure injury of right buttock, stage 2 Stable Chronic Improving. Approx 2 x 1.5 inches . Dietician to participate to optimize nutrition. Report changes to provider . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record revealed no documentation of the clarification of the staging of the wounds completed by the DON on 7/11/23 that documented an unstageable and Stage III wounds compared to the clinician assessments as documented on 7/14/23, 7/18/23 and 7/21/23, of the wounds documented as stage 2's. Further review of the medical record revealed no documentation of the dietician to have been notified of R506's wounds and no documentation of the dietician to have acknowledged the development of R506's wounds at that time. Review of a Nursing note dated 7/23/23 at 8:00 PM, documented in part . T (temperature): 101 . BP (blood pressure): 99/54 . P:92 irregular, R (respirations): 40, SPO2% 89%-91% on room air . odor coming from coccyx area . Resident transferred to (hospital name) via ambulance . Review of the hospital documents revealed the following: A Wound Care Progress Note dated 7/26/23 at 5:54 PM, documented in part . unstageable pi (pressure injury) to gluteal cleft that surgery is managing. Stage 3 pi (pressure injury) to left gluteus . A Operative Report dated 7/27/23 at 2:05 PM, documented in part . Sacral Wound Debridement . Preoperative Diagnosis- Unstageable Sacral Wound . Postoperative Diagnosis- Stage 3 Sacral wound, 9 x 5 x 1.5 cm (centimeters) . Sharp excisional debridement was performed to the sacral wound down to and including the presacral fascia. There was a moderate amount of purulent/necrotic fluid that was expressed from the wound . There is noted to be 5 cm (centimeters) of undermining along the 10-11 o'clock region, in order to provide adequate exposure to the wound, the wound was unroofed with exposure of more necrotic tissue that was debrided. The debridement was taken until there was healthy bleeding tissue within the wound bed . The new wound measurement were 9 x 5 x 1.5 cm. Given the size and location of the sacral wound it was decided to place a wound VAC to allow for adequate healing . Findings- 9 x 5 x 1.5 cm stage III sacral wound, Moderate amount of purulent/necrotic fluid expressed from wound . An Infectious Disease Progress Note dated 7/27/23 at 6:18 PM, documented in part . Chief Complaint- EMS (emergency medical services) reports AMS (altered mental status) per NH (nursing home). EMS reports pt (patient) is normally A&Ox3 (alert and oriented times three) . admitted from an extended care facility . due to altered mental status and hypotension. On admission patient was noted to have a . sacral decubitus ulcer which had been foul-smelling and draining purulent drainage. On admission . had leukocytosis and tachycardia. Patient had hypotension, which improved with administration of fluids. He was placed on empiric antibiotics in the form of vancomycin. Blood cultures are pending at this time . The surgical service has seen this patient and there are plans for debridement of the sacral ulcer . Impression . Infected unstageable decubitus ulcer in the coccygeal area, at the natal cleft . Sepsis, secondary to #1 (infected unstageable coccygeal ulcer) . Recommendations . Continue Zosyn 4.5 g (gram) IV (intravenous) every 8 hours, vancomycin (per dosing pharmacy), pending culture results from the OR (operating room) . Monitor temperatures and white blood cell count . Continue local care to decubitus ulcer- anticipate need for further debridement . On 4/3/24 at 3:19 PM, Registered Dietician (RD) E was interviewed and asked their involvement with residents that have pressure wounds. RD E stated they are to be notified once the wound is identified and they complete an assessment on the resident and modify the residents care as necessary. RD E was asked to look into their assessment, files, and notes for any documentation of having to been notified of R506's wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/4/23 at 9:17 AM, a follow up interview was conducted with RD E who stated they had not been notified of R506's wounds prior to their hospitalization . RD E stated that usually they are notified when the skin impairment is first identified. On 4/4/24 at 10:17 AM, the Director of Nursing (DON) (who also served as the wound nurse during July 2023) was interviewed and asked how a skin tear initially identified on 7/8/23 could worsen to an unstageable and stage III wounds (buttock/coccyx) in three days without the front-line staff (nurses and aides) to have been able to identify and notify the physician of the worsening of the wound. The DON was also asked to clarify their assessment that was documented on 7/11/23 describing