STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235414	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at West Branch	445 S Valley St West Branch, MI 48661

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview, and record review the facility failed to ensure code status accuracy for six residents (#4, #8, #22, #29, #36, #40) of six residents reviewed for advance directives, resulting in Resident #22's record having conflicting code status documented and Residents #4, #8, #29, #26 and #40 DNR order forms were inaccurately completed. Findings Include: Resident #4: During initial tour on [DATE], Resident #4 was observed self-propelling throughout the hallway. She was well groomed and appeared to be in good spirits during the short interaction. On [DATE] at 1:40 PM, a review was completed of Resident #4's medical records and it revealed she admitted to the facility on [DATE] with diagnoses that included, Intracerebral Hemorrhage, Kidney Disease, Major Depressive Disorder and Polyneuropathy. Resident #4 is cognitively intact and able to make her needs know to the facility. Further review completed of Resident #4's chart yielded the following results: Progress Notes: [DATE] at 11:57: Resident alert and able to make her needs known, resident is here for LTC quarterly evaluation complete, resident is up in her wheel chair self propels around facility, no complaints offered will continue follow. Care Plan: (Resident #4) has elected a DNR status. Initiated on [DATE]. Do Not Resuscitate Order: -Signed by the Resident #4 and two witnesses on [DATE] and [DATE] There was no clearly delineated physician signature on the DNR form. Resident #8: (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During initial tour on [DATE], Resident #8 was observed resting bed. On [DATE] at 2:15 PM, a review was completed of Resident #8's medical records and it revealed the resident admitted to the facility on [DATE] with diagnoses that included, Metabolic Encephalopathy, Sepsis, Down Syndrome, Acute Respiratory Failure and Chronic Kidney Disease. Resident #8 is not cognitively intact and unable to make her own decisions. Further review was completed and yielded the following results: Do Not Resuscitate Order: -Signed by Resident #8 responsible party on [DATE] and only signed by one witness, when the form required two witnesses. There was no clearly delineated physician signature on the DNR form. Resident #36: On [DATE] at approximately 2:25 PM, a review was completed of Resident #36's medical records and it revealed he admitted to the facility on [DATE] with diagnoses that included, Congestive Heart Failure, Alcohol Dependency, Gastro-Esophageal Reflux Disease, Peripheral Vascular Disease, Atrial Fibrillation. Resident #36 is cognitively intact and able to make his needs known. Further review was conducted of Resident #36's records and yielded the following results: Do Not Resuscitate Order: -Signed by Resident #36 and two witnesses [DATE]. There was no clearly delineated physician signature on the DNR form. Resident #29: On [DATE] at approximately 2:30 PM, a review was completed of Resident #29's medical record and it revealed she readmitted to the facility on [DATE] with diagnoses that included, Adult Failure to Thrive, Heart Failure and Respiratory Failure. Resident #29 is cognitively intact and can make her needs knows to facility staff. Further review yielded the following results: Do Not Resuscitate Order: -Signed by Resident #29 and two witnesses [DATE]. There was no clearly delineated physician signature on the DNR form. Resident #40: On [DATE] at approximately 2:35 PM, a review was completed of Resident #40's medical records and it revealed she admitted to the facility on [DATE] with diagnoses that included, Dementia, Hyperlipidemia, Major Depressive Disorder, Hypertension and Overactive Bladder. Further review yielded the following results: Do Not Resuscitate Order: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Signed by Resident #40 and two witnesses [DATE]. There was no. There was no clearly delineated physician signature on the DNR form. It can be noted on four of the DNR forms Physician Z signed as the witness and not the physician. On all the forms there was no clear delineation for physician signature which voided the residents wishes for their DNR status. At the bottom of the facility-initiated document it stated, This form was prepared pursuant to, and in compliance with, the Michigan Do-Not-Resuscitate Procedure Act. Review was completed Michigan Do-Not-Resuscitate Procedure Act 193, the Act stated, .333.1053 Execution of order; authorized persons: form; printed or typed names; signatures; witnesses; identification bracelet; possession; access. Sec. 3 .2. An order executed under this section shall be on a from described in section 4. The order shall be dated and executed voluntarily and signed by each of the following persons: a. the declarant's attending physician; c. two witnesses [AGE] years ago or older .3. The names of all signatories shall be printed or typed below the corresponding signatures. A witness shall not sign an order unless the declarant or the declarant's patient advocate appears to the witness to be of sound mind and under no duress, fraud or under influence . The Act provided a On [DATE] at 2:00 PM, an interview was conducted with Social Work Director Y regarding the process for residents and/or responsible party to elect a code status. Director Y explained upon admission to the facility it is the responsibility of the admissions department and floor nurses to complete code status planning with the residents. If during their stay they elect to change the code status social services is not involved in this process. This writer and Director Y reviewed Resident #4's DNR Order and it was pointed out the second witness signature was the physician signing as the witness. On [DATE] at 2:40 PM, an interview was conducted with DON (Director of Nursing) and Regional Clinical Nurse O regarding the facility's DNR form. It was explained the physician signed the DNR order but signed under witness. They were asked if there was a specific signature line for the physician (separate from witness) and they stated there was not. 39059 Resident #22: On [DATE], at 1:14 PM, a record review Resident #22's electronic medical record revealed an admission on [DATE] with diagnoses that included Stroke, Diabetes and post traumatic stress disorder. Resident #22 required assistance with activities of daily living and had intact cognition. A review of the physician orders revealed the following active orders: Do not Resuscitate (DNR) Revision Date [DATE] Full Code Revision Date [DATE] A review of the Code Status: revealed Do Not Resuscitate (DNR), Full Code. A review of the Care plans revealed no care plan in regard to the resident's advanced directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Code Status Elective Form Date [DATE] revealed the box for full Resuscitation -(Full Code) was check marked and the FULL Provide all medically appropriate care (i.e., CPR, AED, 911, intubation, drugs, etc.) . The Resident/Responsible Party line was signed by the resident. The Witness #2 line appeared to be signed by the Medical Director. On [DATE], at 2:36 PM, a record review of the requested list of Residents with a DNR advanced directive which was provided by the facility revealed Resident #22 was on the list. On [DATE], at 10:23 AM, a record review along with Unit Manager M of Resident #22's physician orders was conducted. UM N was asked if Resident #22 was a full code or a DNR and UM N stated, (they) are a DNR and I see what you see. UM N planned to clarify the code status with the resident and call the physician. On [DATE], at 11:00 AM, UM N offered that they had talked with Resident #22. They do elected to continue to be a full code and a new advanced directive/Full Code form was signed. On [DATE], at 10:48 AM, a further review of the miscellaneous tab in the electronic medical record revealed a new document uploaded on [DATE] that read CURRENT CODE STATUS . with the line Resident/Responsible Party Date [DATE] revealed Resident #22's signature. A further review of the physician orders revealed only the one advance directive order Full Code . Active [DATE].

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake Numbers MI00134226, MI00134335, and MI00136587. Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedure for pressure ulcer (wounds caused by pressure) prevention and management and ensure accurate and complete documentation for four residents (Resident #9, Resident #36, Resident #59, and Resident #67) of four residents reviewed, resulting in a lack of implementation of planned and meaningful interventions, pressure ulcer development, pressure ulcer worsening, unnecessary pain, and the likelihood for decline in overall health status. Findings include: Resident #9: On 5/6/24 at 11:10 AM, Resident #9 was observed sitting in a powered wheelchair in their room. Their spouse was present in the room and an interview was completed. When queried regarding their stay at the facility, Resident #9 revealed they came to the facility for therapy after being in the hospital and planned to discharge home. When queried regarding their electric wheelchair, Resident #9 revealed it was their personal chair from home. Resident #9 revealed they had Multiple Sclerosis (MS- disabling autoimmune of the central nervous system causing permanent disability) and limited mobility. Resident #9 was asked if they had any wounds and stated, Pressure ulcer on my butt. When queried if the pressure ulcer developed at the facility, Resident #9 replied that it did. Resident #9 was asked if they experienced pain from the pressure ulcer and replied yes. Record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses which included MS, diabetes mellitus, paraplegia (lower extremity paralysis), acute respiratory failure, tracheostomy (surgically created opening in the front of the neck to the trachea to allow air exchange), suprapubic catheter (surgically created opening through the abdominal wall to the bladder to allow for urine drainage), cerebral infarction (stroke) affecting right side, and weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required substantial/maximum to total assistance to complete dressing, bathing, and mobility. The MDS further revealed the Resident was at risk for pressure ulcer development but did not have any pressure ulcers. Review of the facility-provided CMS-802 form detailed Resident #9 had a facility-acquired (FA) Stage 3 (full thickness tissue loss with visible subcutaneous fat). Review of Resident #9's Electronic Medical Record (EMR) revealed a care plan entitled, The resident has actual impairment to skin integrity AEB (As Evidenced By) wound to tracheostomy r/t tracheostomy status, Accidental decannulation requiring ER visit to reinsert. 4/23/24- Trach removed by ENT / Decannulated. 