STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235401	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark Retirement Community	1551 Franklin Street, SE Grand Rapids, MI 49506

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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. 41424 Based on observation, interview, and record review, the facility failed to provide an environment that promoted and enhanced resident dignity for 1 resident (Resident #13) of 2 reviewed for dignity, resulting in the potential of feelings of frustration, anxiety, embarrassment and loss of self-worth, impacting their quality of life and promoting a negative psychosocial outcome for the residents. Findings include: Resident #13: Review of an Admission Record revealed Resident #13 was a male with pertinent diagnoses which included Alzheimer's disease, dementia, heart failure, chronic pain, kidney disease, stage 3, blood in urine, urinary tract infection, edema, duiretic therapy (increased productin of urine) and cellulitis of left lower limb. Review of Care Plan revised on 08/15/24, revealed the focus, .The resident has an ADL self-care performance deficit r/t (related to) Dementia . with the intervention .Toilet Use: The resident is totally dependent on 1-2 staff for toilet use .Encourage the resident to use bell to call for assistance (note: no call light was availabe to the resident while in the dining area) . During an observation on 08/22/24 at 09:19 AM, observed Resident #13 out of his room seated at the dining room table in the recliner type chair with another resident. The resident did not have a book, magazine, music playing, or activities to enterain himself. During an observation on 08/22/24 at 09:53 AM, Resident #13 was seated in the recliner type chair while seated at the dining room table. The resident did not have a book, magazine, music playing, or activities to enterain himself. During an observation on 08/22/24 at 11:38 AM, Unit Manager V was adjusting Resident #13 when he was seated in the recliner type chair at the dinign room table. She spoke to him briefly. The resident did not have a book, magazine, music playing, or activities to enterain himself. During an observation on 08/22/24 at 12:31 PM, Resident #13 was seated in the recliner type chair at the dining room table. The resident did not have a book, magazine, music playing, or activities to enterain himself. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark Retirement Community	1551 Franklin Street, SE Grand Rapids, MI 49506

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/22/24 at 02:02 PM, Resident #13 was still seated in the recliner type chair while seated at the dining room table. The resident did not have a book, magazine, music playing, or activities to enterain himself. During an observation on 08/22/24 at 02:03 PM, Resident #13 informed visitors there to visit with another resident he had to use the restroom. The visitors reported to the staff in the nursing office, Resident #13 had to use the bathroom. During an observation on 08/22/24 at 2:20 PM, Resident #13 was not assisted by staff, instead the staff assisted returning resident to bed and left him seated in the recliner type chair even after he told them he had to use the bathroom. Informed the Director of Nursing 08/22/24 at 2:22 PM, Resident #13 had requested multiple times to use the restroom and no one had came to provide assistance to him. DON B reported he would get someone to provide assistance for him to take him to the restroom and continued to talk to a CNA while they were standing just behind the resident, near the counter which was just across from the table Resident #13 was seated at, finished his conversation with the CNA and she summoned another CNA to come assist her with providing care to Resident #13. The staff took him to the shower room to use the bathroom as his roommate, Resident #31, was COVID positive and the staff would have to don personal protective equipment to take him to use the bathroom in his room. In an interview on 08/22/24 02:30 PM, Licensed Practical Nurse (LPN) T reported she had come back to the room to gather some pants for Resident #13 as he had soiled them. Using the reasonable person concept, though Resident #13 had decreased ability to verbally express his own thoughts due to his cognitive deficits, he clearly expressed his need to use the bathroom to numerous individuals and was left to sit in soiled briefs and clothing. This emotional distress has the potential to continue well past the date of the incident based on the reasonable person concept.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Clark Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1551 Franklin Street, SE Grand Rapids, MI 49506	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on interviews and record review, the facility failed to report an allegation of neglect in 1 of 1 (Resident #34) of 16 residents reviewed for reporting, resulting in the potential for continued violations involving neglect and/or abuse going unreported. Findings include: Review of an Admission Record revealed Resident #34 was a male with pertinent diagnoses which included amyotrophic lateral sclerosis (ALS), heart disease, muscle wasting and atrophy, repeated falls, and obstructive uropathy (obstructing urine flow). Review of Minimum Data Set (MDS) dated [DATE], revealed, .Section F: Preferences for Customary Routine and Activities: .E. How important is it to you to chose your own bedtime? Very important .F. how important is it to you to do your favorite activities? Very important .H. Bladder and Bowel: Urinary Continence: Frequently incontinent .Bowel Continence: Always incontinent . Review of No Type Specified note dated 8/15/2024 at 5:06 PM, revealed, .Investigation: 8/11/24 Allegation (Resident #34) .IDT- Collaboration with DON (Director of Nursing), Administrator, RN (Registered Nurse) Supervisor completed a full investigation pertaining to abuse and neglect allegation. After interviewing the respected staff and resident, all information states there was no incident of abuse or neglect .Staff working directly with the resident was interviewed and disclosed the resident was in bed prior to her coming onto shift (6p-10p). The allegation stated the resident was in his chair at the time employee arrived on shift 3rd shift with a soiled brief and wetness in his chair (10p-6a) .Resident (Resident #34) was interviewed and had no issues/problems or concerns to endorse when asked about the specific day and timeframe of the alleged allegation. Resident endorsed being tired that day, and wanted to stay in bed. Resident has a current dx of AMYOTROPHIC LATERAL SCLEROSIS which causes muscle weaking and causes him to be wheelchair bound for ambulation. Resident is A & Ox3 (alert & oriented) and is able to make his needs known. Resident skin was assessed by DON and no skin issue present (no redness, no pain, no s/s (signs and/or symptoms) of infection, clean, dry and intact). Resident had no concerns he wanted to disclose during the interview. Will continue to monitor for health and safety . This writer requested an incident report and investigation for the allegation of abuse/neglect for Resident #34 for the previous three months and none were provided. This writer had to request again and received the investigation completed by DON B but no incident report was provided for the allegation during survey or prior to exit from the facility. This incident was not reported to the state agency. Review of No Type Specified note dated 8/15/2024 at 12:14 PM, revealed, .IDT: Investigated potential allegation: 8/11/24 2nd shift. After full investigation allegation: skin check- no skin issues, no redness, no s/s of infection, skin on buttock is normal color of ethnicity and no pain, interview conducted and follow up. Allegation turned out to be inconclusive with no findings or validity to the claim. Will continue to monitor for health and safety . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Clark Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1551 Franklin Street, SE Grand Rapids, MI 49506	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of submitted investigation completed by Director of Nursing (DON) B revealed, the following, .Review of Personal Interview dated 8/14/2024, revealed, .Personal Interview: (Resident #34): Resident (Resident #34) was interviewed by (DON B), RN BSN DON. (Resident #34) Stated he didn't have any concerns about Sunday 8/11/24 2nd shift. He endorsed that Sunday he was feeling a little tired so he did not want to get up into chair, he wanted to stay in bed. The interviewer asked if he was ever up in his chair on Sunday 2nd shift and he endorsed no. (Resident #34) had no further concerns during interview . Review of Phone Interview dated 8/15/24, revealed, .Phone interview: (CNA BB) was interviewed by (DON B) RN, DON. She stated that she worked the 6p-10p shift on Sunday (8/11/24), and when she arrived the resident (Resident #34) was already in bed and not in chair. (CNA BB) called nurse (RN K) in to assist with a soiled brief and linen change. (CNA BB) endorsed after the brief change she lowered the bed and exited the resident room. (CNA BB) endorsed doing her last set of rounds on (RESIDENT #34) (resident) at 9:40pm where resident was still dry from the brief change prior, and bed was lowered in the respected position . Review of Investigation: 8/11/24 Allegation (RESIDENT #34) revealed, .IDT- Collaboration with DON, Administrator, RN Supervisor completed a full investigation pertaining to abuse and neglect allegation. After interviewing the respected staff and resident, all information states there was no incident of abuse or neglect . Staff working directly with the resident was interviewed and disclosed the resident was in bed prior to her coming onto shift (6p-10p). The allegation stated the resident was in his chair at the time employee arrived on shift 3rd shift with a soiled brief and wetness in his chair (10p-6a) Resident (RESIDENT #34) was interviewed and had no issues/problems or concerns to endorse when asked about the specific day and timeframe of the alleged allegation. Resident endorsed being tired that day, and wanted to stay in bed. Resident has a current dx of AMYOTROPHIC LATERAL SCLEROSIS which causes muscle weaking and causes him to be wheelchair bound for ambulation. Resident is A & 0x3 and is able to make his needs known. Resident skin was assessed by DON and no skin issue present (no redness, no pain, no s/s of infection, clean, dry and intact). Resident had no concerns he wanted to disclose during the interview. Will continue to monitor for health and safety . Review of the schedule for 8/11/24 revealed, .First shift had 4 CNAs, 2 Nurses; Second shift had 3 CNAs, 2 Nurses . In an interview on 08/22/24 at 09:23 AM, LPN OO reported it would have been her weekend to work but she did not remember any incident involving (Resident #34). In an interview on 08/22/24 at 08:44 AM, RN K reported she could not remember any incident with Resident #34 and she reported she did not see it on her schedule for her to work that night (Sunday 8/11/24). (continued on next page)

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	235401	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark Retirement Community	1551 Franklin Street, SE Grand Rapids, MI 49506