the wound as an unstageable and stage III wound. The DON was asked why treatment was not implemented for the identified wounds from 7/11/23 to 7/19/23 and why the dietician was not notified of R506's wounds to have a collaborative interdisciplinary approach to promote the healing of R506's wounds. The DON stated the facility had up until a month (per the facility's protocol) to ensure the dietician's involvement in wound care and would look into the other concerns and follow back up. At 11:00 AM, the DON returned and stated the coccyx had an unstageable wound and the left buttocks had a stage III wound. The DON stated R506 was a difficult case for them, and the DON pointed out the refusals made by the resident to not be assessed by the wound clinician on the wound care days, the DON was then asked why the facility staff failed to coordinate the wound care for R506 with the wound clinician and the facility staff. The DON was asked how a resident who requires total dependence for all care was placed in their wheelchair every wound clinic day, knowing the resident would refuse to lay back down once in their wheelchair (as documented in the resident's care plan), the DON stated it was the resident's right to get in their wheelchair and right to refuse the wound assessment. The DON stated during the time of July 2023 they had so many issues with the wound physicians/clinicians and ended up changing wound care providers in September 2023. No further explanation or documentation was provided by the end of the survey. 34275 R501 A complaint was filed with the State Agency (SA) that alleged when they were noted on or about 1/24/24 that R501 had two pressure sores, one on their penis area and one on their bottom. The complainant noted that they were discharged to the Hospital on 2/5/24 and again informed the resident had multiple pressure ulcers in those locations when they arrived at the Hospital. A review of R501's clinical record revealed the resident was initially admitted to the facility on [DATE] and their last admitted was 2/13/24 with diagnoses that included, in part: diabetes, chronic kidney disease, obesity and heart failure. A review of the Minimum Data Set (MDS) dated [DATE] noted the resident's Brief Interview for Mental Status (BIMS) score was 15/15 (intact cognition) and noted the resident needed one to two person assistance for most Activities of Daily Living (ADLs). Review of Section M of the MDS noted the resident did not have a pressure ulcer. Continued review of R501's clinical record, documented, in part, the following: Skin Observation(1/2/24): Resident has NO New skin issues . (authored by the DON). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Health Status Note (1/22/24): Writer and wound care nurse notified by aide that resident had a new open area to sacrum and penis. Wound care nurse and writer did observe open area to sacrum noted as shearing r/t (due to) transfers. Open area to penis noted r/t new placement of foley .Wound care NP (nurse practitioner) to eval . *It should be noted that there were no notes in the resident's electronic record that indicated he was see by the wound care NP. Order (1/22/24): Wound Care: Apply Triad paste to open area on penis. One time a day for wound care and every 24 hours as needed for wound care. Care Plan (4/18/23): Focus: The resident has potential skin impairment r/t (related to) incontinence, generalized weakness, history of masd (moisture associated skin damage), pressure and incisions . Interventions: Monitor skin when providing cares, notify nurse of any changes to skin appearance (2/23/17) . Educate resident/family/caregivers of causation factures and measures to prevent skin injury (7/31/23) . Encourage good nutrition and hydration in or to promote heathier skin (7/31/23) .Focus: The resident has actual impairment to skin integrity r/t fx (fracture) with incision, assistance needed with mobility/ADLs .will refuse care until an aide he approves of is available to provide care .Interventions: .Assist to turn and reposition when in bed as tolerated (9/16/2020) . *It should be noted that there were no interventions noted for skin impairment following the discovery of open wounds dated 1/22/24. Hospital Records (2/5/24): ED (emergency department) 2/5/24 .H & P (history and Physical exam) .patient was seen and examined on February 5, 2024 .Assessment and Plan .sacral decubitus ulcer .Will have Wound care evaluate the patient .Wound History: Stage 2 pressure injury coccyx .assessment: Wound Length: 5.5 cm x Wound Width: .6 cm .Wound surface area: 3.3 cm .Wound: Penis: Wound bed tissue assessment: Yellow; sloughing; red; bleeding; painful; fragile .length 1.5 cm .width: 4 cm . R501 