STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235429	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at the Bay	1500 Spring St Petoskey, MI 49770

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 34568 Based on observation, interview, and record review, the facility failed to implement and maintain interventions to prevent the development and progression of pressure ulcers for two Residents (R9, R18) of four residents reviewed for pressure ulcers. This deficient practice resulted in the development of one unstageable pressure ulcer and the potential for development of new/additional pressure ulcers. Findings include: Resident #18 (R18) Review of R18's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnosis including right tibia fracture, right fibula fracture and nutritional deficiency. Review of R18's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicative of moderate cognitive impairment. Further review of the MDS, section M, revealed R18 was marked at risk of developing pressure ulcers and had three unstageable-suspected deep tissue pressure ulcers. Review of R18's Skin and Wound Evaluation dated 7/9/24 read, in part, .Type: Pressure .Stage: Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration .Location: Right heel. Acquired: In-house Acquired .Exact Date: 5/22/24 .Staged by: (blank) .Wound Measurements: .8 cm2 (centimeters squared) by 1.3 cm by .9 cm .Wound bed: Eschar 100% .Additional Care: Heel Suspension/Protection device, Mattress with Pump, Turning/Repositioning program . On 7/15/24 at 2:18 p.m., an interview was attempted with R18 who was lying in her bed after eating her lunch meal. R18 could not recall if she had a pressure ulcer. It was observed that R18's had an air mattress with the air pump attached to the footboard of her bed. R18's air pump was not turned on nor was it plugged into the outlet located on the wall during this interview. On 7/16/24 at 8:45 a.m., an interview was attempted with R18 who was lying in her bed eating her breakfast meal. R18 stated that she was not wanting to eat her breakfast at this time. R18's air mattress pump was not turned on nor plugged into the outlet located on the wall during this interview. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/16/24 at 9:00 a.m., an interview was conducted with the Director of Nursing (DON). When asked, the DON stated R18's right heel pressure ulcer was facility acquired due to a brace that was placed on R18's right leg after surgery. The DON stated the pressure ulcer was healing at this time, being treated with betadine as it was not open, and R18 was to have an air mattress with pump as an intervention. The DON was notified that the air mattress had not been turned on or plugged in during previous observations. On 7/16/24 at 1:00 p.m. a wound observation was conducted with Registered Nurse/Unit Manager (RN/UM) S and RN T for R18's right heel. RN T placed a barrier down with all supplies needed for R18's wound care and proceeded to wash their hands. RN S and RN T placed clean latex gloves on their hands but did not don any further Personal Protective Equipment (PPE) to treat R18's wound. When asked if further PPE was needed, RN S stated R18's wound is closed and has never opened, so they did not need further PPE. RN T removed R18's blue puffy boot to expose R18's right foot and heel. RN T began to wash R18's foot with a clean wet washcloth and soap when R18 stated, Ouch that hurts! RN T then used a sterile cloth to wipe betadine over R18's right heel where the pressure ulcer was located. During the pressure ulcer care, RN S stated they were not going to do measurements. Near the bottom of the right heel R18 had an observed dark, thick purple scab approximately the size of a quarter, with bright pink tissue surround the scab. A follow-up interview was conducted with the DON who clarified R18 has an unstageable pressure ulcer with eschar on the right heel which was facility acquired. When asked if R18's air mattress pump was always supposed to be on, the DON confirmed that it should be. The DON stated she is unsure why R18's pump had been turned off and unplugged. Review of R18's Wound Assessment Details Report dated 7/16/24 read, in part, Braden Score:15 (At Risk) . Wound: Right heel .Source: Facility Acquired .Date Identified: 7/16/24; Identified by: RN S .Size (cm) 2.75 x 2.00 x unknown .area 5.5 cm2 .Current Plan and Comments: Bilateral puffy boots, Air Mattress, Turn Schedule, Nutritional Supplements, Betadine . Review of R18's Care Plan read, in part, .5/22/24 Right heel deep tissue Pressure injury .interventions: air mattress (date initiated: 5/13/24) . 