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/21/24 at 03:23 PM, Director of Nursing (DON) B reported he did not complete an incident report nor was there one in risk management (where the incident reports were completed) and he performed an investigation for the incident which occurred on Sunday, 8/11/24. DON B reported he had received an email from a staff member (Certified Nursing Assistant (CNA) M) she had sent to him when she worked third shift on 8/11/24. DON B reported CNA M tended to over exaggerate and was pointing fingers at other staff members. DON B reported (CNA M) had reported when she came on her shift (10:00 PM) , (Resident #34) was in his chair and his chair was soaked as he had been up since 4:30 PM. DON B reported when he completed his investigation he had not interviewed all the staff who had worked second shift or third shift on 8/11/24. Nor had he interviewed other residents and staff on the concerns expressed by (CNA M) in regards to (CNA BB). DON B reported he had brought the situation up to the Admininstrator in a meeting on Monday, 8/12/24, and sought direction on how to proceed from there. DON B reported (CNA M)had sent the email on Sunday night approximately 1:00 AM, and he reported he did not review it until the next day. In an interview on 08/22/24 at 4:00 PM, Certified Nursing Assistant (CNA) M reported .At 10:00 o'clock, she was told (Resident #34) was in his room watching TV and he didn't want to go to bed, so when the previous shift CNA left, CNA M reported she went into his room to see if he was ready for bed. CNA M reported the first thing she smelled right by the doorway as she went to enter his room was smell of somebody who had an accident. CNA M reported (Resident #34) reported to her the previous staff member had told him she cannot find help to place him in the bed and he wanted to go to bed. (Resident #34) had told her he had waited over at least an hour and a half for her to find someone to place him in his bed and she never got anyone to help place him in bed. CNA M reported Resident #34 was asking if she would be able to put him to bed, and he reported he did not want to call the police, he said Can you make sure you can put me in bed as he did not want to call the police. CNA M reported she got someone to assist her to place him in the bed, his pants were soaked, his wheelchair seat was soaked. CNA M reported when she spoke to other staff who worked second shift, she indicated they were never asked to help the CNA place Resident #34 in bed otherwise they would have assisted her. CNA M reported RN PP helped me help Resident #34 into the bed. CNA M reported CNA E indicated to her that CNA BB never came to ask him for assistance to place Resident #34 in bed or he would've put him to bed. CNA M indicated she reported the concern with neglect to the nurse on the unit, RN PP but she also sent an email to the DON to make sure because she was very concerned it was a case of neglect by allowing the resident to sit in his wheelchair for so long, soiled with urine and feces, and his powerchair seat had been soaked in urine. CNA M reported the feces had dried to his skin/brief because it had been in the brief for so long. CNA M indicated she felt so bad for Resident #34 and no one should have to be left in a situation like that especially those who can't take care of themselves. CNA M reported she had reached out to the DON the next day she worked (Wednesday August 14, 2024), as she was off on Monday and Tuesday and he reported to her he had not even reviewed her e-mail yet. CNA M reported the nurse had placed a note in the DON's mailbox and when the CNA came back to work, she checked his box and the note was still in there. CNA M reported she was happy that she had sent the email as well as he would have never seen it or be aware if she hadn't followed up with him when she had returned to work. CNA M reported when there was suspicion of abuse or neglect, you would inform the nurse and contact the DON as well. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark Retirement Community	1551 Franklin Street, SE Grand Rapids, MI 49506

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy, Abuse Prevention, Screening & Reporting reviewed on January 2018, revealed, .It is the position of [NAME] Retirement Community that resident abuse, neglect, mistreatment, involuntary seclusion, and misappropriation will not be tolerated and will be fully investigated .Abuse - means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish (42 CFR 488.301) . Neglect-failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness .Willful - means the individual deliberately, not that the individual must have intended to, inflict injury or harm .Reporting Procedure: The Administrator/Designee will: 1. Report any known or alleged incidents of abuse, neglect, mistreatment, involuntary seclusion, misappropriation, exploitation and/or injuries of unknown origin to the Department of Licensing and Regulatory Affairs, Long Term Care Division. The Facility Reported Incidents are to be reported utilizing the Long-Term Care Provider Portal .2. Reporting will be done immediately, but not exceeding 24 hours after facility becomes aware of an incident . (Note: policy was not updated to reflect changes in regulations) .3. AFC and HFA licenses require notification of any allegation of abuse, neglect, mistreatment, involuntary seclusion, misappropriation , exploitation and/or injuries of unknown origin to the state Central Intake at [PHONE NUMBER] .Employee Reporting Requirements: 1. Employee(s) are responsible for reporting any abuse, neglect, involuntary seclusion, misappropriation, exploitation and/or injuries of unknown origin. Reporting must be done immediately. The Administrator (Abuse Coordinator), Director of Nursing or facility designee must be notified .

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41424

Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse/neglect for 1 of 1 resident (Resident #34) reviewed for abuse, resulting in an allegation of abuse not being identified and thoroughly investigated allowing for the potential for mistreatment and/or abuse.

Findings include:

Review of an Admission Record revealed Resident #34 was a male with pertinent diagnoses which included amyotrophic lateral sclerosis (ALS), heart disease, muscle wasting and atrophy, repeated falls, and obstructive uropathy (obstructing urine flow).

Review of Minimum Data Set (MDS) dated [DATE], revealed, .Section F: Preferences for Customary Routine and Activities: .E. How important is it to you to chose your own bedtime? Very important .F. how important is it to you to do your favorite activities? Very important .H. Bladder and Bowel: Urinary Continence: Frequently incontinent .Bowel Continence: Always incontinent .

Review of No Type Specified note dated 8/15/2024 at 5:06 PM, revealed, .Investigation: 8/11/24 Allegation (Resident #34) .IDT- Collaboration with DON (Director of Nursing), Administrator, RN (Registered Nurse) Supervisor completed a full investigation pertaining to abuse and neglect allegation. After interviewing the respected staff and resident, all information states there was no incident of abuse or neglect .Staff working directly with the resident was interviewed and disclosed the resident was in bed prior to her coming onto shift (6p-10p). The allegation stated the resident was in his chair at the time employee arrived on shift 3rd shift with a soiled brief and wetness in his chair (10p-6a) .Resident (Resident #34) was interviewed and had no issues/problems or concerns to endorse when asked about the specific day and timeframe of the alleged allegation. Resident endorsed being tired that day, and wanted to stay in bed. Resident has a current dx of AMYOTROPHIC LATERAL SCLEROSIS which causes muscle weaking and causes him to be wheelchair bound for ambulation. Resident is A & Ox3 (alert & oriented) and is able to make his needs known. Resident skin was assessed by DON and no skin issue present (no redness, no pain, no s/s of infection, clean, dry and intact). Resident had no concerns he wanted to disclose during the interview. Will continue to monitor for health and safety .

This writer requested an incident report and investigation for the allegation of abuse/neglect for Resident #34 for the previous three months and none were provided. This writer had to request again and received the investigation completed by DON B but no incident report was provided for the allegation during survey or prior to exit from the facility. This incident was not reported to the state agency.

Review of No Type Specified note dated 8/15/2024 at 12:14 PM, revealed, .IDT: Investigated potential allegation: 8/11/24 2nd shift. After full investigation allegation: skin check- no skin issues, no redness, no s/s of infection, skin on buttock is normal color of ethnicity and no pain, interview conducted and follow up. Allegation turned out to be inconclusive with no findings or validity to the claim. Will continue to monitor for health and safety .