returned to the facility on [DATE]. A skin observation (2/14/24) documented: .scrotum are open areas multiple, Coccyx open area . (Authored by Wound Nurse F). Skin Observation (2/14/24): .Resident has NEW skin issue(s) observed 1 Other (specify)- groin 3 open pressure .Other (specify) penis pressure, right gluteal fold- stage III pressure . Three Skin and Wound Evaluation dated 2/16/24 did not provide necessary information as to the type, location, acquired status, stage. Wound measurements were noted. Wound Evaluations with accompanied photos provided only measurements and noted as undiagnosed . A review of the MAR/TAR noted R501 did not receive any treatments to open areas on the scrotum and/or penis from 2/14/24 through 2/16/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/4/24 at approximately 10:25 AM, an interview was conducted with the DON. Wound Nurse F was also present during the interview. The DON was asked as to R501's facility acquired pressure ulcers noted on 1/22/24. The DON reported that they believed the only open area found on 1/22/24 was on the resident's penis. When asked if there was any documentation as to the staging and description, location, measurements of the wound as noted, the DON reported that there was not as they believed the wound had healed. When asked if the resident was seen by the Nurse Practitioner (NP), the DON reported No. When asked as to the notes from the Hospital that noted the resident had wounds including those on the coccyx and penis upon admission on 2/5/24, the DON reported that the pictures were different than the hospital notes. When asked why the assessments were not fully completed upon R501's return from the hospital on 2/14/24, Wound Nurse F reported that they were not fully checked as completed. When asked what treatments were put in place for multiple open areas on the scrotum and/or penis, the DON did not provide a response. A review of the facility policy titled, Skin Protection Guideline (7/7/21), noted, in part: .Purpose: .To ensure residents that admit and reside at our facility are evaluated and provided individualized interventions to prevent, reduce and treat skin breakdown .Evaluation: Our facility applies a process to identify residents with or at risk for developing a pressure injury: upon admission/readmission .Transfer out/in . With significant changes in condition and Routinely .process includes: .Implementing, monitoring and modifying interventions to stabilize, reduce or remove underlying risk factors .Because a resident can develop a PU/PI (pressure ulcer/injury) within hours .the at risk resident needs to be identified and have interventions implemented promptly at attempt to prevent PU/PI .Skin should be assessed as soon as possible .where possible .within the first 2 hours .Planning: An individualized plan of care will be developed based on predicting factors for skin breakdown .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Deficient Practice #1 This citation pertains to Intake Number(s): MI00138031, MI00138863, MI00140340, and MI00141846. Based on observation, interview, and record review, the facility failed to ensure schedule II (2) controlled substances (drugs that have high potential for abuse and/or addiction) were accurately reconciled, administered, and documented; and discrepancies in counts were addressed for eight (R502, R509, R511, R512, R513, R514, R515, and R516) of 12 residents reviewed for medications. Findings include: A review of a complaint submitted to the State Survey Agency revealed an allegation that staff were not administering medications (controlled substances) according to physician's orders and proper procedures. On 4/3/24 at 1:03 PM, an observation of the Oak Unit medication cart was conducted with Licensed Practical Nurse (LPN) 'B' and the following observations were made: R509 LPN 'B' was asked to present R509's Morphine Sulfate Solution (a controlled liquid medication used to treat pain). The amount of medication in the bottle was compared with the amount documented on R509' Medication Monitoring/Control Record (a form used to document medication removed from the supply in order to keep an accurate record of the medication). The amount of medication in the bottle was 27 milliliters (ml). The last entry documented on the control record was dated 4/3/24 at 6:00 AM and noted there was 21. 