4/30/2024- Stage 3 PI (Pressure Injury) to Right posterior thigh (Initiated: 4/17/24). The care plan included the following interventions: - Evaluate resident for S/SX (signs/symptoms) of possible infections (Initiated: 4/18/24) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Pain: Evaluate residents for changes in pain level and if appropriate request a scheduled pain medication from physician (Initiated: 4/18/24) - Ensure that heels are elevated while resident is lying in bed (Initiated: 5/1/24) - Encourage res to only stay in her WC an hour at a time for off-loading purposes (Initiated: 5/1/24) - Follow facility protocols for treatment of injury (Initiated: 5/1/24) - The resident needs APM (Alternating Pressure Mattress) mattress to protect the skin while in bed (Initiated: 5/1/24) - The resident needs WC cushion to protect the skin while up in chair (Initiated: 5/1/24) - Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations (Initiated: 4/18/24). A second care plan entitled, The resident has potential for impairment to skin integrity r/t (related to) Multiple sclerosis, Decreased mobility Right Hemiplegia s/p (status post) CVA (stroke) . (Initiated: 4/15/24) was noted in Resident #9's EMR. The care plan included the following interventions: - Apply barrier cream per facility protocol to help protect skin from excess moisture (Initiated: 4/15/24) - Encourage that heels are elevated while resident is lying in bed (Initiated: 4/15/24) - Dietary Consult as needed (Initiated: 4/15/24) - Monitor skin when providing cares, notify nurse of any changes in skin appearance (Initiated: 4/15/24) - Nutritional Supplements as ordered (Initiated: 4/15/24) - Pressure reduction bed mattress (Initiated: 4/15/24) - Wheelchair pressure reduction cushion (Initiated: 4/15/24) Review of Resident #9's Visual/Bedside Kardex revealed the Resident required two assist for bed mobility and two assist with a Hoyer (full mechanical lift) for transferring in and out of bed. Review of documentation in Resident #9's EMR revealed the following: - 4/28/24 at 5:38 AM: Daily Skilled Nursing Note . Resident is receiving skilled services for . Wound Care . New skin issue noted this shift . to right buttocks, to be abrasion W/TX (with treatment) in place (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 4/28/24 at 11:13 AM: Wound Evaluation . MASD (Moisture Associated Skin Damage) . Rear Right Thigh . New . Length 4.14 cm (centimeters) . Width 2.52 cm . Wound Bed: Granulation . Bleeding . Exudate . Moderate . Sanguineous/Bloody . Periwound: Edges: Attached . Surrounding Tissue: Denuded (exposed, damaged, or missing tissue) . Excoriated (skin erosion) . Treatment . Calcium alginate . foam . Notes: history of MASD and wounds to bilateral buttock . Will address pressure as well as potential for MASD turning into pressure injury. APM mattress ordered. Res has own [NAME] with built in cushion. Res and family declined ROHO cushion. Incontinence cares continued to keep resident dry. Education Res encouraged to turn and reposition at least q 2 hours as well as only get up in WC (wheelchair) for 1 hour at a time . - 4/28/24 at 2:18 PM: Daily Skilled Nursing Note . Resident is receiving skilled services for . Wound Care . Resident with pressure wound . open area to buttocks. Encouraged resident to lay down after meals; treatment in place. - 4/30/24 at 8:30 AM: Wound Evaluation .Pressure - Stage 3 . Rear Right Thigh . Deteriorating - 2 days old . Acquired: In-House Acquired . Length: 7.28 cm . Width: 5.06 cm . Deepest Point: 0.1 cm . Wound Bed . Granulation . 50% . Slough (dead tissue that is liquid or wet) . 50% . Exudate . Light . Serosanguineous . Edges: Attached . Surrounding Tissue: Fragile, Macerated . Treatment . Calcium alginate . Foam, Silicone . Additional Care . Cushion . Incontinence management . Moisture barrier . Moisture control . Healable . Progress: Deteriorating . Notes: APM mattress ordered. Res declined ROHO cushion to WC as has a built-in cushion on [NAME] 'specially made for (them)'. Dark areas noted to wound are blanchable. - 5/1/24 at 1:10 PM: Skin/Wound Note . APM mattress ordered . declined ROHO cushion to WC as has a built-in cushion on [NAME] (electric wheelchair) 'specially made for (Resident)'. Dark areas noted to wound are blanchable. Res encouraged not to stay in wc (wheelchair) for more than 1 hour at time. Also, encouraged to turn and reposition at least q (every) 2 hours to off load right buttock area. Review of Resident #9's Health Care Provider Orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR) revealed the following: - Rt (right) gluteal fold -- cleanse with NS (Normal Saline), apply calcium alginate (wound care treatment indicated for moderate to heavily draining wounds including stage three to four pressure ulcers) to wound bed . Cover with comfort foam, Apply zinc (protective skin barrier ointment) to peri wound every night shift for wound care (Start Date: 4/28/24; Discontinued: 5/1/24). Note: the treatment was not completed on 5/1/24 - Santyl External Ointment (debriding wound care treatment used to remove necrotic/dead tissue) 250 unit/gm (gram) . Apply to Right Posterior Thigh topically as needed for Missing / Soiled Dressing (Start Date: 5/1/24) The treatment was documented as completed once on 5/5/24. - Santyl External Ointment 250 unit/gm . Apply to Right Posterior Thigh (pressure ulcer) topically every day shift for Stage 3 . Cleanse Right Posterior thigh with normal saline. Pat dry. Apply Santyl to wound base. Cover with large silicone foam (Start Date: 5/2/24) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Note: The treatment was not completed on 5/4/24. - APM mattress to bed. Settings: Comfort Level #3. Check for proper functioning q shift. every shift for APM (Start: 5/6/14 at 6:00 PM) On 5/7/24 at 11:26 AM, Resident #9 was sitting in their electric wheelchair in their room near the doorway. The Resident was grasping their hands together and displayed an uncomfortable appearance. When asked how long they had been sitting up in their chair, Resident #9 responded they had been up since before breakfast because they got a shower in the morning. Resident #9 was asked if they recalled what time they got up and revealed they did not know but that it had been a few hours. Resident #9 then stated they were waiting for a staff member to assist them to go back to bed but had to wait because their Certified Nursing Assistant (CNA) went to lunch. Resident #9 verbalized they were told they should not sit up in their chair all day because of the pressure ulcer on their bottom. When queried why they had to wait for their CNA to go to lunch before going back to bed, Resident #9 explained the CNA had answered their call light and told them they would put them back in bed after they took their lunch break and found another staff member to help. Resident #9 was then asked if they were able to reposition themselves in the chair and indicated they could not. When asked if the staff assisted to reposition them in the chair when they were sitting up, Resident #9 replied they did not. On 5/8/24 at 8:36 AM, an observation of Resident #9 was completed in their room. The room lighting was dim with the shade covering three quarters of the window and the room lights off. The Resident was in bed, positioned on their back with their eyes open. When queried regarding pain, Resident #9 stated their butt hurt. Resident #9 was asked to rate the pain on a numerical scale from zero (no pain) to 10 (worst imaginable pain) and stated, Eight. At 8:38 AM on 5/8/24, an interview was completed with Registered Nurse (RN) A. When queried regarding Resident #9's wound, RN A confirmed the Resident had a facility-acquired pressure ulcer. RN A was asked when they would be completing Resident #9's dressing change and stated, Usually in afternoon. RN A indicated they would inform this Surveyor prior to wound care treatment completion for observation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An observation of wound care for Resident #9 was completed on 5/8/24 at 11:07 AM with Unit Manager Wound Care RN P and RN A. RN P was observed obtaining supplies from the treatment cart prior to entering the room. When queried regarding the current wound and treatment, RN P stated, Santyl to the right posterior thigh. RN P also stated they were also obtaining wound cultures because it (wound) is worsening. When asked if the wound had an odor, RN P verbalized it did and they had contacted the Physician to get an order for wound cultures. RN P was asked if they were going to obtain wound measurement and stated, We do pictures (computer image program which calculates wound length and width). When asked it the pictures measure wound depth, RN P replied, No. Okay, I see your point. Upon entering the room, Resident #9 was observed in bed positioned on their back. When queried if they had gotten out of bed since our last conversation, Resident #9 indicated they had not. Resident #9 was positioned on their left side by RN A and RN P. The staff removed the Resident's brief, and a pungent, foul odor was immediately noted. The dressing in place over the right rear buttocks/thigh was observed to be thoroughly saturated with a grey colored drainage which had leaked onto the surrounding skin and was present on the removed brief. RN P proceeded to remove the soiled dressing and the pungent, foul odor increased and permeated the room. The soiled dressing was saturated with a distinct malodorous off-white/ grey/light green colored drainage. The foul odor remained after the wound bed was cleansed by RN P with normal saline on a gauze pad. The wound was semi-circular shaped and slightly smaller than a softball with defined borders. The wound bed was approximately 90% necrotic black colored eschar and white slough with detectable depth. A visible area of tunneling was observed within the wound bed. When queried regarding the tunneling, RN P revealed they were not aware of any tunneling previously. When queried regarding the depth of the wound/tunnel, RN P measured the depth and stated, 2.7 (cm). RN P proceeded to measure the wound bed and stated, 7.5 (cm) by 8 (cm). RN P was observed applying Santyl ointment to the wound bed to the entire bed of the wound and areas of healthy tissue surrounding the wound bed. RN P then applied a new dressing and the Resident was positioned on their back in bed by RN A and RN P. An interview and review of Resident #9's EMR was completed with RN P on 5/8/24 at 12:15 PM. When queried regarding Resident #9's pressure ulcer, RN P verified the pressure ulcer was facility-acquired. RN P was asked about facility documentation indicating the pressure ulcer was a Stage 3 and stated, It is unstageable (full thickness tissue loss where the actual depth of the wound cannot be determined due to the wound bed being covered with slough and/or eschar) now. RN P revealed the pressure ulcer had progressively deteriorated. When queried regarding the pressure ulcer development and the Resident's skin integrity upon admission in that area, RN P replied, Tissue looked good when they got here. RN P was then asked the Resident's risk for pressure ulcer development upon admission and revealed they were at high risk. When queried what interventions are implemented for Resident's admitted to the facility with a high risk for pressure ulcer development, RN P indicated all facility mattresses are pressure redistributing. RN P was asked to clarify if they were saying Resident #9 had an alternating air mattress in place since they were admitted and responded they did not. RN P explained that the regular mattress facility mattresses are pressure redistributing, and that the facility does not implement specialty/alternating air mattresses until a Resident develops a pressure ulcer. RN P indicated the care plan and interventions in place at the time the pressure ulcer developed where included on the potential for impairment to skin integrity care plan. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A follow up interview was conducted with RN P on 5/8/24 at 2:06 PM. When queried regarding the Wound Evaluation documentation in Resident #9's EMR classifying the wound as MASD on 4/28/24, RN P stated, We thought it was moisture at first. When queried why they thought it was moisture, as the Resident had a urinary catheter and documentation indicates the Resident's skin was consistently warm and dry, RN P did not provide an explanation. RN P indicated the pressure ulcer developed quickly. When asked if anything had changed in the Resident's medical condition and/or mobility status prior to the pressure ulcer being identified, RN P stated, The family brought in the (electric wheelchair) and they like to sit in it. When queried if the cushion on the electric wheelchair was pressure reducing as indicated on the care plan, RN P replied, The family was adamant regarding the cushion in place on the wheelchair now. RN P explained the family had told them that the cushion was made for that electric wheelchair and to fit the Resident and they did not want the facility to remove the attached cushion and place one on top of the plain seat. When asked if they were saying the family was concerned that a generic pressure reduction wheelchair cushion would not fit the electric chair appropriately and create other concerns, RN P indicated the Resident's family believed the cushion was a pressure reduction cushion. RN P was asked if they had investigated the current cushion in place on the electric wheelchair and/or looked for pressure reduction cushions designed for that electric wheelchair and replied, No. When asked why they had not, if they were concerned that sitting in the electric wheelchair was a cause of the pressure ulcer, RN P revealed they had not thought of that. When asked if staff should be assisting the Resident to reposition in their chair when sitting up, RN P replied, If they let us. When asked if staff should document if a Resident refuses to turn/reposition, RN P stated, Yes, the nurse should. RN P revealed CNA's are supposed to inform the Resident's nurse and the nurse documents the refusal as CNA's do not have access to the same documentation system. When queried what specific interventions were implemented prior to Resident #9's developing a pressure ulcer, RN P stated, Regular, pressure redistribution mattress, barrier cream with incontinence, and an RD (Registered Dietician) consult. When queried if Resident #9 should have been turned and repositioned due to their high risk of pressure ulcer development, RN P confirmed. RN P was asked the frequency in which dependent Resident's should be turned and repositioned, RN P replied, Every two hours. When asked why that intervention was not included on the care plan, RN P did not provide a response. When asked if staff document when and/or the frequency in which Residents are turned/repositioned, RN P stated, Do not document. When queried if Resident #9 required two-person assistance for turning and repositioning, RN P confirmed they did. When queried how they knew the Resident was being turned and repositioned every two hours prior to the pressure ulcer developing, RN P revealed they were unable to say they were. When asked why more frequent turning and repositioning following the pressure ulcer development, RN P did not provide a response. RN P was then asked why the alternating air mattress was not added to the Resident's care plan until 5/1/24 and not added to the TAR with settings until 5/6/24 when the area was first identified on 4/28/24. RN P was unable to explain the different dates on the care plan and the TAR. When asked when the alternating air mattress was actually applied to the Resident's bed, RN P verbalized the mattress was ordered on 5/1/24 but was unable to state when it was applied. RN P stated they would look for a work order for the mattress application. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #9 was observed in their room on 5/9/24 at 8:54 AM. The Resident was in bed, positioned on their back. When queried regarding the frequency in which staff reposition them in bed, Resident #9 stated, They don't. With further inquiry, Resident #9 revealed staff turn them in their bed when they provide incontinence care and when they place the sling under them to get them in and out of bed. When asked how frequently that occurs, Resident #9 indicated three or four times a day. Resident #9 was then asked if staff had spoken to them about the cushion in their electric wheelchair and indicated they had. Resident #9 revealed the cushion was made for the chair and that was the reason they did not want staff to remove it. When asked if they would be open to a different cushion, if it would provide better pressure reduction/redistribution and was fitted to the chair, Resident #9 replied they would be. An observation of the electric wheelchair revealed it was a Pride Mobility brand. The seat cushion was black, approximately 3 inches tall, and felt like foam when depressed. A copy of a Delivery Order for Resident #9's alternating air mattress was received and reviewed. The Order detailed, Submitted: 5/1/24 . Updated: 5/6/24 . The document included a delivery date of 5/1/24 but did not indicate if the date was the actual or planned delivery date. Resident #59: Review of intake documentation dated received 1/12/23 and 1/17/23 detailed concerns related to Resident #59 developing a pressure ulcer and infection while at the facility. An interview was completed with Confidential Witness S on 5/7/24 at 10:17 AM. When queried regarding Resident #59, Confidential Witness S revealed the Resident passed away. When asked about their stay at the facility, Confidential Witness S revealed Resident #45 fell at home, broke their hip, and had been sent to the facility for therapy. Confidential Witness S detailed they were present when Resident #59 was admitted to the facility and revealed the facility staff would not take the Resident to their room or assist them to get comfortable until all the admission documentation was signed. Confidential Witness S stated, (Resident #45) was hurting so bad and they were sitting in a wheelchair. Confidential Witness S indicated they should have taken the Resident out of the facility right then because the care continued to decline. When queried regarding their concerns, Confidential Witness S stated, (Resident #59) got a bedsore while they were there and specified Family Member Confidential Witness T, who is a nurse, found the pressure ulcer and informed facility staff. Confidential Witness S stated, The person (nurse) who was there when (Confidential Witness T) noticed it (pressure ulcer) didn't even know (Resident #59) had it. When queried how Confidential Witness T identified the pressure ulcer, Confidential Witness S indicated they were assisting to provide care to the Resident. Confidential Witness S stated, They didn't have enough staff. When asked why they stated the facility did not have adequate staff, Confidential Witness S replied, While we were there, no one even came in to move (turn/reposition) (Resident #59). Confidential Witness S verbalized someone from the Resident's family was at the facility daily to assist Resident #59. With further inquiry, Confidential Witness S revealed the pressure ulcer became infected and stunk. Per Confidential Witness S, the Resident was transferred to the hospital at the request of the family and did not return to the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/7/24 at 10:32 AM, an interview was completed with Confidential Witness T. When queried regarding Resident #59's stay at the facility, Witness T verbalized the Resident developed a pressure ulcer and had an elevated [NAME] Blood Cell (WBC) count (indicating infection) that was not addressed in a timely manner. Confidential Witness T revealed they were with the Resident when they were discharged from the hospital and observed the hospital staff complete a skin assessment prior to discharge. Confidential Witness T stated, (Resident #59's) butt was a bit red but not open. Confidential Witness T continued, Three or four days after (Resident #59) was (at facility), they started complaining that their butt hurt so bad. When asked if the facility staff assessed Resident #59's complaints of pain, Confidential Witness T replied they did not. Confidential Witness T then stated, The next day Physical Therapy was in there (Resident #59's room). We turned (the Resident) and there was a hole, a huge decub (decubitus or pressure ulcer). They (staff) didn't even know about it. When queried if they were referring to Physical Therapy or nursing staff not knowing about the pressure ulcer, Confidential Witness T verbalized neither were aware. Confidential Witness T then stated, The nurse came in and was really rude to me. Confidential Witness T revealed the nurse left the room and then came back in and told me (Resident #59) had a really high WBC a couple days prior. I think it was 30 (normal is less than 11). When asked what happened then, Confidential Witness T stated, The nurse asked me if I thought (Resident #59) needed to go to the ER and I said absolutely. (Resident #59) went to the ER that day and got admitted . Confidential Witness T revealed the Resident got lots of IV's (intravenous medications) and wound care. Never went back to the facility. Confidential Witness T was asked how frequently they were at the facility and replied, Every day. When queried how frequently staff turned and repositioned the Resident, Confidential Witness T stated, I never saw them turn (Resident #59). When asked if the Resident has a specialty and./or alternating air mattress in place, Confidential Witness T replied, No. Resident #59's medical records were not present in the facility Electronic Medical Record (EMR). An interview was conducted with the Director of Nursing (DON) and Clinical Director Registered Nurse O on 5/7/24 at 9:30 AM. Per the staff, a different EMR system was in use at the time of Resident #59 stay in the facility. Records from the previous EMR, including Medication Administration Record (MAR), Treatment Administration Record (TAR), order summary of all healthcare provider orders during stay, care plan, progress notes, wound documentation, face sheet, and all Incident and Accident Reports were requested from the facility Director of Nursing (DON) at this time. An email was received from the facility Administrator on 5/7/24 at 1:47 PM stating there were no Incident and Accident reports for Resident #59. Review of Resident #59's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses which included right femur fracture and nondisplaced sacrum fracture, falls, dementia, and heart disease. Review of the Nursing Evaluation Admission assessment dated [DATE] revealed the Resident was alert and orientated to person place, time, and situation, required staff assistance to complete Activities of Daily Living (ADL), and had no alterations in skin integrity. The medical record revealed Resident #59 was discharged from the facility and transferred to the hospital emergency department on 1/10/24. Review of documentation in the EMR revealed the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 1/3/23 at 1:47 PM: Nursing Evaluation (Admit .) . Resident admitted from (hospital) . Skin Integrity: The resident has skin integrity concerns. 0 . Resident is alert. Resident is oriented x 4 (person, place, time, & situation) . Resident has no nutritional risk factors noted . incontinent of bladder . incontinent of bowel . weakness . needs assistance with ADL's . Signed by Nurse U - 1/3/23 at 1:47 PM: Nursing Evaluation (Admit .) . Resident admitted from (hospital) . Skin Integrity: The resident has skin integrity concerns. 0 . Resident has nutritional risk factor r/t (related to) presence of pressure ulcer. Resident has nutritional risk factor r/t: surgical incision . Resident is confused . continent of bladder . continent of bowel . needs assistance with ADL's . Signed by Nurse U and Nurse V. The provided documentation did not indicate when the assessments were signed. - 1/4/23 at 1:35 PM: Skin & Wound Evaluation . Pressure . Deep Tissue Injury: Persistent non- blanchable deep red, maroon or purple discoloration . Location: Coccyx . Present on Admission . New . Length: 5.2 cm . Width: 1.5 cm . Depth: Not Applicable . Wound Bed . Pink or Red . Treatment (Blank) . Additional Care: (Blank) . Progress: New . - 1/8/23 at 3:06 PM: Health Status Note (nurses note) . 1+ pitting edema noted in BLE (Bilateral Lower Extremities); increased edema noted on right femur fracture side. (Family) states increased confusion/ changed mentation in resident. Dr. notified. New orders received and noted. - 1/10/23 at 10:59 AM: Skin & Wound Evaluation . Pressure . Stage 2 (partial thickness tissue loss) . Location: (Blank) . In-House acquired . New . Length: 2.7 cm . Width 2.5 cm . Wound Bed . Intact serum filled blister . Surrounding Tissue . Blister . Erythema: Redness of the skin - may be intense bright red to dark red or purple . Edema (swelling) . Pitting edema extends < 4 cm around wound . Treatment (Blank) . Additional Care: (Blank) . Progress: New . - 1/10/23 at 11:07 AM: Skin & Wound Evaluation . Pressure . Deep Tissue Injury . Coccyx . Present on Admission . New . Length: 4.4 cm . Width: 2.6 cm . Depth: 0.2 cm . Wound Bed . Eschar . Exudate: Light . Sanguineous/Bloody . Pain Frequency: Continuous . Treatment (Blank) . Additional Care: (Blank) . Progress: Deteriorating . - 1/10/23 at 1:55 PM: Health Status Note (nurses note) . res with abnormal labs WBC of 30, worsening of wounds. orders to send to ER for eval. (Family) in room [ROOM NUMBER] called report given . No wound images were included/provided with the Skin & Wound Evaluation assessments to assist in identifying unidentified wound location. A review of the provided Order Summary Report for Resident #59 was completed. There were no orders with a Start Date of 1/8/23. A copy of Resident #59's care plan and MAR were requested but not received. Review of Resident #59's TAR and order summary the Resident had a wound care order and treatment for their right hip surgical incision but there were no orders and/or treatments in place for a coccyx pressure ulcer and no new orders for the pressure ulcer identified on 4/10/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Wound Care RN P on 5/8/24 at 2:06 PM. Provided wound documentation for Resident #59 was reviewed with RN P at this time. When queried regarding the location of the newly identified Stage two pressure was on 1/10/23, RN P confirmed the assessment did not specify and they did not know. When queried regarding the lack of treatment and/or interventions, RN P was unable to provide an explanation. An interview and review of provided documentation for Resident #59 was completed with RN O on 5/9/24 at 9:00 AM. When queried regarding the location of the facility acquired stage two pressure ulcer on 1/10/23, RN O confirmed the assessment did not include the location of the wound. When queried regarding the coccyx wound worsening, RN O indicated they would need to review the medical record. With further inquiry regarding the wound location, treatments for both pressure ulcers, and interventions in place to prevent worsening, RN O stated they would review the documentation and follow up with responses. No additional information was received by the conclusion of the survey. The facility wound care/treatment and pressure ulcer policies/procedures were requested from the Administrator on 5/7/24 at 9:42 AM. The policy/procedure entitled, Skin Protection Guide (Effective Date: 7/7/21) was received. Review of the policy/procedure revealed, To provide evidenced based practice standards for the care and treatment of skin. To ensure residents that admit and reside at our facility are evaluated and provided individualized interventions to prevent, reduce and treat skin breakdown . Evaluation . The first step in the prevention of PU/PI's, is the identification of the resident at risk . An admission evaluation helps identify residents at risk of developing a PU/PI, and residents with existing PU/PI's. Because a resident at risk can develop a PU/PI within hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent PU/PI: Skin should be examined as soon as possible upon admission, re-admission or return. Where possible, prioritize completion of the skin evaluation within the first 2 hours . Pressure is the primary cause of pressure injuries. An effective turning and repositioning schedule can help reduce the risk of developing a pressure injury . 