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of submitted investigation completed by Director of Nursing (DON) B revealed, the following, .Review of Personal Interview dated 8/14/2024, revealed, .Personal Interview: (Resident #34): Resident (Resident #34) was interviewed by (DON B), RN BSN DON. (Resident #34) Stated he didn't have any concerns about Sunday 8/11/24 2nd shift. He endorsed that Sunday he was feeling a little tired so he did not want to get up into chair, he wanted to stay in bed. The interviewer asked if he was ever up in his chair on Sunday 2nd shift and he endorsed no. (Resident #34) had no further concerns during interview . Review of Phone Interview dated 8/15/24, revealed, .Phone interview: (CNA BB) was interviewed by (DON B) RN, DON. She stated that she worked the 6p-10p shift on Sunday (8/11/24), and when she arrived the resident (Resident #34) was already in bed and not in chair. (CNA BB) called nurse (RN K) in to assist with a soiled brief and linen change. (CNA BB) endorsed after the brief change she lowered the bed and exited the resident room. (CNA BB) endorsed doing her last set of rounds on (RESIDENT #34) (resident) at 9:40pm where resident was still dry from the brief change prior, and bed was lowered in the respected position . Review of Investigation: 8/11/24 Allegation (RESIDENT #34) revealed, .IDT- Collaboration with DON, Administrator, RN Supervisor completed a full investigation pertaining to abuse and neglect allegation. After interviewing the respected staff and resident, all information states there was no incident of abuse or neglect . Staff working directly with the resident was interviewed and disclosed the resident was in bed prior to her coming onto shift (6p-10p). The allegation stated the resident was in his chair at the time employee arrived on shift 3rd shift with a soiled brief and wetness in his chair (10p-6a) Resident (RESIDENT #34) was interviewed and had no issues/problems or concerns to endorse when asked about the specific day and timeframe of the alleged allegation. Resident endorsed being tired that day, and wanted to stay in bed. Resident has a current dx of AMYOTROPHIC LATERAL SCLEROSIS which causes muscle weaking and causes him to be wheelchair bound for ambulation. Resident is A & 0x3 and is able to make his needs known. Resident skin was assessed by DON and no skin issue present (no redness, no pain, no s/s of infection, clean, dry and intact). Resident had no concerns he wanted to disclose during the interview. Will continue to monitor for health and safety . Review of the schedule for 8/11/24 revealed, .First shift had 4 CNAs, 2 Nurses; Second shift had 3 CNAs, 2 Nurses . In an interview on 08/22/24 at 09:23 AM, LPN OO reported it would have been her weekend to work but she did not remember any incident involving (Resident #34). In an interview on 08/22/24 at 08:44 AM, RN K reported she could not remember any incident with Resident #34 and she reported she did not see it on her schedule for her to work that night (Sunday 8/11/24). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/21/24 at 03:23 PM, Director of Nursing (DON) B reported he did not complete an incident report nor was there one in risk management (where the incident reports were completed) and he performed an investigation for the incident which occurred on Sunday, 8/11/24. DON B reported he had received an email from a staff member (Certified Nursing Assistant (CNA) M) she had sent to him when she worked third shift on 8/11/24. DON B reported CNA M tended to over exaggerate and was pointing fingers at other staff members. DON B reported (CNA M) had reported when she came on her shift (10:00 PM) , (Resident #34) was in his chair and his chair was soaked as he had been up since 4:30 PM. DON B reported when he completed his investigation he had not interviewed all the staff who had worked second shift or third shift on 8/11/24. Nor had he interviewed other residents and staff on the concerns expressed by (CNA M) in regards to (CNA BB). DON B reported he had brought the situation up to the Admininstrator in a meeting on Monday, 8/12/24, and sought direction on how to proceed from there. DON B reported (CNA M)had sent the email on Sunday night approximately 1:00 AM, and he reported he did not review it until the next day. In an interview on 08/22/24 at 4:00 PM, Certified Nursing Assistant (CNA) M reported, At 10:00 o'clock, she was told (Resident #34) was in his room watching TV and he didn't want to go to bed, so when the previous shift CNA left, CNA M reported she went into his room to see if he was ready for bed. CNA M reported the first thing she smelled right by the doorway as she went to enter his room was smell of somebody who had an accident. CNA M reported (Resident #34) reported to her the previous staff member had told him she cannot find help to place him in the bed and he wanted to go to bed. (Resident #34) had told her he had waited over at least an hour and a half for her to find someone to place him in his bed and she never got anyone to help place him in bed. CNA M reported Resident #34 was asking if she would be able to put him to bed, and he reported he did not want to call the police, he said Can you make sure you can put me in bed as he did not want to call the police. CNA M reported she got someone to assist her to place him in the bed, his pants were soaked, his wheelchair seat was soaked. CNA M reported when she spoke to other staff who worked second shift, she indicated they were never asked to help the CNA place Resident #34 in bed otherwise they would have assisted her. CNA M reported RN PP helped me help Resident #34 into the bed. CNA M reported CNA E indicated to her that CNA BB never came to ask him for assistance to place Resident #34 in bed or he would've put him to bed. CNA M indicated she reported the concern with neglect to the nurse on the unit, RN PP but she also sent an email to the DON to make sure because she was very concerned it was a case of neglect by allowing the resident to sit in his wheelchair for so long, soiled with urine and feces, and his powerchair seat had been soaked in urine. CNA M reported the feces had dried to his skin/brief because it had been in the brief for so long. CNA M indicated she felt so bad for Resident #34 and no one should have to be left in a situation like that especially those who can't take care of themselves. CNA M reported she had reached out to the DON the next day she worked (Wednesday August 14, 2024), as she was off on Monday and Tuesday and he reported to her he had not even reviewed her e-mail yet. CNA M reported the nurse had placed a note in the DON's mailbox and when the CNA came back to work, she checked his box and the note was still in there. CNA M reported she was happy that she had sent the email as well as he would have never seen it or be aware if she hadn't followed up with him when she had returned to work. CNA M reported when there was suspicion of abuse or neglect, you would inform the nurse and contact the DON as well. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy, Abuse Prevention, Screening & Reporting reviewed on January 2018, revealed, .It is the position of [NAME] Retirement Community that resident abuse, neglect, mistreatment, involuntary seclusion, and misappropriation will not be tolerated and will be fully investigated .Abuse - means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish (42 CFR 488.301) . Neglect-failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness . Willful - means the individual deliberately, not that the individual must have intended to, inflict injury or harm .Investigation: All reports of alleged or suspected abuse, neglect, mistreatment, involuntary seclusion, injuries of unknown source exploitation and misappropriation shall be investigated thoroughly, objectively, and expeditiously .The Administrator or designee does an immediate investigation into the alleged incident, ensuring that the following steps are taken: a. Resident(s) will be protected from further abuse, and neglect, mistreatment, involuntary seclusion, and misappropriation .b. An assessment of the resident will be completed under the direction of the administrator/physician/director of nursing/police/designee. The resident and or legal responsible party will be included in the assessment determination .Assessment includes both subjective and objective data and may include and is not limited to, head to toe assessment inspecting for signs of injuries, i.e., bleeding, laceration(s), limitations in range of motion, changes in personality or behavior, guarding, fearful body posture, or statements of harm or fear. Resident may also be sent to an acute care setting for further assessment such as in the case of suspected or actual sexual abuse .Assessments will be conducted with the resident's or legal representatives consent or as otherwise directed law enforcement. c. An Incident/Accident report will be completed . d. The attending physician/designee and legal representative (if in place) will be notified of the incident . e. The resident(s) care plan will be updated based on assessment and identified needs of the resident(s) . f. Any employee(s) suspected of abuse or neglect will be suspended pending results of the investigation . g. Any volunteer or visitor suspected of abuse or neglect will be banned from the facility pending results of the investigation. If visitation is requested by the resident/responsible party, it may be granted in designated areas approved by the administrator . h. When the perpetrator is unknown, appropriate staff will be made aware of the situation and will be asked to monitor for suspicious activity, and asked to report any suspicious activity and or any information which may be related to the incident/: allegation . i. If the alleged or known perpetrator is another resident, interventions will be put into place to protect all residents at risk. Interventions may include, but are not limited to; increased supervision, temporary separation (less than 24 hours), and specific psychological and or medical therapy . j. Interviews with resident(s), staff and or other witnesses will be completed. All interviews will be documented and signed . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. The Administrator and or the Director of Nursing may notify other services as needed to assist with the investigation (i.e. police, ombudsman, etc.). Note: If a crime or a suspicion of a crime occurred anyone may contact the (Local) Police Department . l. If the investigation indicates that the employee did commit abuse, neglect, mistreatment, involuntary seclusion and or misappropriation, he/she will receive disciplinary action up to and including termination . m. The incident and the results of the investigation must be reported according to the reporting guidelines (see Reporting section of this policy) . n. The results of the investigation will be reported to the [NAME] President of Resident Living and Support Services/Designee . o. If the alleged violation is substantiated, appropriate corrective action will be taken. p. During the screening, assessment and investigative process, all materials collected pertinent to the investigation are retained and safe guarded . Other: Residents and/or their responsible party will be informed of the complaint/concern procedure at the time of admission, including to whom they are to make a complaint should it occur. Concern forms will be made accessible to residents and/or their guardian/responsible party .

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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** 41424 Based on observation, interview, and record review, the facility failed to implement resident comprehensive care plans for 1 resident (Resident #28) of 2 residents reviewed for care planning resulting in a lack of service for residents to maintain their highest practicable physical, mental, and psychosocial well-being Findings include: .A nursing care plan includes nursing diagnoses, goals and/or expected outcomes, individualized nursing interventions, and a section for evaluation findings .The plan promotes continuity of care and better communication because it informs all health care providers about a patient's needs and interventions and reduces the risk for incomplete, incorrect, or inappropriate care measures. Nurses revise a plan when a patient's status changes .The plan of care communicates nursing care priorities to nurses and other health care providers. It also identifies and coordinates resources for delivering nursing care . [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing, Tenth Edition - E-Book (Kindle Location 15861 of 76897). Elsevier Health Sciences. Resident #28: Review of an Admission Record revealed Resident #28 was a female with pertinent diagnoses which included dementia, stroke, and dysphagia (damage to the brain responsible for production and comprehension of speech). Review of Care Plan revised on 8/21/24, revealed the focus, .(Resident #32) is at risk for skin integrity impairment as evidence by impaired mobility and cognition . with the intervention .Encourage resident to wear blue bootie to right foot when up in wheelchair and in bed . Review of Care Plan revised on 8/21/24, revealed the focus, .Resident needs assistance with ADLs due to impaired cognition related to dementia, chronic pain, diagnosis of depression . with the intervention .Keep elevating leg rests and foot pedals in high position and upright at all times when in w/c . During an observation on 8/20/24 at 10:10 AM, Resident #28 was seated at the dining room table with her Ensure, she had a decorative throw pillow on her right side and she had a bed pillow behind her legs while her feet where on the foot rests. Her legs were not elevated nor where the foot pedals in a high position. ssThere was a head support flipped over the back of the wheelchair. No blue boots were noted on her feet. During an observation on 08/20/24 at 10:15 AM, Resident #28's blue boots were observed on the chair next to her dresser in her room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/21/24 at 09:43 AM, observed Resident #28 seated at the dining room table in her wheelchair. Resident #28 had the decorative throw pillow next to her right side/leg/hip area, the side was opening and stuffing was sticking out. The head rest was flipped over the back of the wheelchair still. Resident #28 had blue boots on both of her feet, and she had a pillow behind her legs. Her legs were not elevated in the footrests. She was observed leaning to the right side. During an observation on 08/22/24 at 09:15 AM, Resident #28 was leaning to the right side in her wheelchair, and she did not have a pillow on her right side, she did not have a pillow behind her legs/calves, she did not have her blue boots on her feet. she did have the head rest pulled down behind her head. During an observation on 08/22/24 at 11:32 AM, observed Resident #28 seated at the dining table without the decorative throw pillow on her right side, she did not have the blue boot on her right foot. The footrests were elevated but she did not have her feet on them. She had her feet dangling from her seated position and not touching the ground. In an interview on 08/22/24 at 11:54 AM, Certified Nursing Assistant (CNA) F reported if a resident refused to wear boots, they would attempt to redirect and/or reapproach later time. CNA F reported she would inform the nurse of the refusal. CNA F reported they used the pillow behind her legs for comfort as her legs do become uncomfortable and they use the decorative throw pillow to assist with positioning to provide the extra support for her. In an interview on 08/22/24 at 03:15 PM, Director of Nursing (DON) B reported Resident #28 had the intervention of one blue boot, her legs were to be elevated when up in the wheelchair. A note would be entered in the record for a refusal. DON B reported he was able to ensure care plan interventions were being completed when audit rounds were completed. Review of the policy, Care Plans, Comprehensive Person-Centered revised March 2022, revealed, .1. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions .12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment .

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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** 36221 Based on observation, interview, and record review, the facility failed to update/revise a comprehensive care plan after a change in resident condition in 1 of 14 residents (Resident #30) reviewed for comprehensive care plans, resulting in an inaccurate reflection of the resident's status, and the potential for unmet medical, physical, mental, and psychosocial needs. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.18.11, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care . According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing, Tenth Edition - E-Book (Kindle Location 15861 of 76897). Elsevier Health Sciences.A nursing care plan includes nursing diagnoses, goals and/or expected outcomes, individualized nursing interventions, and a section for evaluation findings .The plan promotes continuity of care and better communication because it informs all health care providers about a patient's needs and interventions and reduces the risk for incomplete, incorrect, or inappropriate care measures. Nurses revise a plan when a patient's status changes . The plan of care communicates nursing care priorities to nurses and other health care providers. It also identifies and coordinates resources for delivering nursing care . Resident #30 Review of an Admission Record revealed Resident #30 was a female, with pertinent diagnoses which included Alzheimer's disease, dementia, depression, arthritis, osteoporosis, and a history of falls. Review of a Minimum Data Set (MDS) assessment for Resident #30, with a reference date of 6/3/24, revealed a Brief Interview for Mental Status (BIMS) score of 2, out of a total possible score of 15, which indicated severe cognitive impairment. Review of an Incident Note for Resident #30, dated 8/12/24 at 6:01 PM, revealed .Resident was found lying on the floor next to the curtain (which separates both sides of the room). Resident was found lying on her left side. Wheelchair was right next to her feet. Resident had shoes on. Resident states she was trying to clean something .unable to fully understand statement. Resident was assessed, no injuries noted and no lumps on head noted. Staff was able to transfer her into wheelchair with no issues. Once in the wheelchair, resident stated that she was having pain in her left upper thigh. No visible injuries and/or redness. Resident stated she was in pain when assessing ROM (Range of Motion) in LLE (Left Lower Extremity). Placed an ice pack on site. Notified Hospice, a nurse was sent out to assess, currently in the process of sending resident to ER (emergency room) . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Summary for Resident #30, dated 8/16/24 at 10:36 PM, revealed .(Resident #30) admitted at (10:30 AM) from (Hospital Name) after repair of left hip fracture . In an observation on 8/20/24 at 10:57 AM, Resident #30 was noted in bed in her room, apparently asleep with her eyes closed. Observed Resident #30's bed in a low position, with the left side of the bed along the wall. Observed a blue padded mat folded and leaning against the wall at the foot of her bed. No padded mat observed along the right side of Resident #30's bed. In an observation on 8/20/24 at 1:48 PM, Resident #30 was noted in bed in her room, with the left side of the bed against the wall. Resident #30 was awake and holding her legs in a folded position, leaning toward the right side of her bed. Observed a blue padded mat on the floor along the right side of Resident #30's bed. In an observation on 8/21/24 at 2:21 PM, Resident #30 was noted in bed in her room, apparently asleep with her eyes closed. Observed Resident #30's bed in a low position, with the left side of the bed along the wall. Observed a blue padded mat on the floor along the right side of Resident #30's bed. In an observation on 8/22/24 at 1:42 PM, Resident #30 was noted in bed in her room, apparently asleep with her eyes closed. Observed Resident #30's bed in a low position, with the left side of the bed along the wall. Observed a blue padded mat on the floor along the right side of Resident #30's bed. Review of a current Care Plan for Resident #30 revealed the focus .Risk for Falls . initiated 5/28/24. No interventions noted related to the use of a padded mat along the right side of Resident #30's bed. In an interview on 8/22/24 at 1:46 PM, Unit Manager V reported Resident #30 experienced a fall with a fracture on 8/12/24 and was sent to the hospital for surgery. Unit Manager V reported when Resident #30 readmitted from the hospital, a padded mat was implemented to be placed along the right side of Resident #30's bed. Unit Manager V reviewed Resident #30's current Care Plan and reported it had not been updated with this new intervention. In an interview on 8/22/24 at 3:17 PM, Licensed Practical Nurse (LPN) S reported the blue padded mat along the right side of Resident #30's bed was a new intervention put in place upon her readmission from the hospital. LPN S reported Resident #30 has confusion and attempts to get out of bed without staff assistance, so the blue padded floor mat was added to prevent injury.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to ensure residents' mechanical diet order recommeded by the speech language pathologist was added in a timely manner and the recommended diet was followed for meals; 2. resident was evaluated by therapy and interventions implemented to address positioning were in place in 1 of 1 resident resulting in the potential for aspiration, decreased range of motion and worsening of contractures. Findings include: Resident #28: Review of an Admission Record revealed Resident #28 was a female with pertinent diagnoses which included dementia, stroke, and dysphagia (damage to the brain responsible for production and comprehension of speech). Review of Care Plan revised on 8/21/24, revealed the focus, .(Resident #28) is at risk for altered nutrition/hydration status r/t (related to) hypothyroidism with CHF (congestive heart failure) requiring meds which may impact appetite/weight .(Resident #28) also has intolerance to lactose . with the intervention . Observe tolerance to diet; chew/swallow; no drooling, coughing, choking, runny nose or eyes with food/fluids; if notice notify MD (medical doctor) and SLP (speech language pathologist), Nurse .Regular diet, thin liquids, lactose intolerant, may use straws. Sit in upright posture for all meals . Review of Order dated 05/09/24, revealed, .Speech eval r/t (related to) coughing with meals, poor intake . Review of SLP (Speech Language Pathologist) Evaluation and Plan of Treatment dated 5/1/24, revealed, . Patient required supervision at mealtime prior to onset?=Yes .Patient Behaviors: Patient has a decreased appetite and declines certain foods. Staff reported that patient is fearful of eating and worried about choking at times .Patient needs assistance feeding self?+Yes .Clinical Impressions/Reason for Skilled Services: Patient presents with oropharyngeal dysphagia which necessitates skilled SLP services for dysphagia to assess/evaluate for safest level of oral intake . Review of SLP Discharge Summary dated 6/12/24, revealed, .Discharge: Mechanical soft diet and thin liquids .Patient continues to benefit from 1:1 verbal/written/tactile cuing to check and clear pocketed food items from her R-buccal cavity. Additionally, she benefits from small bites/sips, and limiting environmental distractions during PO intake .What modified diet is recommended for the patient to swallow solids safely? = Soft & bite sized .Solids = Mechanical soft/chopped textures .Liquids = Thin liquids .Strategies Compensatory Strategies/Positions: 1. Small bites/sips .2. Slow rate of intake .3. Liquid wash as needed .4. Check for pocketing. 5. Limit environmental distractions/stimuli .6. Setup tray to limit the amount of food presented to increase safety secondary to impulsivity with eating . Review of Orders dated 7/15/24, revealed, .Lactose intolerance diet mechanical soft texture, thin consistency, no dairy, ok for straws. Minced and moist meat . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nutrition/Dietary Note dated 7/18/2024 at 2:24 PM, revealed, .Nutrition Note: Spoke with dtr (daughter). Agreeable to SLP consult . Note: No documented consult completed for Resident #28 following this order. Review of Orders dated 8/1/24, revealed, .Regular diet mechanical soft texture, thin consistency, related to cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it) . Review of Orders dated 8/8/24, revealed, .Lactose intolerance diet mechanical soft texture, consistency . Review of Nutrition/Dietary Note dated 7/15/2024 at 5:14 PM, revealed, .Nutrition Note: Pocketing per CNA (Certified Nursing Assistant) with significant effort to remove. Nursing downgraded to mechanical soft texture with dtr/DPOA consent to trial. Wt (weight) stable per monthly review. Assistance eating provided in 3500 dining room, supervision. Defer to medical for SLP consult as needed . Review of Nutrition/Dietary Note dated 7/18/2024 at 2:03 PM, revealed, .Nutrition Note: Mech soft diet texture downgrade on 7/15. Intake reviewed. FAR primarily 26-50%, similar to prior. Staff report less pocketing. Socially engaged, less invested in food intake despite 1:1 with strong encouragement for intake. Wt stable 122lbs this month. Staff note coughing on beverages. Recommend SLP consult. Called dtr to review, no answer. Emailed and coordinated with CCC (Clinical Care Coordinator) Request for SLP consult placed on medical provider communication log . Note: No documented consult for Resident #28 following this note. Review of Health Status Note dated 8/18/2024 at 6:26 PM, revealed, .48 hour recap .Res has been A&O x1 . Appetite remains poor, with much encouragement needed with both food and fluids. Res is not remembering to drink unless drink is handed to her. Consuming approximately 25% @ meals. Sleeping at her norm. Speech has had increase of slurring. No new coughing episodes noted. She has been monitored when given drinks. No SOB noted. Breaths have been even and unlabored . In an interview on 08/22/24 at 09:36 AM, Nutrition Manager for Dietary JJ reported the nurse/dietician enter the order into the system and the dietary department printed out the slips for the meals. She reported the slips have the likes/dislikes, allergies, and the resident's type of diets on them. Review of Resident #28's lunch dietary meal slip for 08/22/24, revealed, .Allergies: Lactose, Diet: Lactose Intolerance, Fluid Consistency: Thin, Texture: Mechanical Soft; Additional Diet Notes: No dairy, ok for straws, minced and moist meat . In an interview on 08/22/24 at 11:19 AM, Dietitian FF reported nursing would report their concerns to the speech therapist with any resident who had trouble consuming their meals. Dietician F reported the was a diet order system which printed off of the electronic medical record system. The dietary staff would review the meal tray prior to delivery as well as the CNAs when the meal was delivered to ensure the accuracy of the tray. Dietician FF reported there was a resident who had an exception to their mechanical diet order which indicated right in the order the resident was allowed to have strips of bacon. Review of the electronic medical record revealed the except was not provided for Resident #28. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/22/24 at 12:01 PM, observed Resident #28 was seated at the table with her lunch supervised by Certified Nursing Assistant (CNA) N. CNA was prompting her to eat. Resident #28 had ground up meat, whole peas (not mashed), and mashed potatoes with gravy. During an observation on 08/22/24 at 09:15 AM, Resident #28 had pancakes, scrambled eggs, and two strips of bacon. In an interview on 8/21/24 at 2:17 PM, Unit Manager V reported the speech language pathologist (SLP) would have given the nurse a recommendation sheet and the nurse would have put the order in the resident's medical record. When queried why it took so long for the order to be entered when the SLP discharged the resident on 6/12/24, Unit Manager V reported she was not sure why it took so long for the order to be entered. Reviewed the medical record for Resident #28, Unit Manager V reported there should have been an order entered when the resident was discharged from speech therapy. In an interview on 08/21/24 at 02:04 PM, Unit Manager V reported when a resident was already at the facility the request for therapy to re-evaluate the resident was more informal and would request verbally, have a conversation. If a referral was needed, an order would be obtained from the provider. Review of Care Plan revised on 8/21/24, revealed, .(Resident #28) is at risk for altered nutrition/hydration status r/t (related to) hypothyroidism with CHF (congestive heart failure) requiring meds which may impact appetite/weight .