75 ml remaining after 0.25 ml was given (removed) which equaled a 5.25 ml discrepancy between what was documented as given and what was actually in the bottle of medication. When queried about the discrepancy, LPN 'B' stated, It [NAME] out when we get to the bottom of the bottle. LPN 'B' reported she counted each controlled substance with the outgoing nurse from the midnight shift, but did not report the discrepancy to anyone. Further review of R509's control record revealed 30 ml was delivered and received on 3/29/24. There was no nurse's signature to indicate who received the medication from the pharmacy. Further review of R509's clinical record revealed R509 was admitted into the facility on [DATE] with diagnoses that included: Multiple Sclerosis. R509 signed onto hospice on 2/29/24. R516 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN 'B' was asked to present R516's Acetaminophen with Codeine tablets (a controlled medication used to treat pain). There were zero tablets observed in the blister pack. The last entry on the control record was dated 4/2/24 at 2:00 AM and the amount remaining was noted as one. When queried about the discrepancy between the amount of medication remaining in the blister pack and the amount documented on the control record, LPN 'B' reported she gave the medication that morning, but did not document that she pulled the tablet from the supply. LPN 'B' stated, I was just about to go back and document it. LPN 'B' reported she gave the medication at 9:00 AM, four hours earlier. A review of R516's clinical record revealed R516 was admitted into the facility on [DATE] with diagnoses that included: history of stroke. R511 LPN 'B' was asked to present R511's Norco (Hydrocodone-Acetaminophen) tablets from the medication cart. There were 12 tablets observed in the blister pack (a sheet of medications where each individual tablet can be punched out of the back of the sheet through a foil seal). The last entry documented on the control record for R511's Norco was dated 4/2/24 at 8:01 PM and noted there were 13 tablets remaining after one was given on that date. When queried about the discrepancy between the physical amount of tablets in the blister pack and the amount documented on the control record, LPN 'B' reported she removed one tablet earlier in the morning and administered it to R511, but did not document that she pulled the tablet from the supply. LPN 'B' reported she did not have time to sign out the medication on the control record. At that time, LPN 'B' grabbed a pen and wrote that she removed one tablet at 9:14 AM (approximately four hours earlier) and that there were 12 tablets remaining. At that time, LPN 'B' was asked to provide the names of all residents she administered controlled substances to that day. LPN 'B' reported she only administered controlled substances to R516 and R511. A review of R511's clinical record revealed R511 was admitted into the facility on [DATE] with a diagnosis of fusion of spine. R512 LPN 'B' was asked to present R512's Percocet (oxycodone-acetaminophen) tablets from the medication cart. There were 20 tablets observed in the blister pack. The last entry documented on the control record for R512's Percocet was dated 4/3/24 at 2:00 AM and noted there were 21 tablets remaining after one was given at that time. When queried about the discrepancy, LPN 'B' stated, I just gave him one but didn't have time to document it. Further review of R512's control record for Percocet revealed on 3/31/24, 30 tablets were dispensed by the pharmacy. The control record indicated on 4/1/23, LPN 'D' received 30 tablets of Percocet from the pharmacy for R512. It was documented by LPN 'D' that one tablet was removed from the supply, but there was no documentation that indicated the date or time the medication was given. A review of R512's clinical record revealed R512 was admitted into the facility on [DATE] and readmitted on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, an interview was conducted with LPN 'B'. When queried about whether she documented any controlled medications that she pulled from the supply, LPN 'B' reported she did not because she did not have time to and planned to do it later. When queried about the protocol for administering controlled substances, LPN 'B' did not offer a response. When queried about why she reported she only administered controlled substances to R516 and R511 when she also administered them to other residents, including R512, LPN 'B' did not offer a response. On 4/3/24 at 1:25 PM, an observation of the [NAME] Unit medication cart was conducted with Licensed Practical Nurse (LPN) 'C' and the following observations were made: R513 LPN 'C' was asked to present R513's Norco tablets from the medication cart. There were 21 tablets observed in the blister pack. The last entry on the control record was dated 4/3/24 at 12:00 PM, documented by LPN 'C', and indicated there were 23 tablets remaining after one tablet was given at the documented time. When queried about the discrepancy, LPN 'C' reported the count