22927 Record review of the National Press [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37668 Based on observation, interview and record review, the facility failed to ensure that planned interventions for fall prevention were in place for one resident (Resident #14) of two residents reviewed, resulting in a lack of implementation of planned interventions for fall prevention and the potential for injury. Findings include: 39059 Resident #14: On 5/06/24, at 10:00 AM, Resident #14 was lying in their bed. There was a fall mat to the left side of the bed. The right side of the bed was about a foot from the wall. On 5/06/24, at 12:30 PM, a record review of Resident #14's electronic medical record reveled an admission on 4/20/2020 with diagnoses that included Stroke, difficulty in walking and Alzheimer's disease. Resident #14 required assistance with activities of daily living and had intact cognition. A review of the SBAR Date 5/2/2024 04:24 (4:24 am) revealed Resident had a fall. The fall was un-witnessed. Patient found next to his bed on the floor . no injuries upon assessment noted . A review of the The resident is High risk for falls r/t (related to) Gait/balance problems, Hemiparesis right side, Alzheimer's Disease. Date Initiated: 04/202/2023 Goal The resident will be free of minor injury through the review date . Interventions . 4.28.23 - Fall mat to exit side of ed, when in bed, and medical work up 5/2/2024 - floor mat to both sides of ed, 5/ On 5/08/24, at 2:23 PM, Resident #14 was lying in their bed. There was a fall mat to the left side of their bed. The right side of the bed was approximately 1 foot from the wall with no fall mat observed on the floor to the right side of the bed. On 5/09/24, at 9:20 AM, an observation along with Unit Manager (UM) N of Resident #14 and their room. There was a fall matt to the left side of the bed and not a fall mat on the right side of the bed. The right side of the bed was not against the wall. UM N was asked what interventions the facility put in place for Resident #14's most recent fall and UM N he did have bilateral fall mats before he moved rooms. UM N was alerted that Resident #14 was observed in their bed all days of the survey without the second fall mat and UM N did not respond.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 22927 Based on observation, interview, and record review, the facility failed to to change a urinary catheter causing recurrent urinary tract infections (UTI) for one resident (Resident #18), resulting in Resident #18's urinary catheter not being changed per physician's orders, which caused recurrent urinary tract infection with the likelihood for prolonged illness and hospitalization . Findings include: Record review of the facility 'Urinary Tract Infections/Bacteriuria-Clinical Protocol' policy dated 4/2018 revealed the physician and staff will identify individuals with a history of symptomatic urinary tract infections, and those who have risk factors (for example, an indwelling urinary catheter, kidney stones, urinary outflow obstruction, etc) for URIs. Monitoring: (2.) When a resident has a persistent or recurrent urinary tract infection after treatment with antibiotics, the physician will review the situation carefully with the nursing staff and consider other or additional issues (such as urinary obstruction or indwelling catheter change or removal) before prescribing additional courses of antibiotics. Physicians should justify continuing or resuming antibiotic treatment beyond an initial course. Record review of the facility 'Urinary Indwelling Catheter Management Guideline' policy dated 11/28/2017 revealed indwelling catheters may be associated with significant complications, including bacteremia, febrile episodes, bladder stones, fistula formation, and erosion of the urethra, epididymitis, chronic renal inflammation, and pyelonephritis . catheter and drainage bags should be changed based on clinical indications such as: Infection . Resident #18: Observation and interview on 05/06/24 at 10:56 AM with Resident #18 stated that there was no bathroom in the room and the one down the hall is always busy. Observed Resident #18 was seated at edge of bed with his smoke apron fold on his pillow and talking about the smoke times changing. Record review on 05/06/24 at 01:04 PM of Resident #18's May 2024 Medication Administration Record (MAR) revealed the resident was on an antibiotic cephalexin 500mg oral 4 times daily for 7 days started 5/5/2024 for urinary tract infection (UTI). In an interview and records review on 05/08/24 at 07:26 AM with Licensed Practical Nurse/Infection Control Preventionist/Unit Manager (LPN/ICP/UM) N acknowledged that the facility followed the Mcgeer's UA collection recommends changing the catheter indwelling portion and collect from the clean catheter a sample of urine for laboratory use. Record review of Resident #18's medical record with LPN/ICP/UM N revealed: On 8/5/23 urinalysis laboratory results of Proteus Miribilis and was treated with antibiotic Rocephin intramuscular (IM) 1gram once daily for 5 days for urinary tract infection. Record review of Resident #18's medical record with LPN/ICP/UM N revealed: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #18's Treatment Administration Record (TAR) dated August 2023 revealed urinary (Foley) catheter changed on 8/19/2023. Record review of Resident #18's August 2023 Physician order to change Foley catheter every 30 days. Record review of the September 2023 MAR/TAR revealed the order to change urinary catheter on 9/19/2023 was blank as no performed. Record review of Resident #18's October 2023 MAR/TAR noted urinary catheter was changed on 10/18/23. Record review of Resident #18's hospital record dated 10/25/23 of a Gram-Negative urinalysis report. Record review of Resident #18's Medication Administration Record (MAR) revealed antibiotic Bactrim 800/160 mg oral twice daily from 10/25/2023 through 11/10/2023. Record review of Resident #18's November 2023 MAR/TAR revealed there was no urinary catheter care or urinary catheter change orders on the MAR/TAR. Record review of Resident #18's December 2023 MAR/TAR revealed there was no catheter care or change urinary catheter orders on the MAR/TAR. Record review of Resident #18's January 2024 Urinalysis (UA) dated 1/2/2023 noted Citrobacter Freundii and Pseudomonas Aeruginosa and enterococcus Faecalis. LPN/ICP/UM N stated that the catheter was changed at the hospital and that Resident #18 went to the hospital with sepsis. Record review of Resident #18's February 2024 MAR/TAR noted that no urinary catheter change was noted. Record review of resident #18's urinalysis report dated 2/22/2024 results of positive with Serratia fonticola and enterococcus Faecalis. Resident #18 was treated on 2/20/2024 with antibiotics of Rocephin 1 gram intramuscular one time daily for urinary tract infection for 5 days, and then on 2/22/2024 started Macrobid 100mg oral twice daily for 7 days for urinary tract infection. The February 2024 Treatment Administration Record for Foley catheter care every shift and as needed revealed there to be blank spot as not performed. Record review of Resident #18's Nursing progress note dated 2/20/2024 at 3:45 AM noted: UA obtained after changing collection bag. Per day shift nurse in report, Unit Manager P stated no need to change catheter. Record review of Resident #18's March 2024 MAR/TAR no Foley catheter change noted. Record review of Resident #18's April 2024 MAR/TAR revealed no Foley catheter change. The April 2024 Treatment Administration Record for Foley catheter care every shift and as needed revealed there to be blank spots as not performed. Record review of Resident #18's May 2024 Medication Administration Record (MAR) revealed that Resident #18 started antibiotic cephalexin (Keflex) 500mg oral tablet by mount four (4) times a day for urinary tract infection for 7 days. In an interview and record review on 05/08/24 at 07:39 AM with Licensed Practical Nurse/Infection Control Preventionist/Unit Manager (LPN/ICP/UM) N acknowledged the May 2024 Urinary tract infection was being treated with Keflex 500mg PO 4x daily and that there were recurrent urinary tract infections for Resident #18. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of 'Monthly Infection Control Log (Line List)' dated May 2024 revealed that Resident #18 was listed on 5/4/2024 with urine infection with organism pending but started Keflex (antibiotic medication) on 5/5/2024 and was documented as facility acquired.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 22927 Based on observation, interview and record review, the facility failed to ensure interventions to prevent weight loss for two residents (Resident #18, Resident #50) of 16 residents reviewed for weight loss, resulting in Resident #18 to experience a 5.79% weight loss in 60 days and Resident #50 to experience a 12.30% weight loss. in 30 days. Findings include: Record review of the facility 'Nutritional Status Management' dated 4/2/2018 revealed it was important to maintain nutritional status, to the extent possible to ensure each resident is stable to maintain the highest practicable level of well-being. the early identification of residents with, or at risk for, impaired nutrition or hydration status may allow the interdisciplinary team to develop and implement interventions to stabilize or improve nutritional status before complications arise. Resident #18: Record review of Resident #18's 'Weight Summary' log revealed a body weight on 3/4/2024 of 190.0 pounds. On 5/3/2024 Resident #18's body weight of 179.0. weight loss calculator identified a 5.79% weight loss in 60 days was noted. Record review of Resident #18's progress notes dated 5/3/2024 had no nutritional notes related to the 11-pound weight loss in 60 days. Progress notes on 5/5/2024 at 1:41 PM revealed was returned to the facility post hospital evaluation and was weighted at 179 pounds. Record review of physician progress note dated 5/6/2024 at 8:57 PM had no mention or evaluation of the 11-pound weight loss. In an interview on 05/07/24 at 12:35 AM with Registered Dietitian (RD) J revealed that he started in March 2024 and had multiple building to cover. The RD J reviewed Resident #18's medical record for weight loss. RD J reviewed Resident #50's medical record for weight loss and revealed that he did evaluate the record and noted on 4/5/2024 for the weight loss. Resident #50: Record review on 05/06/24 at 01:21 PM of Resident #50's weight log revealed body weight on 2/21/24 of 122. 