(Resident #28) also has intolerance to lactose . with the intervention .Sit in upright posture for all meals . Review of Occupational Therapy Evaluation & Plan of Treatment dated 1/9/24, revealed, .Pt will tolerate upright positioning in w/c at table in order to improve self-feeding independence .Baseline: 1/9/24: semi reclined in w/c. Per staff, she had a lot of discomfort/pain with sitting upright at this time .Current referral: Patient is [AGE] year old female who was referred to OT services for self-feeding assessment d/t (due to) reduced intake and increased difficulty. May also benefit from positioning assessment .Clinical Impressions: Patient presents with significant UB (upper body) weakness, and poor positioning during meals. Assist to place fork into R hand, and then pt with difficulty stabbing food, and increased time to bring to mouth. Will benefit from strengthening as tolerated as well as further assessing positioning changes while self-feeding . Reason for Therapy: .facilitate sitting tolerance and postural control . Review of Care Plan revised on 8/21/24, revealed the focus, .Resident needs assistance with ADLs due to impaired cognition related to dementia, chronic pain, diagnosis of depression . with the intervention . Transfer: 2 staff assist using the hoyer lift with yellow sling .Bed Mobility: The resident is totally dependent on 1-2 staff for repositioning and turning in bed Q (every) 2 hrs and as necessary . Review of the remainder of the care plan showed no interventions in place to address the resident's propensity to lean to the right side when up in her wheelchair. Note: No interventions noted by therapy in the care plan to assist with positioning while up in her wheelchair. Review of Health Status Note dated 7/26/2024 at 1:05 PM, revealed, .Today resident is presenting with slurred speech, poor positioning in wheelchair (poor trunk control), poor appetite, not acting quite like herself. Vitals taken, hypertensive but otherwise WNL(within normal limits) . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Clark Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1551 Franklin Street, SE Grand Rapids, MI 49506	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/20/24 at 10:10 AM, Resident #28 was seated at the dining room table with her Ensure, she had a decorative throw pillow on her right side, and she had a bed pillow behind her legs while her feet where on the footrests. Her legs were not elevated nor where the foot pedals in a high position. There was a head support flipped over the back of the wheelchair. Resident #28 was observed still leaning to the right side. During an observation on 08/21/24 at 09:43 AM, observed Resident #28 seated at the dining room table in her wheelchair. Resident #28 had the decorative throw pillow next to her right side/leg/hip area, the side was opening up and stuffing was sticking out. The head rest was flipped over the back of the wheelchair still. Resident #28 had blue boots on both of her feet, and she had a pillow behind her legs. Her legs were not elevated in the footrests. She was observed leaning quite far to the right side. During an observation on 08/22/24 at 09:15 AM, Resident #28 was leaning to the right side in her wheelchair, and she did not have a pillow on her right side in the wheelchair seat. During an observation on 08/22/24 at 11:32 AM, observed Resident #28 seated at the dining table without the decorative throw pillow on her right side, she did not have the blue boot on her right foot. The footrests were elevated but she did not have her feet on them. She had her feet dangling from her seated position and not touching the ground. In an interview on 08/22/24 at 11:54 AM, Certified Nursing Assistant (CNA) F reported the staff used the pillow behind her legs for comfort as her legs do become uncomfortable and they use the decorative throw pillow to assist with positioning to provide the extra support for her. In an interview on 08/21/24 at 02:04 PM, Unit Manager (UM) V reported following a review of Resident #13's medical record there was not a recent evaluation from occupational therapy for Resident #13's positioning. UM V reported the facility changed therapy providers in March. When reviewed the speech evaluation, it was indicated Resident #13 had poor positioning during meals .the need to facilitate sitting tolerance and postural control. In an interview on 8/22/24 at 03:32 PM, Physical Therapist HH reported she had not received a request to assess or evaluate Resident #13. PT HH reported when there was a breakdown in function, the nursing staff were told to contact us, referral goes to the physician from the nurse who contacted us. PT HH reported when she was on the units treating other residents, if she saw a concern she would reach out to nursing to gather information on the resident to determine if there was a need to complete an evaluation. PT TT reported when they make recommendations for equipment to assist the resident, she would go back and follow up with the nurses to determine if the resident received the equipment and if needed complete additional follow up.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to provide the necessary care and services, consistent with professional standards of practice to prevent, treat, and promote healing of pressure uclers in 1 of 3 residents (Resident #31) reviewed pressure ulcers, resulting in the lack of repositioning and implementation of care planned interventions, delayed healing of pressure ulcers for the resident, and the potential for infection and the development of new ulcers. Findings include: Positioning interventions redistribute pressure and shearing force to the skin. Elevating the head of the bed to 30 degrees or less decreases the chance of pressure ulcer development from shearing forces (WOCN, 2010). Change the immobilized patient's position according to tissue tolerance, level of activity and mobility, general medical condition, overall treatment objectives, skin condition, and comfort (NPUPA, EUPAP, PPPIA, 2014). A standard turning interval of to 2 hours does not always prevent pressure ulcer development. Consider repositioning the patient at least every 2 hours if allowed by his or her overall condition. When repositioning, use positioning devices to protect bony prominences (WOCN, 2010). The WOCN guidelines (2010) recommend a 30-degree lateral position (Figure 48-15), which should prevent positioning directly over the bony prominence. To prevent shear and friction injuries, use a transfer device to lift rather than drag the patient when changing positions (see Chapter 39). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 72244-72253). Elsevier Health Sciences. Kindle Edition. Category/Stage 2: Partial thickness: Partial thickness loss of dermis presenting as a shallow open a ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or serosanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation. Bruising indicates deep tissue injury. http: //www. npuap. org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/ Resident #31: Review of an Admission Record revealed Resident #31 was a male with pertinent diagnoses which included paralysis following a stroke affecting left side, diabetes, muscle weakness, and altered mental status. Review of Care Plan revised on 5/21/24, revealed the focus, .The resident has potential/actual impairment to skin integrity of all extremeties r/t (related to) fragile skin. Resident had two stage 2 pressure ulcers on bottom 12/12/23, resolved in April 2024. DTI (Deep tissue injury) April 2024 on right heel . with the intervention .Blue heel booties on when in bed, heels up pad when in bed .Foot tent for bed. Remove the top arm when providing care. Put back onwhen care complete and put sheet/cover over top of tent arms . Review of Orders dated 12/13/23, revealed, .Offload by turing side to side in bed, stay off back. May still be up in chair for couple hours during the day . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Provider Note dated 4/29/24, revealed, .He complains of bilateral leg pain .He slides down the bed and his feet his (sic) the base of the bed .Pressure injury of right foot, unstageable .Pressure injury of left buttock, stage 2, decubitus ulcer (injury to the skin and underlying tissue resulting from prolonged pressur on the skin .People most as risk are those with a condition that limits their ability to change positions) of right buttock, stage 2 .He needs pads at the end of his bed. His feet are often resting against his bed . Review of Incident Note dated 4/29/2024 at 2:19 PM, revealed, .Res had complaints of leg pain UR and this nurse was assessing where pain discomfort located. During assessment, observed a deep brown spot on res right heel of his foot. NP, and Don evaluated the area and reported that it is a deep tissue injury. NP, DON, and son are aware of this. Don is ordering a bed extender to allow more room for res B/L feet. Orders: are skin prep BID, right heel per NP order . Review of NP Progress Note dated 6/3/24, revealed, .Pressure injury of right foot, unstageable (CMS/HCC) Assessment & Plan: 1cm dark brownish/purple area on right heel, no open skin, no sign of infection . Continue Skin prep bid to right heel .Monitor for pressure, and pad heel .Decubitus ulcer of right buttock, stage 2 (CM S'HCC) Assessment & Plan: Discussed need to offload area. Discussed moving bed so that he can be on his side and still watch TV Continue Pressure relief mattress .Area has healed. Protective barrier ointment being used .Discussed getting out of bed, and he does this every Tuesday when his son comes to visit. He prefers stay in bed otherwise . Review of Long Term Care Evaluation Lookback dated 6/11/2024 at 3:18 PM, revealed, .N Adv - Long Term Care Evaluation Lookback: Reason for evaluation: Monthly evaluation. Fall(s) since last evaluation: No. Antibiotic(s) since last evaluation: No. Skin change(s) since last evaluation: Yes. Skin change details: buttock excoration/open in skin . Review of Skin & Wound Evaluation dated 6/14/24, revealed, .Type: Pressure .Stage 2 .Left Gluteus .In house acquired .Progress: New .Area: 4.4 CM .Length: 6.3 CM .Width: 3.2 CM . Review of Skin & Wound Evaluation dated 7/11/24, revealed, .Type: Pressure .Stage 2 .Left Gluteus .In house acquired .New .Area: 0.6 CM .Length: 1.0 CM .Width: 0.9 CM .Goal of care: Healable .Progress: Stalled . Review of Health Status Note dated 7/12/2024 at 07:20 AM, revealed, .Note Text: Skin prep applied to right heel blister for protection. Feet elevated and booties in place to feet . Review of Skin & Wound Evaluation dated 7/26/24, revealed, .Type: Pressure .Stage 2: Partical Thickness skin loss with exposed dermis .Left Gluteus .In House Acquired .New .Area: 35.8 CM .Length: 9.2 CM . Width: 7.0 CM . Review of Skin & Wound Evaluation dated 8/2/24, revealed, .Type: Pressure .Stage 2: Partical Thickness skin loss with exposed dermis .Left Gluteus .In House Acquired .New .Area: 11.9 CM .Length: 5.7 CM . Width: 4.5 CM .Progress: Deteriorating . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 8/6/24, revealed, a Braden score of 13.0 with indicated resident was at a moderate risk due to the resident was bedfast, very limited in mobility, friction & shear was a problem: requires moderate to maximum assistance in moving .Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance . During an observation on 08/20/24 at 09:27 AM, Resident #31 was observed lying supine in the bed, no tent at the foot of the bed and no foot bolster in place. During an observation on 08/20/24 at 11:26 AM, Resident #31 was observed lying supine in the bed, no tent at the foot of the bed and no foot bolster in place. Resident's head of the bed was approximately 30 degrees. During an observation on 08/20/24 at 01:13 PM, Resident #31 was observed lying supine in the bed, no tent at the foot of the bed and no foot bolster in place. Resident's head of the bed was approximately 30 degrees. During an observation on 08/21/24 at 10:06 AM, Resident #31 was lying in his bed, he had a tent at the foot of the bed, head of the bed was approximately 30 degrees, he had a gown on, he was supine position. The blankets were not over the tent at the end of the bed. During an observation on 08/22/24 at 11:40 AM, Resident #31 was observed lying in his bed, the tent framing was at the foot of the bed but the sheet or blankets were not placed over the tenting frame. There was not foot bolster under his feet. During an observation on 08/22/24 at 12:37 PM, Resident #31 was was observed lying in his bed, the tent framing was at the foot of the bed but the sheet or blankets were not placed over the tenting frame. There was not foot bolster under his feet. In an interview on 08/20/24 at 11:45 AM, Certified Nursing Assistant (CNA) L reported she typically works the same unit, they have a list of residents assigned to them, if she were to help on another unit she would ask the other staff, talk to the nurse or she could look at the kardex for the resident in the computer to determine the resident needs for care. In an interview on 08/22/24 at 02:25 PM, Licensed Practical Nurse (LPN) S reported she would seek another intervention to address the focus, she would enter an IDT note in the medical record documenting the resident had refused the care plan intervention, and add a note (if necessary) to the communication book for the provider. In an interview on 08/22/24 02:30 PM, LPN T reported the CNAs struggle to keep him offloaded but if you provide an explaination to him as to why he needed to be repositioned, he would've been compliant about it, he does still have a sore on his foot, he should be tented and offloaded, and turned every 2 hours. In an interview on 8/21/24 at 02:20 PM, Unit Manger V reported changes were discuss at the stand up meeting the following day or on Monday morning. We discuss if the intervention was appropriate for the resident and if any changes needed to be made they were completed at that time. We do not have a formal IDT team, we do talk about all the residents every day anyways. (continued on next page)