was off when she counted with the outgoing nurse from the midnight shift. When queried about what was done when the discrepancy of two less tablets remaining in the supply versus what was documented, LPN 'C' reported the outgoing nurse said she would take care of it. When queried about why LPN 'C' continued to document the incorrect number of remaining tablets at 12:00 PM if a discrepancy was discovered that morning, LPN 'C did not offer a response. On 4/3/24 at 2:06 PM, a review of R513's MAR for April 2024 revealed no documentation that R513's Norco that was pulled from the supply at 12:00 PM was administered to the resident (as evidenced by no signature from the nurse to indicate the medication was given). A review of R513's clinical record revealed R513 was admitted into the facility on [DATE] with a diagnosis of COPD. R514 LPN 'C' was asked to present R514's Hydrocodone-acetaminophen tablets from the medication cart. There were three tablets remaining in the blister pack. The last entry documented on the control record was dated 4/3/24 at 5:00 AM and it was noted that four tablets were remaining at that time. When queried about the discrepancy, LPN 'C' reported she gave R514 one tablet during her shift but did not sign it out on the control record yet. LPN 'C' explained that she did not document on the control record until the resident took the medication and did not document at the time the medication was removed from the supply. On 4/3/24 at 1:50 PM, a review of R514's MAR for April 2024 revealed R514 was scheduled to receive one dose of the Hydrocodone-acetaminophen 5-325 mg at 2:00 PM. There was no documentation on the MAR that indicated LPN 'C' administered the medication as she reported during her interview. Further review of R514's clinical record revealed R514 was admitted into the facility on [DATE] with a diagnosis of seizures. R515 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN 'C' was asked to present R515's Hydrocodone-acetaminophen (Norco) tablets from the medication cart. There were 15 tablets observed in the blister pack. The last entry on the control record was dated 4/3/24 at 5:00 AM and noted there were 16 tablets remaining in the supply. When queried about the discrepancy, LPN 'C' reported she gave the medication, but did not document it. On 4/3/24 at 2:03 PM, a review of R515's MAR for April 2024 revealed R515 was scheduled to receive a dose of Hydrocodone-acetaminophen 7.5-325 mg (Norco) at 12:00 PM. There was no documentation on the MAR that indicated LPN 'C' administered Norco to R515, as evidenced by no signature. Further review of R515's clinical record revealed R515 was admitted into the facility on [DATE] and readmitted on [DATE] with a diagnosis of neurocognitive disorder with lewy bodies. On 4/3/24 at 1:50 PM, an interview was conducted with the Director of Nursing (DON). When queried about the process for administration of controlled substances, the DON reported when a controlled medication was pulled from the supply, the nurse signed the narcotic book (Control Record) and documented the exact time the medication was pulled, how many was pulled, and what the remaining amount was. Then, the nurse administered the medication to the resident, ensured they took it, and signed it out on the MAR to indicate the resident took the medication. The DON further explained that if a resident refused a controlled medication or if it was dropped on the floor after it was pulled, a second nurse's signature was required on the control record to indicate the medication was wasted. When queried about the process for accounting for all controlled substances in the cart and to ensure the count was accurate, the DON reported the outgoing nurse and the incoming nurse conducted a count of all controlled substances in the medication cart. If there were any discrepancies, over or under the actual count, the nurse was required to alert the DON or Assistant Director of Nursing (ADON) right away to determine if it needed to be investigated. The DON was not notified of any discrepancies for R509 and R513. On 4/3/24 at 3:20 PM, the DON followed up and reported the midnight nurse reported the discrepancy with R513's Norco to the ADON, but an actual count should have been done so that the count matched what was actually in the medication supply. A review of a facility policy titled, Controlled Substances, revised 11/2022, revealed, in part, the following: Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record .If the count is correct, an individual resident controlled substance record is made for each resident who will be receiving a controlled substance .The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: .Records of personnel access and usage .medication administration records .Declining inventory records .Destruction, waste and return to pharmacy records .Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count .The nurse coming on duty and the nurse going off duty make the count together and document ad report any discrepancies to the director of nursing services . A review of a facility policy titled, Medication Administration-General Guidelines, dated 4/2018, revealed, in part, the following: .Medications are administered in accordance with written orders of the prescriber . 30675 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R502 Review of the clinical record revealed R502 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included: acute kidney failure, acute pancreatitis without necrosis or infection, spinal stenosis, and sprain of ligaments of cervical spine. According to the Minimum Data Set (MDS) assessment dated [DATE], R502 had intact cognition and received opioid medication for three of the seven days during this assessment reference period. Review of the physician orders, Medication Administration Records (MARs), controlled substance records, and progress notes revealed multiple missing documentation without explanation of the missed scheduled, and/or as needed (PRN) Percocet (narcotic pain medication) administrations. On 9/19/23 at 9:57 AM, the order was changed from Percocet Oral Tablet 5-325 MG to Percocet Oral Tablet 7.5-325 MG Give 1 tablet by mouth every 8 hours as needed for pain. The MAR documented R502 was administered the above prn Percocet order five times on: 9/14 at 9:09 AM 9/14 at 5:12 PM 9/15 at 9:20 AM 9/15 at 5:18 PM 9/16 at 1:18 AM The controlled substance record revealed the following 13 discrepancies of the Percocet medication being documented as removed, but not documented as administered on the corresponding MAR on: 9/14/23 at 11:00 PM 9/16 at 8:00 AM 9/16 at 4:00 PM 9/17 at 8:00 AM 9/17 at 4:00 PM 9/18 had a line through the entire entry 5:00 AM with 20 Percocet tablets on hand and one given with 19 remaining. The next documented entry was on 9/18 at 8:00 AM which identified there were 19 tablets on hand with one tablet removed and a total of 18 tablets remaining. The bottom portion of this control record to document Record of Waste and Spoilage was left blank and there was no additional documentation in the clinical record to explain the control record discrepancy. 9/20 at 12:35 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/20 at 5:00 PM 9/20 at 8:00 PM 9/21 at 2:00 AM 9/21 at 8:14 AM 9/21 at 1:06 PM 9/21 at 5:35 PM On 9/26/23, the resident was prescribed Percocet Oral Tablet 7.5-325 MG give 1 tablet by mouth every 4 hours for pain (scheduled at 12:00 AM; 4:00 AM; 6:00 AM; 12:00 PM; 4:00 PM; 8:00 PM). The controlled substance record for the scheduled Percocet revealed on 10/18/23, the nurse documented the scheduled Percocet on the record of waste and spoilage under DESCRIBE IN DETAIL that read, Spilled water on med. Although two signatures were required per facility process, this was only signed by one nurse. The section for signature #2 was left blank. On 4/3/24 at 1:55 PM, an interview was conducted with the DON. When asked to explain what the facility's process was for ensuring medication was available upon admission, the DON reported their pain management Physician had access to an efax and could send them over to the pharmacy that way. When asked when should medications be available for administration upon admission, the DON reported new residents would normally have right away. The DON further reported they reminded the hospitals to send scripts for three days to ensure they could fax the script directly to pharmacy and the pharmacy would send it on the next delivery. The DON was informed of the concern regarding the delay in medication being available upon admission and the multiple discrepancies with the controlled substances and reported they were now aware of the concern and unable to offer any further explanation. Deficient Practice #2: This citation pertains to intake #MI00141846. Based on interview and record review, the facility failed to ensure medications were available for timely administration for one (R504) of 12 residents reviewed for medication administration. Findings include: A review of a complaint submitted to the State Survey Agency revealed an allegation that staff were not administering medications (controlled substances) according to physician's orders and proper procedures. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R504's closed clinical record revealed the resident was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included: encounter for other orthopedic aftercare, periprosthetic fracture around internal prosthetic left hip joint, difficulty in walking, osteoarthritis, bilateral primary osteoarthritis of hip, and malignant neoplasm of vulva. According to the MDS assessment dated [DATE], R504 had intact cognition and received opioid medication. Review of the physician orders, Medication Administration Records (MARs), available controlled substance records, and progress notes revealed multiple missed medication administrations due to medication not being available and/or delivered from the pharmacy. R504's admission medication, MARs, and progress notes included: 1) Lovenox Injection Solution Prefilled Syringe 30 MG (Milligrams)/0.3ML (Milliliters) (Enoxaparin Sodium) Inject 30 milligram subcutaneously every 12 hours for other (an anticoagulant medication used to prevent blood clots). The MAR documented a code of 9 (which meant Other/See Progress Noteon 12/7/23 at 9:00 PM and 12/8/23 at 9:00 PM). The progress note on 12/8/23 at 6:57 AM read, .Medication in route . The progress note on 12/8/23 at 11:03 PM read, .not available being delivered as she is a new admit .being delivered on tonights run. 2) Albuterol-Budesonide inhalation Aerosol 90-80 MCG/ACT 2 puff inhale orally every 6 hours for breathing (a bronchodilator medication used to prevent and treat wheezing, difficulty breathing, chest tightness and coughing). This was scheduled to be administered at 12:00 AM/6:00 AM/12:00 PM/6:00 PM. The MAR documented the first Albuterol-Budesonide was administered on 12/7 at 6:00 PM. However on 12/9 at 12:00 AM the MAR was coded as 9, on 12/9 at 6:00 AM coded as 2, and on 12/12 at 6:00 PM coded as 9. The progress note on 12/8/23 at 11:02 PM read, In delivery for tonight. Further review of the progress notes revealed there was no corresponding entries to explain the codes of 9 and 2, or explanation of why R504 did not receive the medication as the entry on 12/8/23 indicated it would be in the evening delivery on 12/8/23. It is unknown how this medication had been documented as administered on 12/7/23 (PM dose), despite other staff indicating this medication was not available. 3) HYDROcodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth every 6 hours as needed for pain (Norco - a narcotic pain medication). The MAR documented the first Hydrocodone-acetaminophen administration was not until 12/8/23 at 11:15 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235396	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Silverbell Estates	1255 W Silverbell Rd Orion, MI 48359

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Norco Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain Discontinue Norco 5/325 when 7.5 arrives. This order was started on 12/12/23. The MAR documented the first administration of the Norco 7.5-325 MG was given on 12/13/23 at 5:00 AM. (Despite the instructions in the physician order to discontinue the Norco 5/325 MG when the 7.5-325 MG medication arrived, this was never completed.) 5) Phentermine HCl Oral Capsule 15 MG Give 1 capsule by mouth one time a day for other. This medication was discontinued on 12/13/23. The MAR documented the first administration of the Phentermine HCl was given on 12/12/23 (6 days following admission). Further review of the MARs revealed documentation of a code of 9 on 12/8 and 12/11, and a code of 5 (which meant Hold/See Progress Notes) on 12/9 and 12/10. The progress note on 12/8 at 9:49 AM read, .on order. The progress note on 12/9 at 8:05 AM read, .Waiting to receive from pharmacy. The progress note on 12/10 at 8:14 AM read, .on pharmacy order. The progress note on 12/11 at 9:45 AM read, .waiting to receive from pharmacy. On 4/3/24 at 1:49 PM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for obtaining medication upon admission, the DON reported their pain management Physician had access to and efax and could send them over to the pharmacy that way. When asked when should medications be available for administration upon admission, the DON reported new residents would normally have right away. The DON further reported they reminded the hospitals to send scripts for three days to ensure they could fax the script directly to pharmacy and the pharmacy would send it on the next delivery. The DON was asked when they received deliveries and reported it was usually twice a day. When asked if a nurse identified the medication was not included in the delivery, what should be done, the DON reported the next nurse should call pharmacy to see if on the next delivery, they would also get pre-authorization to pull from the back up box and their Physicians will call the pharmacy for a verbal and the medication gets sent to the facility. When asked if there had