0 pounds and on 3/20/24 weight of 107.0 pounds weight loss calculator identified a 12.30% weight loss in 30 days was noted. Record review of Resident #50's progress notes dated 3/21/2024 noted reason for evaluation was readmission, diet is general, texture is regular, liquids are thin, resident interviewed for preferences & dislikes . Magic cup to support weight was ordered. Record review of Resident #50's progress notes dated 3/22/2024 noted Weight Warning: date 3/20/2024 weight 107.0 pounds, which is a 12.3% weight loss. Magic cup has been added twice daily. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the next nutritional note was dated 4/5/2024 at 9:05 AM Late Entry: revealed that the resident had gained one (1) pound to weight of 108.0 pounds. Continues to trigger for significant weight loss of -10.0% x 30 days. Resident has been added to the NAR (Nutrition at Risk) list for closer monitoring with weekly discussion between RD and Inter-Departmental Team (IDT) . Nutrition note dated 4/20/2024 at 10:34 AM spoke to resident about current diet and food preferences. Resident would like preferences to remain the same as previous stay. No other changes or concerns at this time. Will continue to make any recommendations as needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37668 Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures to ensure accurate dispensing, administration, and reconciliation of controlled substances in one of three medication carts reviewed, resulting in inaccurate narcotic medication reconciliation, undocumented narcotic medications, improperly stored controlled substances, and the potential for controlled substance diversion and medication errors with adverse effects for all 56 facility residents. Findings include: A tour of the C Hall Number Two Medication cart was completed on 5/8/24 at 10:21 AM with Registered Nurse (RN) G. In the top drawer of the medication cart, under multiple resident's insulin syringes, an oral syringe was observed in an open-ended plastic pill crush bag. The oral syringe did not have a cover on the end of the syringe and contained 0.25 milliliters (mL) of a light blue colored substance. No resident and/or medication identification was present on the syringe and/or pill crush bag. RN G was shown the oral syringe and asked what the blue liquid was. RN G stated, That is morphine (narcotic medication utilized for treatment of severe pain). When queried why there was an unlabeled syringe of morphine in the top drawer of the medication cart, RN G stated, I didn't see it and stated they had not placed the syringe in the top drawer of the medication cart and did not see it under the insulin pens. When asked how they knew it was morphine. RN G proceeded to open the narcotic drawer of the medication cart and obtained the only bottle of liquid morphine from the drawer. The medication was labeled for administration to Resident #49 and color of the medication in the bottle matched the color of the liquid in the syringe. The medication label detailed, Morphine 100 mg (milligrams)/mL (20 mg/mL). The syringe was the appropriate syringe for oral administration of liquid morphine. The narcotic medications were counted and reconciled with the facility narcotic Medication Monitoring/Control Record with RN G. The following discrepancies were identified: - Morphine 100 mg/5mL (20 mg/mL) for Resident #49. The Medication Monitoring/Control Record specified, Give 0.25 mL by mouth twice daily . as needed . and specified there should be 16 mL in the bottle. The bottle was observed to contain 15 mL of morphine by RN G and this Surveyor. - Ativan (controlled medication frequently used to treat anxiety) 1 mg tablets for Resident #32. The Medication Monitoring/Control Record specified there should be 26 tablets remaining. There were only 25 tablets in the package. - Xanax (controlled medication frequently used to treat anxiety) 0.25 mg tablets for Resident #12. The Medication Monitoring/Control Record quantified nine tablets should be remaining in the package. The package only contained eight tablets. - Gabapentin (controlled medication frequently used to treat nerve pain and restless leg syndrome) 300 mg for Resident #158. The Medication Monitoring/Control Record revealed there should be 27 capsules left. There were 26 capsules in the medication package. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Xanax 0.25 mg tablets for Resident #158. The Medication Monitoring/Control Record quantified 10 tablets should be remaining in the package. The package only contained nine tablets. RN G revealed they administered three of the four pills but had not signed the medications out on the Medication Monitoring/Control Record. When asked about the fourth narcotic medication inaccuracy, RN G stated they did not administer the medication and it must have been given by night shift. When queried if the narcotic medications were reconciled at shift change with the off-going nurse, RN G indicated the count was completed and they were unable to explain the discrepancy. When asked if they are supposed to document on the Medication Monitoring/Control Record at the time of controlled medication administration, RN G confirmed they were. The inaccurate Medication Monitoring/Control Record sheets and the controlled substance medication packages, along with the liquid morphine were taken to the Director of Nursing (DON) at this time by RN G and accompanied by this RN Surveyor. The DON was shown the oral syringe containing the light blue colored liquid. When queried what was in the syringe, the DON confirmed it was liquid morphine. The DON was informed of when the syringe was in the medication cart and stated, That is not okay. The DON was then shown the bottle of Resident #49's liquid morphine. When asked how much liquid morphine was present in the bottle for Resident #49. The DON stated, 15 (mL). the DON was then shown the Medication Monitoring/Control Record for the morphine and confirmed the inaccuracy. When queried regarding the other discrepancies including the incorrect controlled substance count not being identified during shift-to-shift reconciliation, the DON replied, I don't know. The DON indicated they would address the concern. A policy/procedure related to medication administration and controlled medication storage and reconciliation was requested at this time. A policy/procedure related to medication storage was requested. Review of received document from the facility entitled, Medication Storage Guidelines revealed a pharmacy dating and expiration chart for commonly used medications. A policy/procedure pertaining to medication administration and controlled medication/storage was requested but not received by the conclusion of the survey.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on interview and record review, the facility failed to provide proper antibiotic therapy for wound culture organism for one resident (Resident #36) of two residents reviewed, resulting in Resident #36 receiving Rocephin antibiotic therapy for 7 days prior to wound culture results for wound infection with no susceptibility to the antibiotic. Findings include: Record review of the Center for Disease Control (CDC) website at: https://www.[NAME].com/search?q=cdc+inappropriate+antibiotic+use&qs=HS&pq=cdc+inappropriate+antibiotic+use&sc=10-32&cvid=8435491036D940EC803D0C1F1F024DCF&FORM=QBRE&sp=1&lq=0 Identified Unnecessary antibiotic prescribing increases the risk of antibiotic-resistant infections and adverse events, including Clostridioides difficile infections. In 2015, the National Action Plan for Combating Antibiotic-Resistant Bacteria set a goal of reducing inappropriate outpatient antibiotic use by 50% by 2020. Record review of the facility 'Medication Therapy' policy dated 2001 revealed that each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments. Interpretation and implementation: (2.) All decisions related to medications shall include appropriate elements of the care process, such as: (c.) considerations of the clinical relevance of symptoms and abnormal diagnostic test results Record review of facility 'Clinical Nursing Skills & Techniques' author's [NAME]/[NAME]/[NAME], 9th edition, chapter 9 Medical asepsis, page 254 identified: Multidrug-resistant organisms (MDRO) such as Methicillin Resistant Staphylococcus Aureus (MRSA) . have become increasingly common as a cause of colonization and health care-associated infections (HAI). MRSA is a frequently identified pathogen associated with increased mortality. In recent reports MRSA cause upward of 19% of health care-associated bloodstream infections ([NAME] and [NAME], 2015). Resident #36: Observation on 05/06/24 at 11:20 AM of Resident #36 in small dining room seated up in manual propelled wheelchair was noted to have with Bilateral lower limb amputations. Resident #36 was noted to be able to self-propel using his arms. Resident #36 stated that he does have sores on his bottom when asked by surveyor. Record review on 05/09/24 at 09:30 AM of Resident #36's Minimum Data Set (MDS) for December quarterly dated 12/26/2023 revealed one (1) stage III pressure ulcer. Record review of Resident #36's annual Minimum Data Set (MDS) revised for March 25, 2024, updated the pressure ulcer to one (1) at a stage IV. There had been a decline in the pressure ulcer. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #36's December 2023 Medication Administration Record (MAR) revealed that on 12/9/2023 at 9:00 PM the resident received ceftriaxone sodium (Rocephin) solution reconstituted 1 gram injection intramuscularly at bedtime for wound infection for 7 days, reconstitute with 2.1ml of lidocaine 1%. Record review of the December 2023 MAR revealed that the resident received all doses. Record review on 05/09/24 at 09:56 AM of Resident #36's wound culture from buttock dated 12/9/2023 collected at 4:27 PM, revealed final report date of 12/15/2023 with results of gram-positive cocci, many Streptococcus Agalactiae, few Methicillin Resistant Staphylococcus Aureus (MRSA). Culture organism: Methicillin Resistant Staphylococcus Aureus (MRSA). Susceptibility: listed 8 different antibiotic medications that could have been used. Ceftriaxone sodium (Rocephin) was listed. In an interview and record review on 05/09/24 at 01:33 PM with Licensed Practical Nurse (LPN) LPN/Unit manager/Infection control Preventionist N review of the Resident #36's December 2023 Medication Administration Record (MAR)/Treatment Administration Record (TAR) revealed Ceftriaxone sodium (Rocephin) 1 gram intramuscular (IM) antibiotic start date of 12/9/2023 through 12/15/2023 for wound infection. Record review of the Residents wound culture report dated 12/15/2023 revealed Organisms of Gram-positive cocci, streptococcus alginate, and Methicillin resistant staphylococcus aureus. Record review of the wound culture results did not recommend Rocephin/ceftriaxone antibiotic for treatment and there were no other antibiotic order post wound culture results.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on interview and record review, the facility failed to justify the use of a PRN (as needed) antianxiety medication and document the rationale for indefinite use for two residents (Resident #46, Resident #48) of 4 residents reviewed, resulting in the likelihood for unnecessary medications and adverse effects. Findings include: Record review of the facility '14 Day PRN Psychotropic Medication Guideline' policy dated 11/28/2017 revealed that psychotropic medication affects processes, e.g. cognition or affect. Psychotropic medications include four (4) drug classes: Hypnotics, Anti-Anxiety, Antidepressants and Antipsychotics. Guideline: residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosis specific condition that is documented in the clinical record and (1.) PRN orders for psychotropic drugs are limited to 14 days. (3.) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication . Resident #46: Record review on 05/08/24 01:56 PM of Resident #46's Physician orders revealed Ativan 1mg oral every 4 hours as needed PRN indefinitely. There was no 14 days stop date noted to the order. Record review of Resident #46's 'Antianxiety Medication Consent Form' dated 5/7/2024 at 2:39 PM revealed antianxiety medication Ativan oral 0.5mg one tablet by mouth every 4 hours as needed. In an interview on 05/09/24 at 09:06 AM with the Corporate Clinical Consultant O because the Director of Nursing was not available at the time revealed that the physician order of Resident #46 for anti-anxiety medication Ativan had no 14-day stop date on the order and was changed from every 4 hours as needed to every 2 hours as needed indefinitely. The Consultant O did change the order to place a 14 day stop order date and would speak with the nurse who updated the order to every two hours as needed. 