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	235401	A. Building B. Wing	08/22/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/21/24 at 03:20 PM, Director of Nursing (DON) B reported the change in interventions would be shared during the shift huddles and report of the immediate intervention the staff. Staff would review the care plan and the kardex to determine the needs of the resident. DON B reported at he beginning most shifts staff have the opportunity to review the kardex, there were walking rounds with the offgoing and oncoming CNAs for any changes in care plan interventions or care needs. In an interview on 08/22/24 at 03:15 PM, Director of Nursing (DON) B reported a note would be entered in the record for a refusal. DON B reported he was able to ensure care plan interventions were being completed when audit rounds were completed.

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	235401	A. Building B. Wing	08/22/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41982 Based on interview and record review, the facility failed to attempt a required Gradual Dose Reduction (GDR) of an antidepressant medication, in the absence of a documented contraindication, for 1 (Resident #6) of 5 residents reviewed for unnecessary medications, resulting in the potential that the resident received the medication at an unnecessary dose or for an unnecessary length of time. Findings include: Resident #6 Review of an Admission Record revealed Resident #6 was a female, with pertinent diagnoses which included: depression, unspecified and anxiety disorder, unspecified. Review of a current Physician Order for Resident #6 revealed, PAROXETINE 20MG (milligrams) TAB (tablet) Give 1 tablet orally one time a day for Depression Pharmacy Active 4/4/2023 08:00 Review of a pharmacist (pharmacy name omitted) Note To Attending Physician/Prescriber printed 4/10/24 revealed, (Resident #6) is currently receiving Paxil (brand name for Paroxetine) 20mg QD (once a day). She has diagnoses of depression and anxiety. Dosing History: 3/15/23 admitted on 20MG QAM (daily in the morning) .After reviewing physician evaluations, progress notes, and discussing her mood and behaviors with staff, we believe (Resident #6) is a candidate for a dose reduction. Please consider the following reduction: Reduce Paxil from 20mg to 10mg QD . Medical Director (MD) EE checked the Agree box, wrote will do it @ (at) her next 60 day in the comments section, signed the form, and dated 5/9/24. In an interview on 8/21/24 at 12:12 PM, Unit Manager (UM) V reviewed Resident #6's Note To Attending Physician/Prescriber recommendation to reduce Paxil from 20mg to 10mg that was signed by MD EE on 5/9/24 with this surveyor. UM V reported that, following the pharmacy recommendation, Resident #6 had subsequently been seen by MD EE and the Nurse Practitioner, but that neither of them had decreased Resident #6's Paxil. UM V reported Resident #6's Paxil should have been reduced per pharmacy recommendation. In an interview on 8/21/24 at 2:35 PM, MD EE reported he had agreed with the pharmacy recommendation that a dose reduction should be done with Resident #6 for her Paxil and that he had planned on addressing it at his next visit with her which had not yet occurred. MD EE reported the timing between the pharmacy recommendation and when he was planning on addressing the recommendation happened to be an unusually long lapse in this instance. MD EE reported Resident #6's mood was pretty stable and there was no reason not to try a gradual dose reduction with her on the Paxil. MD EE reported the gradual dose reduction should have already occurred.