been any issues identified with the availability of medications for new residents, or when medication orders were changed, the DON reported their pharmacy deliver was contracted and that it was a problem. The DON was asked to explain further and reported the main issue was getting here in terrible weather. The DON reported they had been conducting audits on controlled medications given a history of concerns with controlled medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was asked about the earlier request to provide the controlled substance records for R504 and reported they were currently working on trying to locate that documentation. There was no documentation provided by the end of the survey.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on interview and record review the facility failed to promptly report abnormal x-ray results to the physician/physician extender for one (R501) of four residents reviewed for change in condition. Findings include: A complaint was filed with the State Agency (SA) that alleged on 10/13/23 the complainant observed R501's arm was swollen, and they were having difficulty breathing. The complainant further noted that the facility was not paying attention to the residents change in condition, so they requested that R501 be sent to the Hospital. A review of R501's clinical record revealed the resident was initially admitted to the facility on [DATE] and their last admitted was 2/13/24 with diagnoses that included, in part: diabetes, chronic kidney disease, obesity and heart failure. A review of the Minimum Data Set (MDS) dated [DATE] noted the resident's Brief Interview for Mental Status (BIMS) score was 15/15 (intact cognition) and noted the resident needed one-to-two-person assistance for most Activities of Daily Living (ADLs). Continued review of R501's clinical record revealed, the following: Chest, Single View: Examination Date: 10/11/23 .Reported Date: 10/11/23 .Findings: Pulmonary vascular congestion .Impression: congestive heart failure. It was noted that the document was reviewed by the Director of Nursing (DON) on 10/29/23. Health Status Note (10/12/23): Resident has audible wheezing sounds. On call provider notified .Chest X-ray has been ordered . Health Status Note (10/12/23): Received report from oncoming shift regarding recent changes in respiratory status .nurse notes audible congestion and wheezing .NP (nurse practitioner) to assess today . *It should be noted that R501's electronic record did not show any indication that the NP assessed the resident on 10/12/23 or reviewed the results of the X-ray noting congestive heart failure. Orders (10/11/23): .Mucus Relief Oral Tablet 400 MG- give 1 tablet by mouth every 8 hours for congestion . Medication Cough/Cold/Allergey . Orders (10/12/23): .Albuterol Inhalation Solution 5 -2.5 MG- 1 dose inhale orally every 6 hours . Health Status Note (10/13/23): Pt (patient) RUE (right upper extremity) has weakness, pt also SOB (shortness of breath) requested that pt be sent to hospital for evaluation . (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress note dated 10/14/23 was reviewed and documented, in part: Pt. seen today per facility request. Pt sister and POA (power of attorney) is here requesting R501 be sent to the hospital due to swelling of his R (right) arm .Writer entered pat. (R501's) Room to assess the .swelling of his right arm .pt. in clear respiratory distress. Patient sent to emergency department via ambulance . * It should be noted that the resident was not at the facility on 10/14/23 as noted on the document. The document itself was signed by Nurse Practitioner (NP) H on 11/15/23. Further there was no documentation in NP H's note that indicated they had reviewed of x-ray results dated 10/11/23. On 4/4/24 at approximately 12:30 PM, an interview was conducted with the DON. The DON was asked to provide evidence that the physician and/or physicians extender (NP H) reviewed the X-ray results dated 10/11/23. The DON reported that they assumed it was reviewed as there were orders for Mucus Relief and Albuterol but could not locate documentation that it was reviewed. When asked about the delay in assessment on 10/12/23, The DON reported that NP H no longer works at the facility and could not answer why it was not completed. NP H was contacted via phone on 4/4/24 at approximately 12:47 PM. A voice message was left. No return call was made prior to exit. The facility policy titled, Laboratory, Radiology and Other Diagnostic Services (6/1/20) was reviewed and documented, in part: Purpose: to ensure laboratory . services meets the needs of resident, that results are reported promptly to the ordering provider to address potential concerns .