38471 Resident #48: During initial tour on 5/6/2024, Resident #48 was observed with their bed in low position and resting. On 5/7/2024 at approximately 9:35 AM, a review was conducted of Resident #48's medical record and it indicated she initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, Sepsis, Alcoholic Cirrhosis, Alcohol Dependency, Anemia and Gastro-Esophageal Reflux Disease. Further review revealed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Orders: - Xanax Oral Tablet 0.5 MG (Alprazolam) -Give 1 tablet by mouth every 4 hours as needed for anxiety. Ordered on 4/18/2024 without a stop date. MAR (Medication Administration Record): April 2024: - Xanax was utilized 32 times. May 2024: - Xanax was utilized 12 times. On 5/7/2024 at 12:45 PM, an interview was conducted Social Services Director Y, regarding Resident #48's Xanax order. Director Y and this writer reviewed the order, and the Director started the Xanax was ordered on 4/18/2024 without a stop date and are beyond the 14th day of therapy. On 5/9/2024 at approximately 9:15 AM, a review was completed of the facility policy entitled, 14 Day PRN Psychotropic Medication Guideline, effective 11.28.17. The policy stated, .A psychotropic medication order with instruction for PRN dosing shall be discontinued after fourteen (14) days .The Director of Nursing (DON) or designee shall be responsible for ensuring the order discontinuation of any psychotropic medication with PRN dosing instruction on or before Day 14 of therapy .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 37668 Based on observation, interview and record review, the facility failed to ensure a medication error rate less than 5% when two medication errors were observed for two residents (Resident #7 and Resident #18) from a total of 27 observations, resulting in a medication error rate of 7.4%. This deficient practice resulted in the potential for adverse medication effects and decreased medication efficacy related to lack of implementation of standards of practice for medication administration and incorrect administration dosage. Findings include: Resident #7: On 5/9/24 at 9:04 AM, Resident #7 was heard coughing from the hallway of the facility. Upon approaching the room, Resident #7 was observed in sitting in their wheelchair, with a nebulizer mask in place and no staff present. The mist from the treatment was minimal in the mask but fluid was present in the inhalation medication chamber. At 9:05 AM on 5/9/24, Registered Nurse (RN) X was observed standing at the medication cart in the hallway, in front of the nurses station and not in close proximity to Resident #7's room. An interview was completed at this time. When queried if Resident #7 has been been assessed and determined capable of self-administering their own medications, RN X replied, Does not. When queried regarding the Resident being unattended while receiving a breathing treatment currently, RN X stated, I started it. With further inquiry, RN X revealed it was a Douneb (Ipratropium-Albuterol Inhalation Solution 0.5-2.5 mg (milligram)/3 milliliter (mL)) treatment. RN X was then asked if they are supposed to stay with residents while they receive their breathing treatments to ensure appropriate administration, RN X stated, If that is our policy, I don't know. When queried regarding best practice and nursing standards for medication administration, RN X did not provide an explanation. An interview was conducted with Clinical RN O on 5/9/24 at 9:07 AM. When queried if facility residents are supposed to be left unattended while receiving inhalation medication nebulizer treatments, RN O replied, I don't know what the policy/procedure is. When asked, RN O stated they would obtain and provide the facility policy/procedure. At 9:09 AM on 5/9/24, Resident #7 remained unattended with the nebulizer mask in place over their face. The Resident was noted to have a harsh, moist sounding cough. On 5/9/24 at 11:00 AM, a follow up interview was conducted with RN O. When queried, RN O confirmed nursing staff should remain with residents during the duration of administration of breathing/nebulizer treatments. When queried regarding observations of Resident #7 and RN X's response, RN O indicated education would be provided. Resident #18: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/2024, at 7:52 AM, during medication administration, Nurse A was observed preparing am medication for Resident #18. Nurse A gathered a Fiasp insulin pen and supplies needed and entered Resident #18's room. Nurse A cleaned the pen, placed the needle and primed the needle with the 2 units required prior to administration. After cleansing Resident #18's abdomen, Nurse A injected into the skin, pushed the plunger on the insulin pen for only 2 seconds and then held the needle into the skin for an additional 2 seconds with a total of only 4 seconds. According to the Fiasp Flex Touch instructions, . Put the needle into the skin all the way Press and hold the button to give the dose Keep the button pressed and slowly count to 10 before taking the needle out of the skin . A policy/procedure related to inhalation medication including nebulizer administration was requested but not received by the conclusion of the survey.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to date and label food items, ensure cold milk, prevent cross-contamination with serving, and a spoiled loaf of bread in the nourishment room for all 56 Residents that receive meals from the kitchen, resulting in food items with no prepared dates, a milk temperature of 51.6 degrees, cross-contamination of food item with serving and a nourishment room loaf of wheat bread having blue/gray fuzzy substance (mold). Findings include: Record review of the facility 'Food Safety Requirements Guideline' policy dated 11/28/2017 revealed it is the practice of the facility to provide safe and sanitary storage, handling and consumption of all foods including those brought to residents by family and other visitors . The food service workers, cooks, dietary aides, dishwashers, food prep aides, or any person who are in the kitchen working with any type of food, are responsible for adhere to the food safety requirements. Kitchen Task: Observation on 05/06/24 at 09:10 AM surveyor observations with Dietary Aide L of the in-kitchen refrigerator observed of the ready to serve fridge noted two maroon serving trays of prepared 8 oz and 4 oz glasses of beverages each glass covered with a small piece of plastic wrap over each glass, a turkey salad sandwich with the name of resident #11 with no date made/no time and not on a tray with a date, there was a peanut butter and jelly sandwich with no name, or no date made. Observation of a plate of sliced bologna and cheese chucks was noted on a small plate wrapped in plastic wrap with no date or name on the food item. Observations in the walk-in cooler of pasteurized eggs was dated 4/26/2024 with expiration date noted on the large box. There were an estimated 25-30 eggs observed. Dietary aide L did not know how long the eggs were good for. In an interview and observation on 05/06/24 at 09:25 AM, the Dietary Director I acknowledged that the pasteurized eggs are good for a month, although there is no expiration date written on the box by kitchen staff. In an observation on 5/6/2024 at 11:40 AM of the noon meal, Cook K donned vinyl gloves and prepared to perform food temps with the surveyor observing. Observation at the start of the meal prep tray line with dietary aide L would place the meal ticket on the tray facing the cook, and then added the cold beverages from a regular maroon meal tray, the tray was removed from the refrigerator within the kitchen and not from the walk-in cooler or freezer. In an observation on 5/6/2024 at 11:50 AM, Cook K proceeded to temp food items of: Beef roast 189.5 temped with purple [NAME] brand digital thermometer, did not clean between meat and potatoes, then temped the mixed vegs, the surveyor stopped the cook and asked about cleaning the thermometer between food items? (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cook K stated, Your right, I should be doing that. With the vinyl gloves on the cook K turned around and opened a drawer in the food service table and pulled out cleaning wipes for food items and cleaned the thermometer and continued to temp food items. Food temps: Whole potatoes 165.6 Mixed vegetables 199.0 Hamburger patties 155.9 Hotdogs 139.5 Puree meat 154.6 Chopped meat 148.8. Puree vegetable 152.6 Mashed potatoes 197.6 Beef Gravy 194.1 during the temperature the purple [NAME] brand digital thermometer fell into the gravy mixture and sunk out of sight. The cook K turned around to the cabinet behind her and grabbed a new purple [NAME] brand thermometer from a package and stuck the thermometer into the gravy mixture to obtain the temperature. The new thermometer was not wiped down or cleaned prior to being stuck into the foods and the vinyl gloves were not changed. Record review of the facility 'Food Safety Requirements Guideline' policy dated 11/28/2017 revealed (3) Physical Contaminations are foreign objects that may advertently enter the food. Examples in but are not limited to staples, fingernails, jewelry, hair, glass, mental . In an observation on 5/6/2024 at 11:55 AM the state surveyor stopped Dietary Aide L to get a temperature of the tomato soup three bowls temped at 121.5 degrees. The dietary aide had to reheat the soup in the microwave, re-temped at 138.7. Record review of the facility 'Food Safety Requirements Guideline' policy, dated 11/28/201,7 revealed (b.) danger Zone refers to temperatures above 41 degrees Fahrenheit (F) and below 135 degrees Fahrenheit (F) that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness . In an observation on 5/6/2024 at 11:58 AM, Cook K had the same gloves on left hand as she grabbed spatula to flip a grilled cheese toasted sandwich from the fry pan and cut it with the spatula/flipper onto a small plate and carried the plate over to the tray line, picked up the grilled cheese sandwich with her gloved hands to tear the sandwich completely apart and placed the sandwich onto a larger plate and then placed a brown plastic bowl of soup onto the plate between the sandwich half's. Cook K then began to dish up and plate the hot foods from the steam table for residents seated in the main dining room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility 'Food Safety Requirements Guideline' policy, dated 11/28/2017, revealed (a.) Cross-contamination refers to the transfer of harmful substance or disease-causing microorganisms to food by hands, food contact surfaces, sponges, cloth towels, or utensils which are not cleaned after touching raw foods, and then touch ready to eat foods . Observation on 5/7/24 at 7:15 AM of the breakfast meal with Cook K revealed a meal of Gravy & Biscuits, cheesy scrambled eggs, bacon/sausage. Observation of beverage tray at the starting end of the meal prep tray line revealed there to be white milk, chocolate milk, juices, and thickened water. All glasses were covered with saran/plastic wrap. There was no ice noted to hold the beverages at cooling temperature below 41 degrees. Observed at the opposite end of the tray line was the coffee station where hot beverage was added to the trays. Observation on 5/7/2024 at 8:17 AM of the third to the last tray taken off the hallway meal tray rack revealed two biscuits & Sausage gravy on a plate with a dark blue insulated plate cover. Maintenance Director Q was in the conference room to witness the temperature of the 8 oz. glass of white milk that temped at 51.6 degrees. The biscuits & Gravy entree temped at 97.5 degrees. Record review of the facility 'Food Safety Requirements Guideline' policy, dated 11/28/2017, revealed (b.) danger Zone refers to temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness . An interview and record review on 05/08/24 at 08:57 AM with the Dietary Director I revealed that she did not have a Certified Dietary Manager certificate, but had a University of Florida 'Nutrition and Foodservice Professional Training 9/10/2021. The state surveyor inquired about serve safe certifications for dietary staff members and the facility did not have those either. Dietary Director I acknowledged to have been in the position for 3 years. In-service in kitchen of equipment if new is performed by Maintenance Director Q and if its procedure it is 1-on-1 coaching, the Dietary Director performs those. An observation on 05/08/24 at 09:15 AM of the nourishment room on the nursing floor, Side 1, revealed tube feeding Jevity 1.5 cal, various nutritional supplements, cookies, snacks, and a loaf of wheat sandwich bread located in an upper cupboard along with a box of oatmeal cream pies. In an observation the wheat sandwich bread loaf appeared to be unopened and when the surveyor flipped the loaf over, there was mold of a blue/gray color noted to the middle of the loaf estimated size of hand palm. Observation at the opening end of the loaf was noted with the blue/gray mold substance estimated size of fifty cent piece noted at the lower/bottom. In an observation and interview on 05/08/24 at 09:24 AM, Licensed Practical Nurse/Unit Manager/Infection Control Preventionist (LPN/UM/ICP) N while standing in the Side 1 nourishment room was asked how often infection control rounds were being done? LPN/UM/ICP N acknowledged doing monthly rounds on the whole building and checks everything for dates and expirations date and the temps in the nourishment room on her unit. Observation with the LPN/UM/ICP N of the Side 1 nourishment room revealed a full loaf of wheat sandwich bread written with black marker 5/3 on the top of the loaf. The state surveyor had the LPN/UM/ICP N turn the loaf over and revealed the blue/gray mold appearing substance to the bottom of the loaf of bread. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and Interview on 05/08/24 09:28 AM with Dietary Director I, while in the nourishment room on the Side 1 nursing floor, revealed the loaf of wheat bread came into the kitchen on 5/3/2024, and when it gets opened the floor staff put the open date on the bread wrapper. Yes, I would use to make sandwiches, the loaf of wheat bread was then turned over to show the moldy blue/gray substance within the wrapper of the loaf of bread.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 22927 Based on interview and record review, the facility failed to ensure that the facility's Fourth Quarter 2023 third party payroll services submitted the Payroll-Based Journal (PBJ) data timely, resulting in the second quarter (April/May/June) 2023 payroll submission to trigger for staffing concerns by CMS. Finding include: Record review of facility 'Reporting Direct Care Staffing Information (Payroll-Based Journal) policy undated revealed that Direct care staffing information is reported electronically to CMS through the Payroll-Based Journal system. Policy Interpretation and Implementation: Complete and accurate direct care staffing information is reported electronically to CMS through the Payroll-Based Journal (PBJ) system in a uniform format specified by CMS. (9.) Direct care staffing information is submitted on the schedule specified by CMS, but no less frequently than quarterly. (10.) Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. Dates are as follows: Fiscal Quarter 1, Date Range: October 1- December 31, Submission Deadline: February 14 Fiscal Quarter 2, Date Range: January 1- March 31, Submission Deadline: May 15 Fiscal Quarter 3, Date Range: April 1 - June 30, Submission Deadline: August 14 Fiscal Quarter 4, Date Range: July 1 - September 30, Submission Deadline: November 14 Record review of the 'Facility Assessment' updated 2/5/2024 identified that Acuity was captured through the Activities of Daily Living and level of physical care required to provide to each specific resident. The resident's acuity is calculated based on how much care a resident need, type of treatments received, and whether or not the resident has a certain condition or diagnosis. Facility 'Staffing type' revealed that the facility utilized staffing ladders to ensure appropriate staffing is being followed per mandatory federal regulation. Staffing ladders is also practiced meeting the needs of the facility population. Record review of 'Resident Council' action form dated 4/5/2024 noted 'Residents waiting for call lights to be answered.' Record review of the Centers for Medicare & Medicaid Services (CMS) PBJ Staffing Data Report FY Quarter 4th of 2023 (October 1-December 31) run date 4/24/2024 noted: Excessively low weekend staffing: Triggered. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/07/24 10:31 AM at the Side 1 nursing station revealed posted up high on the white board with bulletin board on the upper half a 'Nursing Staffing' form dated 5/7/2024 with a census of 56 and handwritten small print numbers that the surveyor could not read without getting much closer. The surveyor then sat in a straight back chair with arms placed in the hallway next to where the medication cart was barked and was not able to read the handwritten numbers on the 'Nursing Staffing' form up above the surveyor's head. Observation and interview on 05/07/24 at 10:56 AM with the Nursing Home Administrator (NHA) the state surveyor asked the NHA to go to the side 1 nursing station, was sat in a chair in the middle of the hallway and was asked to read the Nursing Staffing report posted on the upper bulletin board across from the nursing station. The NHA stated that we could do better and explained that the posting was placed there because of the scheduler and managers were on that nursing station unit, but that has changed and that it needs reviewed. In an interview on 05/07/24 at 11:04 AM with the Corporate Clinical Director of Operations O on the submission of required Payroll Based Journal (PBJ). The Payroll Based Journal triggered the 4th quarter of 2023 for excessive low weekend staffing. The Corporate Clinical Director of Operations O stated that We do have a PBJ policy/procedure, and it is submitted by the corporate payroll department, and that the facility does have analyst that do review the submissions on staffing. Corporate Clinical Director of Operations O was notified of PBJ staffing citation. Corporate Clinical Director of Operations O stated that the corporation changed the third-party payroll services system in January 2023.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation has two Deficient Practice Statements. Deficient Practice Statement One: Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive infection control program, encompassing outcome and process surveillance and accurate data collection/documentation/analysis resulting in lack of accurate and comprehensive infection control tracking, surveillance and data monitoring/analysis, accessibility of hand hygiene supplies/functioning equipment, and the likelihood for spread of microorganisms and illness to all 56 facility residents. Findings include: On 5/6/24 at 9:34 AM, the hand sanitizer dispenser in Resident #157's room did not function. There was no sink in the room. An interview was completed with Resident #157 at this time. When queried if they eat in their room or in the central dining area, Resident #157 revealed they eat in both their room and the central area. When asked, Resident #157 stated, I am a germaphobe and verbalized it was very important to them to wash their hands before they eat and stated they had no wipes to perform hand hygiene in their room. Resident #157 revealed they didn't know I wouldn't have a bathroom (in their room) but at least there is one (communal bathroom) across the hall. Resident #157 then revealed the soap dispenser in that bathroom was broken and they brought in my own soap, dial antibacterial, but they (staff) keep moving it. When queried, Resident #157 revealed they were unsure why the staff kept moving the hand soap as the dispenser did not work. When queried regarding the hand sanitizer dispenser in their room not working and if staff sanitize or wash their hands prior to assisting them, Resident #157 shrugged their shoulders and revealed they did not observe staff performing hand hygiene. Resident #157 then stated, Maybe they don't have enough hand sanitizers. On 5/7/24 at 8:20 AM, the hand sanitizer dispenser in Resident #157's room still did not function. An interview and observation of the hand sanitizer dispenser in Resident #157's room was completed with Maintenance Director Q on 5/7/24 at 8:21 AM. Director Q confirmed the dispenser was not functioning. When queried regarding the hand sanitizer not functioning on 5/6/24 and 5/7/24, Director Q stated, I don't do that, but I have told them it (dispenser) gets gummy, and they need to clean them. When asked who is responsible for filling and maintaining the hand sanitizer dispensers, Director Q stated, (Environmental Services Director W). A tour of the communal bathroom was completed with Director Q at this time. When the hand soap dispenser was depressed to release soap, the top fell down and hand soap was unable to be obtained. The inside of the dispenser was observed to be coated with a dark colored build up. Director Q verified the dispenser was broken and indicated they were unaware but would address. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was completed with Environmental Services Director W on 5/7/24 at 8:42 AM. When queried regarding monitoring hand sanitizer and hand soap dispensers, Director W confirmed housekeeping staff is responsible for filling the dispensers and ensuring they function after filling. When asked if they noted any concerns and/or empty dispensers in the past two days, Director W stated, I noticed a couple yesterday. Director W was asked when the dispensers are checked and replied, Throughout the day. When asked if they kept track of how often the sanitizer and soap dispensers become gummed up and/or how often they are removed and cleaned, Director W stated, No, but I probably should. No further explanation was provided. An interview and review of the facility Infection Control (IC) program was completed with IC Licensed Practical Nurse (LPN) N on 5/9/24 at 9:41 AM. When queried how long they have been in the IC role, LPN N revealed they have been an IC nurse for several years but started at this facility on 2/19/24. LPN N was asked what one of most important actions is to prevent the spread of infection and replied, hand hygiene. When queried regarding process surveillance for hand hygiene including availability and functioning of hand sanitizer and hand soap dispenser, LPN N indicated they check the equipment. When asked if that is included on an audit tool, LPN N stated, No. LPN N was then told about observations of hand soap and sanitizer dispensers not functioning and including black colored film inside the soap dispenser and lack of cleaning schedule. When queried if they were aware, an explanation was not provided. When queried how Residents perform hand hygiene in their rooms, LPN N did not respond. When queried regarding Resident verbalization of lack of accessible hand hygiene equipment for themselves and staff, no explanation was provided. When queried regarding environmental surveillance in Resident rooms including observations of torn fall mats with holes in them, LPN N stated, I haven't got that far yet. When asked about process surveillance on various shifts and times, LPN N revealed they were in the process of implementing new audit/rounding forms as the prior forms were not specific to the facility. LPN N was then asked about vaccination tracking and replied, The Director of Nursing (DON) is doing all vaccinations and revealed they had not reviewed the facility vaccination program for residents or staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When asked, LPN N revealed they completed the infection control data and surveillance for March 2024. A review of the line listing, summary, and mapping tool for March 2024 was completed with LPN N at this time. The line listing provided only included Residents who were receiving antimicrobial treatment. The line listing for March 2024 did not include all carry over infections from February 2024 which may have the potential for transmission but did include Residents who were receiving prophylactic long term antibiotic treatment. When queried regarding tracking of carry-over infections to monitor, identify, and track trends, LPN N revealed they were only aware they needed to carry over prophylactic antibiotics. When queried if the line listing provided was the only outcome surveillance they completed, LPN N replied it was. When queried how they track residents with potential infections and/or individuals who may spread microorganisms but are not receiving treatment, LPN N did not provide an explanation. The total number and type of infections on the summary, map, and line listing did not match. When queried regarding the discrepancies in the data, LPN N reviewed the data but was unable to