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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 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 prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all 35 residents. Findings include: During the initial tour of the kitchen, starting at 9:25 AM on 8/20/24, it was observed that four pans of cooked, whole intact, beef roasts were found on the expediting cart in the preparation walk in cooler dated for 8/20. At this time, there were also a couple pans of beef dated for 8/19, and further review of the walk in cooler found a large container of bean soup (roughly 3 gallons) cooling with two ice wands in the soup. A review of the kitchen's Cooling Log, dated August, found beef roasts that were cooled on 8/19, but none that were logged for being cooked/cooled on 8/20. Further review of the log found the bean soup starting cooling at 8:30 AM this morning (8/20/24), but was unclear if the cooling started at 140F or 190F. At 9:30 AM on 8/20/24, an interview with [NAME] NN found that the beef was all cooked yesterday (8/19/24) and that he had the beef out this morning on the expediting rack while he was making purees. [NAME] NN stated the cart was out for roughly an hour and was recently put back into the walk in. When asked what the temperature of the bean soup was when he started cooling, [NAME] NN stated 140F. At 9:33 AM on 8/20/24, temperatures of the cooked chunks of beef, ranging in roughly 4-8 pound chunks, were found to be 46F-49F, when checked in the middle of the product with a rapid read thermometer. An interview with [NAME] NN found that the beef was cooked off yesterday, cooled down, and staff were unsure why the temperature discrepancy was evident. Food product in the cooler was found to be 37F-39F. A revisit to the kitchen, at 3:35 PM on 8/20/24, found the bean soup that was cooling with two ice wands this morning, was now covered in the walk-in cooler. At this time, the temperature of the bean soup was found to be 55F. A review of the Cooling log found that it states that if food is not below 41F after six hours it should be discarded. According to the 2017 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. During a tour of the kitchen, at 10:02 AM on 8/20/24, it was observed that accumulation of dirt and debris was evident behind the three-compartment sink and dish machine area. Dirt and debris was found on the back coving of the wall and drains in these areas. An interview with Dining Services Director LL found that they have begun to hire some outside help for some of the deep cleaning areas of the kitchen. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 Based on observation, interview, and record review, the facility failed to effectively implement Transmission-Based Precautions (TBP) for COVID-19 positive residents and Enhanced Barrier Precautions (EBP) per facility policy and Centers for Disease Control and Prevention (CDC) guidance, in 4 of 7 residents (Resident #3, #20, #17, and #11) reviewed for infection control, with the potential to affect all 36 residents who reside at the facility, resulting in the potential for disease exposure, cross-contamination, and the development and spread of infection to a vulnerable population. Findings include: Review of the policy/procedure Infection Prevention & Control: COVID-19, dated 2/28/24, revealed .Personal Protective Equipment .HCP (Health Care Providers) who enter the room of a resident with suspected or confirmed SARS-CoV-2 (COVID-19) infection should adhere to Standard Precautions and use a NIOSH Approved N95 (mask), gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) . Resident #3 Review of an Admission Record revealed Resident #3 was a female, with pertinent diagnoses which included obstructive lung disease, dementia, and high blood pressure. Review of a current Care Plan for Resident #3 revealed the focus .Resident is positive for COVID-19 and has the potential for complications r/t (related to) infection . initiated 8/22/24, with interventions which included . Follow Droplet/Contact precautions while assisting, treating and assessing resident (PPE (Personal Protective Equipment) to include gloves, gown, eye protection (face shield and/or goggles) and N-95 or greater mask . initiated 8/22/24. Review of an Infection Note for Resident #3, dated 8/22/24 at 8:47 AM, revealed .Resident tested positive for (COVID-19) this morning. No s/s (signs/symptoms) at this time. Droplet precautions initiated . In an observation on 8/22/24 at 8:59 AM, noted a sign posted on Resident #3's door which indicated Droplet Precautions were in place, and a PPE bin in the hallway outside Resident #3's room. Noted the PPE bin contained disposable gowns, gloves, eye protection, and N-95 masks. The Droplet Precautions sign stated . EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit . Observed Licensed Practical Nurse (LPN) S and Certified Nursing Assistant (CNA) I respond to Resident #3's activated call light. Observed LPN S and CNA I each don a gown and gloves, in addition to a surgical mask (already in use), prior to entering Resident #3's room to assist with morning care. Noted LPN S and CNA I did not utilize eye protection or an N-95 or greater mask while providing morning care to Resident #3. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an observation on 8/22/24 at 9:14 AM, LPN S and CNA I exited Resident #3's room after providing morning care. Observed Resident #3 sitting up in her wheelchair in her room. Noted LPN S and CNA I had removed and discarded the disposable gowns and gloves, but were still wearing the surgical masks. LPN S then returned to Resident #3's room, wearing only a surgical mask for PPE, placed the foot pedals on Resident #3's wheelchair and assisted Resident #3 into the bathroom to use the mirror. In an interview on 8/22/24 at 9:17 AM, LPN S reported all staff at the facility were wearing surgical masks due to COVID-19 positive residents within the facility. LPN S reported Droplet Precautions are in place for Resident #3 because .She has Crohn's disease . LPN S reported the only PPE required to care for Resident #3 was a gown and gloves. In an interview on 8/22/24 at 9:40 AM, CNA I reported in regard to the Droplet Precautions in place for Resident #3, staff are required to don a gown, gloves, and surgical mask prior to entering the room. CNA I reported a N-95 is only required when a resident has COVID-19. CNA I reported eye protection would be utilized if the resident has a cough. CNA I stated if no cough, eye protection is not required. In an observation on 8/22/24 at 10:59 AM, noted a sign posted on Resident #3's door which indicated Droplet Precautions were in place, and a PPE bin in the hallway outside Resident #3's room. Observed Maintenance Technician D don a gown and gloves, in addition to the surgical mask already in use, prior to entering Resident #3's room to perform maintenance on her bed. Noted Resident #3 was present in her room at this time. No eye protection or N-95 mask utilized by Maintenance Technician D while in Resident #3's room. In an observation and interview on 8/22/24 at 11:04 AM, Maintenance Technician D exited Resident #3's room wearing a gown, gloves, and surgical mask. Maintenance Technician D reported he would follow CDC recommendations for what PPE to utilize in a COVID-19 positive resident room. Maintenance Technician D reported the required PPE when entering a COVID-19 positive resident room would be a gown, gloves, mask (did not specify type), and eye protection. Maintenance Technician D reported eye protection would only be used if .close . to the resident. Maintenance Technician D reported he would wear a N-95 mask .when it's required . Maintenance Technician D reported there would be an extra sign on the resident's door indicating a N-95 mask is required in the room. Noted no signage on Resident #3's door indicating a N-95 mask was required. Observed Maintenance Technician D remove the gown and gloves, walk across the hallway, and discard the soiled gown and gloves in an uncovered trash can below the common area sink. Resident #20 Review of an Admission Record revealed Resident #20 was a female, with pertinent diagnoses which included heart failure, dementia, anxiety, depression, stroke, anemia, high blood pressure, and shortness of breath. Review of a current Care Plan for Resident #20 revealed the focus .Resident is positive for COVID-19 and has the potential for complications r/t (related to) infection . initiated 8/22/24, with interventions which included .Follow Droplet/Contact precautions while assisting, treating and assessing resident (PPE (Personal Protective Equipment) to include gloves, gown, eye protection (face shield and/or goggles) and N-95 or greater mask . initiated 8/22/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an Infection Note for Resident #20, dated 8/22/24 at 8:44 AM, revealed .Resident tested positive for (COVID-19) this morning. No s/s (signs/symptoms) at this time. Droplet precautions initiated . In an observation on 8/22/24 at 9:23 AM, noted a sign posted on Resident #20's door which indicated Droplet Precautions were in place, and a PPE bin in the hallway outside Resident #20's room. Noted the PPE bin contained disposable gowns, gloves, eye protection, and N-95 masks. The Droplet Precautions sign stated .EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit . Observed Housekeeper U don a N-95 mask and gloves, and enter Resident #20's room to clean her bathroom. No gown or eye protection utilized while in Resident #20's room. Noted Resident #20 was present in her room at this time. In an observation and interview on 8/22/24 at 9:30 AM, Housekeeper U exited Resident #20's room wearing a N-95 mask. Housekeeper U reported she was instructed to wear a N-95 mask and gloves when in resident rooms with Droplet Precautions in place. Observed Housekeeper U continue down the hallway, don gloves (while still wearing the same N-95 mask worn upon exiting Resident #20's room), and enter Resident #3's room to clean. No gown or eye protection utilized by Housekeeper U while in Resident #3's room. Noted Resident #3 was present in her room at this time. In an interview on 8/22/24 at 11:02 AM, LPN T reported Resident #3 and Resident #20 are both on Droplet Precautions due to a diagnosis of COVID-19. LPN T reported staff are required to don a gown, glove, N-95 mask, and eye protection prior to entering the room for any resident with a COVID-19 diagnosis. Resident #17 Review of an Admission Record revealed Resident #17 was a male, with pertinent diagnoses which included osteomyelitis (bone infection), spinal abscess (pocket of pus), heart disease, and high blood pressure. Review of an Order Summary Report for Resident #17 revealed the active physician order .Piperacillin Sod-Tazobactam So Solution Reconstituted 3-0.375 GM Use 3.375 gram intravenously (IV) every 6 hours . with a start date of 8/14/24. Review of a current Care Plan for Resident #17 revealed the focus .The resident has infection of the spine . initiated 8/14/24, with interventions which included .Administer antibiotic (Piperacillin Sod-Tazobactam So Solution Reconstituted 3-0.375 GM, Q6 hr (every 6 hours) .IV PICC (Peripherally Inserted Central Catheter) LINE) as per MD (Physician) orders . and .Enhanced Barrier precaution applied . both initiated 8/14/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an observation and interview on 8/21/24 at 2:08 PM, Licensed Practical Nurse (LPN) J entered Resident #17's room to administer IV medication. Observed LPN J don gloves and prepare .Piperacillin Sod-Tazobactam So Solution Reconstituted 3-0.375 GM . for Resident #17. Observed LPN J hang the pharmacy prepared antibiotic and prime the IV tubing. LPN J then disinfected Resident #17's PICC line access site with an alcohol wipe, flushed the PICC line with normal saline, connected the IV tubing, and started the IV pump to administer the medication. Noted LPN J did not don a gown prior to accessing Resident #17's PICC line and administering the IV medication. LPN J reported she was unsure if Resident #17 was on Enhanced Barrier Precautions, and stated Enhanced Barrier Precautions were for .wounds and Foley's (indwelling catheters) . No signage noted outside Resident #17's room to indicate Enhanced Barrier Precautions were in place. In an interview on 8/21/24 at 2:32 PM, Certified Nursing Assistant (CNA) E reported the nurse typically notifies the CNA's at the start of the shift about which residents are on Enhanced Barrier Precautions. CNA E reported for residents on Enhanced Barrier Precautions, staff are required to don a gown and gloves for care. CNA E reported the gown is located on the back of the resident's door, and all staff share the same gown. CNA E reported Resident #17 is currently on Enhanced Barrier Precautions. In an observation on 8/21/24 at 2:42 PM, LPN J returned to Resident #17's room to disconnect the IV tubing from his PICC line. Observed LPN J don gloves, disconnect the tubing, disinfect