provide an accurate explanation. Resident #7 was included on the line list as having a HAI (Healthcare Acquired Infection) a respiratory infection. The line listing detailed a chest x-ray was completed on 3/9/24 and the infection date of onset was also 3/9/24. The line listing also detailed Levaquin (antibiotic) was started on 3/8/24 and that the infection criteria was met but did not include Resident #7's signs/symptoms of infection. LPN N was asked why the antibiotic was started prior to the chest X-ray, how the infection met criteria as well as when the signs/symptoms began and what they were. LPN N revealed they did not maintain paper documentation of infection criteria as the facility nursing staff completed a McGeer Infection Symptom Tracking assessment in the Electronic Medical Record (EMR). When asked to clarify if they were saying that the floor nursing staff determined if an infection met criteria for treatment, LPN N reiterated they fill out the form. Resident #7's McGeer Infection Symptom Tracking assessment was reviewed with LPN N at this time. The form revealed criteria was not met for treatment. When queried why the line listing indicated the Resident met criteria when the assessment form indicated they did not, LPN N revealed they did not know without reviewing the Resident's EMR. Resident #10 was listed as having a HAI skin infection for a boil which met criteria. The infection onset date was listed as 3/9/24 and the antibiotic start date was listed as 3/9/24. When queried if 3/9/24 was the date of the first sign/symptom of infection or the date the antibiotic was started, LPN N indicated they did not know. When asked how the infection met criteria, LPN N reviewed the Resident's EMR and stated, It did not meet criteria at the time the antibiotic was started. After reviewing the Resident's EMR, LPN N stated, It did start to drain after the antibiotic was started. When queried if cultures were completed, LPN N revealed they were not. An unsampled Resident was included on the line list as having a community acquired Urinary Tract Infection (UTI). Per the line list, the Resident was admitted to the facility on [DATE] and Urinalysis (UA) with Culture and Sensitivity (C &S) was obtained on 3/28/24 which showed Aerococcus (bacteria rarely identified in urine). The list detailed the Resident was started on Bactrim (antibiotic) and Augmentin (antibiotic) on 3/28/24. When asked to see the UA with C&S for this Resident, LPN N indicated they do not maintain copies and would need to look in the EMR. After looking in the EMR for several minutes, LPN N was asked if they had found the report and replied they had not. LPN N continued to review the EMR for several more minutes and was asked if the UA with C &S results were in medical records and stated, I think it is the wrong resident. When asked what they meant, LPN N revealed the data on the list was incorrect and that was supposed to be for a different resident. LPN N was asked if they wanted to take a break to figure it out and indicated they did. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:00 PM on 5/9/24, an interview was completed with Clinical Registered Nurse (RN) O. RN O revealed they would finish the IC task. A review of the concerns identified during the IC review with LPN N was completed. RN O verbalized there were errors and room for improvement. When queried how the facility tracks and monitors Residents with signs and symptoms of infection who are not receiving antimicrobial treatment, RN O replied, Signs and symptoms of infection on the Medication Administration Report (MAR). RN O indicated a clinical alert is generated if there is a change. When asked how that is tracked as part of the IC program and surveillance for potential infections and mitigation, RN O revealed it is not tracked/maintained as part of IC surveillance documentation. Review of facility provided policy/procedure entitled, Surveillance for Infections (Revised September 2017) revealed, The infection preventionist will conduct ongoing surveillance for healthcare-associated infections (HAI's) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions . 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent future infections .3. Infections that will be included in routine surveillance include those with: a. evidence of transmissibility in a healthcare environment; b. available processes and procedures that prevent or reduce the spread of infection; c. clinically significant morbidity or mortality associated with infection (e.g., pneumonia, UTI's, C. difficile); and d. pathogens associated with serious outbreaks. (e.g., invasive Streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza). 4. Infections that may be considered in surveillance include those with limited transmissibility in a healthcare environment; and/or limited prevention strategies. 5. Nursing staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the charge nurse as soon as possible . 4. For targeted surveillance using facility-created tools, follow these guidelines: a. DAILY (as indicated): Record detailed information about the resident and infection on an individual infection report form (e.g., Infection Treatment/Tracking Report, Infection Report Form, or similar form). b. MONTHLY: Collect information from individual resident infection reports and enter line listing of infections by resident for the entire month (e.g., Line Listing of Infections by Resident or similar form). c. MONTHLY: Summarize monthly data for each nursing unit by site and by pathogen (e.g., Facility-Wide Monthly Infection Report by Site, Facility-Wide Monthly Infection Report by Pathogen, or similar form). d. MONTHLY/QUARTERLY: Identify predominant pathogens or sites of infection among residents in the facility or in particular units by recording them month to month and observing trends. (See Facility-Wide 12-Month Pathogen Trends or Facility-Wide 12-Month Infection Site Trends or similar tool.) e. MONTHLY/ QUARTERLY: Compare incidence of current infections to previous data to identify trends and patterns. Use an average infection rate over a previous time period (for example, over the past 12 months) as the baseline. Compare subsequent rates to the average rate to identify possible increases in infection rates . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility provided policy/procedure entitled, Infection Prevention and Control Guideline (Revised: 9/15/23) revealed, The objective of this guideline is to provide a comprehensive Infection Control Guideline that establishes a facility-wide system for the prevention, identification, investigation and control of infections of residents, staff and visitors the is based upon facility assessment, best practices and regulatory compliance for the goal of quality systems for care .It is the practice of this facility's Infection Prevention and Control Program (IPCP), based upon information from the Facility Assessment and following national standards and guidelines to prevent, recognize and control the onset and spread of infection . includes a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement . Surveillance: A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility . 39059 Deficient Practice Statement Two: Based on observation, interview and record review, the facility failed to administer medications in a sanitary manner for one resident (Resident #40) out of a sample of five residents observed during medication pass task, resulting in cross-contamination of oral medications consumed. Findings include: On 5/6/2024, at 2:11 PM, during medication administration task, Nurse F removed two narcotics from their package and paced them directly on the top of the medication cart. Nurse F was asked if they normally place medications directly on top of the medication cart and Nurse F quickly grabbed a medication cup and stated I spilled the cup. Nurse F cleaned their hands, donned gloves and then picked up the two pills off the medication cart. Nurse F crushed the two pills, placed them in pudding and administered to Resident #40.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 22927 Based on observation, interview and record review, the facility failed to monitor and justify the administration of an antibiotic for one resident (Resident #36) of two residents reviewed, resulting in Resident #36 receiving an antibiotic without appropriate clinical rationale and the possibility of antibiotic resistance due to inappropriate usage. Findings include: Record review of the facility 'Surveillance of Infections' policy dated 9/2017 revealed the infection preventionist will conduct ongoing surveillance for healthcare-associated infections (HAI's) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. (7.) When infection or colonization with epidemiologically important organisms is suspected, cultures may be sent, if appropriate, to a contracted laboratory for identification or confirmation. Cultures will be further screened for sensitivity to antimicrobial medications to help determine treatment measures. Record review of the facility 'Antibiotic Stewardship' policy undated revealed that antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. (1.) The purpose of the antibiotic stewardship program is to monitor the use of antibiotics in our residents. (11.) When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. Record review of the facility 'Medication Therapy' policy dated 2001 revealed that each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments. Interpretation and implementation: (2.) All decisions related to medications shall include appropriate elements of the care process, such as: (c.) considerations of the clinical relevance of symptoms and abnormal diagnostic test results Resident #36: Observation on 05/06/24 at 11:20 AM of Resident #36 in small dining room seated up in manual propelled wheelchair was noted to have with Bilateral lower limb amputations. Resident #36 was noted to be able to self-propel using his arms. Resident #36 stated that he does have sores on his bottom when asked by surveyor. Record review on 05/09/24 at 09:30 AM of Resident #36's Minimum Data Set (MDS) for December quarterly dated 12/26/2023 revealed one (1) stage III pressure ulcer. Record review of Resident #36's annual Minimum Data Set (MDS) revised for March 25, 2024, updated the pressure ulcer to one (1) at a stage IV. There had been a decline in the pressure ulcer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235414	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at West Branch	445 S Valley St West Branch, MI 48661

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #36's December 2023 Medication Administration Record (MAR) revealed that on 12/9/2023 at 9:00 PM the resident received ceftriaxone sodium (Rocephin) solution reconstituted 1 gram injection intramuscularly at bedtime for wound infection for 7 days, reconstitute with 2.1ml of lidocaine 1%. Record review of the December 2023 MAR revealed that the resident received all doses. Record review on 05/09/24 at 09:56 AM of Resident #36's wound culture from buttock dated 12/9/2023 collected at 4:27 PM, revealed final report date of 12/15/2023 with results of gram-positive cocci, many Streptococcus Agalactiae, few Methicillin Resistant Staphylococcus Aureus (MRSA). Culture organism: Methicillin Resistant Staphylococcus Aureus (MRSA). Susceptibility: listed 8 different antibiotic medications that could have been used. Ceftriaxone sodium (Rocephin) was listed. In an interview and record review on 05/09/24 at 01:33 PM with Licensed Practical Nurse (LPN) LPN/Unit manager/Infection control Preventionist N review of the Resident #36's December 2023 Medication Administration Record (MAR)/Treatment Administration Record (TAR) revealed Ceftriaxone sodium (Rocephin) 1 gram intramuscular (IM) antibiotic start date of 12/9/2023 through 12/15/2023 for wound infection. Record review of the Residents wound culture report dated 12/15/2023 revealed Organisms of Gram-positive cocci, streptococcus alginate, and Methicillin resistant staphylococcus aureus. Record review of the wound culture results did not recommend Rocephin/ceftriaxone antibiotic for treatment and there were no other antibiotic order post wound culture results. Record review of 'Nursing 2017 Drug Handbook' page 45 identified ceftriaxone sodium as a third-generation cephalosporin drug classification. Third generation cephalosporins are less active than first- and second-generation drugs against gram-positive bacteria, but are more active against gram-negative organisms .