Resident #17's PICC line access site with an alcohol wipe, and flush the PICC line with Heparin per physician orders. Noted LPN J did not don a gown prior to accessing Resident #17's PICC line. In an interview on 8/21/24 at 2:52 PM, CNA P reported information on which residents were on Enhanced Barrier Precautions would be .in the system . CNA P reported if a resident was on precautions, there would be a sign outside the door to the resident's room and a bin containing Personal Protective Equipment (PPE). In reference to the gowns hanging on the backside of some resident room doors, CNA P stated she believed those were .left over . with no further clarification provided. In an interview on 8/22/24 at 12:21 PM, Certified Nursing Assistant (CNA) W reported she did not recall receiving any education in regard to Enhanced Barrier Precautions (EBP). CNA W reported she may have received a text, but does not recall the content of the message. CNA W reported EBP are for residents with indwelling catheters and wounds. CNA W reported these residents have a reusable gown hanging on the backside of the entry door (to their room) that staff are supposed to wear when providing care. CNA W reported she does not recall seeing any signage related to EBP, and stated whether or not a resident is on EBP .might be in the care plan . CNA W reported staff all share the same reusable gown for a resident on EBP. CNA W reported if a resident has COVID-19, staff are required to wear a gown, eye protection, gloves, and a N95 mask when in the resident's room. In an interview on 8/22/24 at 3:27 PM, with Administrator A and Director of Nursing (DON) B, DON B reported for Enhanced Barrier Precautions, there is a reusable gown in the resident room that is changed out at the end of each shift. DON B reported the reusable gown is a visible trigger to identify residents on Enhanced Barrier Precautions. DON B reported the facility does not post signs to indicate when Enhanced Barrier Precautions are in place. DON B reported there should be a physician order for Enhanced Barrier Precautions in the electronic medical record, and the Care Plan should indicate Enhanced Barrier Precautions are in place. DON B reported for a COVID-19 positive staff member, staff should don a gown, gloves, N95 mask, and eye protection prior to entering the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a current Order Summary Report for Resident #17 revealed no physician order for Enhanced Barrier Precautions. Review of the policy/procedure Enhanced Barrier Precautions, dated 8/2022, revealed .Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents .EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing) .EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization .EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk .Staff are trained prior to caring for residents on EBPs .Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required .PPE is available outside of the resident rooms . 41424 In an interivew on 08/22/24 at 11:38 AM, Unit Manager (UM) V reported she was guessing the night shift nurses were the ones who identified the COVID positive residents or the DON as he was there this morning. UM V reported the residents must've appeared symptomatic and they tested all the residents. UM V reported she woke up to a text message that there was COVID in the building. The scheduler had it a couple weeks ago, but she only came over her to the printer as her office was in another part of the building. During an observation on 08/22/24 at 12:02 PM, COVID-19 Reagent bottle lying on it's side on the counter top at the hand washing station on the 3200 unit. During an observation on 08/22/24 at 12:37 PM, the gowns were hung from the back of the door for room [ROOM NUMBER], the resident in the room was COVID positive. For room [ROOM NUMBER], the gowns were hung on the wall directly ahead when enter the room, the resident would brush against them as he would enter his room. His roommate was COVID positive. 41982 Resident #11 Review of an Admission Record revealed Resident #11 was a male, with pertinent diagnoses which included: Alzheimer's Disease (a form of dementia) with late onset and functional quadriplegia (paralysis of all limbs). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a Restorative Nursing Screener / GG Evaluation document dated 8/18/24 at 3:02 PM revealed, . AS_2. Self Care .2. Eating: The ability to use suitable utensils to bring food and / or liquid to the mouth and swallow food and / or liquid once the meal is placed before the resident . Resident #11 was coded as being Dependent. Review of Resident #11's current Care Plan revealed a focus of ADL (Activities of Daily Living) FUNCTIONAL/REHAB POTENTIAL: The resident has an ADL self-care performance deficit r/t (related to) visual impairment, cognitive impairment, and decreased mobility . last revised on 3/7/24 and interventions that included (Resident #11) requires Total assistance x 1 person with eating daily. Allow the resident to maintain independence as much as possible. With a date initiated of 3/23/23. Review of Resident #11's Infection Note dated 8/22/24 at 8:41 AM revealed, Resident tested positive for Covid this morning. No s/s (signs/symptoms) at this time. Droplet precautions initiated. Son, (name omitted), notified. Educated regarding precautions in place if visiting . During an observation and interview on 8/22/24 at 9:36 AM, observed Licensed Practical Nurse (LPN) S outside of Resident #11's door. LPN S reported she was getting ready to go into Resident #11's room to feed him. LPN S was wearing a surgical mask. LPN S donned (put on) a gown and gloves. LPN S then retrieved Resident #11's breakfast tray from the cart, knocked on Resident #11's room door, and entered the room. LPN S did not don an N-95 mask (a type of respirator) nor eye protection prior to entering the room. In an interview on 8/22/24 at 11:49 AM, Director of Nursing, Infection Preventionist (DON, IP) B reported when a resident tested positive for COVID, they were placed on droplet precautions. DON, IP B reported PPE (personal protective equipment) that needed to be worn when entering the room of a resident on droplet precautions included the following: gown, gloves, eye protection (goggles or face shield), N95 mask, and foot booties. DON, IP B reported the staff member who entered Resident #11's room to feed him should have been wearing a gown, gloves, eye protection, N95 mask, and foot booties prior to entering the room.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982 Based on interview and record review, the facility failed to ensure a resident who was eligible for a recommended vaccine was offered that vaccine in a timely manner for 1 resident (Resident #29) of 5 residents reviewed for immunizations, resulting in a delay in the resident to be given the opportunity to receive or decline the pneumococcal vaccination. Findings include: Review of the policy Pneumococcal Vaccine with a revised date of October 2023 revealed, Policy Statement All residents are offered pneumococcal vaccines to aide in preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation 1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series .7. Administration of the pneumococcal vaccines are made in accordance with the current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. According to the Centers for Disease Control and Prevention (CDC) PCV20 Vaccination for Adults [AGE] years and Older dated 02/09/23, revealed, .Routine vaccination: Adults [AGE] years or older who have- Previously received both PCV13 and PPSV23, AND PPSV23 was received at age [AGE] years or older: Based on shared clinical decision-making, 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine dose . www.cdc.gov/vaccines/hcp/admin/downloads/job-aid-SCDM-PCV20-508.pdf Resident #29 Review of an Admission Record revealed Resident #29 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: cerebral infarction, unspecified (stroke); essential (primary) hypertension (high blood pressure); and hyperlipidemia (high cholesterol). Review of Resident #29's documented Immunizations in the electronic medical record revealed, Immunization Prevnar 13 (a type of pneumococcal vaccine) Date Given 1/21/2016; Immunization Pneumovax 23 (a type of pneumococcal vaccine) Date Given 7/2/2008 There was no documentation that the PCV20 vaccine had been offered to or refused by this resident. In an interview on 8/22/24 at 11:49 AM, DON, IP B reported he had been the Infection Preventionist at the facility since May 2024. DON, IP B reviewed Resident #29's immunization record with this surveyor and reported Resident #29 was eligible to receive the PCV20 vaccine but that there was no record that it had been offered to or refused her, or her responsible party. DON, IP B reported the pharmacy was supposed to notify the facility when anybody was eligible for any type of vaccine. DON, IP B reported he had received verbal consent on 8/21/24 from Resident #29's DPOA (durable power of attorney) for Resident #29 to receive all vaccines (flu, pneumococcal, and COVID-19), so she would be offered the PCV20 soon.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 41424 Based on interview and record review, the facility failed to provide annual required abuse prevention education for all staff members who provide care, services, and supports to the residents. This has the potential to affect all 36 residents residing in the facility at the time of the survey. Findings include: Review of (Vendor) Course Completion Report dated 08/22/24, revealed, 27 employees out of 126 employees had not completed Understanding Abuse and Neglect and/or Recognizing, Reporting, and Preventing Abuse. No Therapy staff or Housekeeping staff listed on the report. Review of Facility Assessment reviewed by the QAA (Quality Assessment and Assurance) Committee on 1/2024, revealed, the abuse and neglect training was provided via the (Vendor) computer module health care education provide to the center staff throughout the year. In an interview on 8/22/24 at 3:27 PM, Administrator A reported in regard to education for abuse and reporting the staff completed the education with the (Vendor) annually. DON B reported the facility provided training through a computer-based program. Requested documentation to verify that all staff had received training in regard to Abuse and Reporting.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 36221 Based on interview, and record review, the facility failed to implement an effective training program for all staff in regard to infection prevention and control and Enhanced Barrier Precautions, resulting in the potential for the spread of disease and infection to a vulnerable population. Findings include: In an interview on 8/22/24 at 12:21 PM, Certified Nursing Assistant (CNA) W reported she did not recall receiving any education in regard to Enhanced Barrier Precautions (EBP). CNA W reported she may have received a text, but does not recall the content of the message. In an interview on 8/22/24 at 3:27 PM, with Administrator A and Director of Nursing (DON) B, DON B reported in regard to education for EBP, the facility posted information on the home page for the electronic medical record system. DON B reported this information was visible to the licensed nurses, but was unsure if it was available to the CNA staff or any other departments. No documentation or signature record to indicate which staff reviewed the information posted within the electronic medical record system. DON B reported all staff were educated on Enhanced Barrier Precautions when the requirement was initiated, however, the facility was unable to locate any materials to verify this education had been completed. DON B reported he started at the facility in January of 2024 and was responsible for the Infection Control Program. DON B reported he had not initiated/provided a formal education to staff in regard to Enhanced Barrier Precautions while at the facility (since January 2024). DON B reported the facility also provides training through a computer-based program. Requested documentation to verify that all staff had received training in regard to Enhanced Barrier Precautions. Review of a Facility Assessment, dated January 2024, revealed .Staff training/orientation begins with our orientation process and continues throughout the year via new employee orientation, skills fairs, staff meetings and as needs are identified .computer module health care education provides the (Facility Name) staff with in depth learning modules throughout the year to improve performance .Infection control training is on-going throughout the year and has been throughout the Covid pandemic. For example: Donning and doffing PPE (Personal Protective Equipment), handwashing, proper mask wearing . Reviewed staff education documentation provided related to infection control. Noted no information to verify staff completed education in regard to Enhanced Barrier Precautions. For additional information see F880.