41978 Resident #9 (R9) Resident #9 was admitted on [DATE] with diagnoses including heart failure, neurogenic bladder, obstructive uropathy, and chronic obstructive pulmonary disease (COPD). Review of R9's MDS assessment, dated 4/4/2024 revealed R9 was dependent on staff for toileting and personal hygiene and required substantial/maximal assistance for mobility, including rolling left and right. Further review of the MDS assessment revealed R9 was at risk for pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An observation on 7/15/2024 at 10:50 a.m. revealed R9 lying in bed, supine (lying on back) with the head of the bed elevated at approximately 45 degrees. The control panel for R9's air mattress was not lit up which indicated the mattress was not actively functioning. Further observation revealed CNA U enter R9's room at which time CNA U was queried as to whether R9's air mattress should be turned on. CNA U stated she was unsure and confirmed the mattress was indeed not functioning. CNA U stated she did not know how to operate the control panel for the mattress. This Surveyor observed CNA U tracing the power cord from the air mattress panel to the power outlet at the head of R9's bed and stated the air mattress was not plugged in. CNA U plugged the air mattress cord into the outlet and confirmed the air mattress was then functioning. CNA U could not state how long the mattress was not functioning. Review of R9's care plan revealed the following, in part: The resident has actual impairment to skin integrity MASD (moisture associated skin damage) r/t limited mobility incontinence. Date Initiated: 11/30/2023 . The resident needs pressure relieving/reducing mattress, pillows to protect the skin while in bed. Date Initiated: 7/11/2024.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on observation, interview, and record review, the facility failed to prevent an injury due to smoking for one resident (R21) of two residents reviewed for smoking. This deficient practice resulted in R21 receiving two burns due to unsafe smoking habits. Findings include: Review of R21's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including contracture of hand and muscle weakness. Review of R21's Brief Interview for Mental Status (BIMS) score revealed a score of 10, indicative of mild cognitive impairment. On 7/15/24 at approximately 12:01 p.m., R21 was observed sitting in the main dining room waiting for lunch. A small burn was observed on both the index finger and middle finger of R21's right hand which were noted yellow in color. Review of R21's Smoking Risk Evaluation, dated 6/10/24, revealed the following, Does Resident Smoke? Yes .Is Resident interested in smoking cessation? Yes .Smoking materials: Cigarettes .Risk Category: Check all that apply (score is 1 point for any checked box on questions 1-7) checked: Resident has known history of or current demonstration of unsafe smoking, Resident has cognitive loss that could affect smoking, Resident has dexterity problem(s) that could affect smoking, Resident can NOT light their own cigarette. Inability to extinguish smoking material properly, Unable to demonstrate safe handling of electronic cigarettes (e-cigs), or Vapor pens .score equals 6 . Review of the facility's Verification of Investigation Form dated 7/10/24 revealed the following, Resident Name: (R21) .Resident was on the smoking patio with supervision x2 (times two), while sitting in the smoking area the CNA (Certified Nurse Aide) noticed that the resident was still holding the cigarette in her right hand between her middle and index fingers, although it was no longer lit. CNA removed the cigarette from resident's hand and noticed a blister on her middle finger .second degree burn to right hand index finger, second degree burn to right hand middle finger .Resident has a history of burns due to smoking with care plan interventions updated. After a complete and through investigation it was found that the staff had not been following the care intervention to use a cigarette extender while resident smokes . Review of R21's Care Plans read, in part, Resident is a current everyday smoker Date Initiated: 6/9/22 . Interventions: Encourage resident to use a vape pen rather than using a cigarette to decrease risk of burns (Date Initiated: 10/10/23) .Resident is to be encouraged to use a smoking holder/extender as she has had a burn on her middle finger of her right hand (Date Initiated: 8/21/23) .The resident requires SUPERVISION while smoking (Date Initiated: 6/5/21) Review of the facility's Smoking Guideline policy dated 11/28/17 read, in part, Resident's who want to smoke are evaluated and assessed for smoking safety .resident/resident representatives will be informed of the need to comply with the smoking policy, as well as any precautionary measures as determined necessary following evaluation. Interventions for safe smoking .will be included in the resident individualized smoking care plan. Any resident with restrictions will have direct supervision during smoking . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 7/17/24 at approximately 11:30 a.m. The DON confirmed R21 was not using an extender per her care plan when the burns were discovered on 7/10/24. The DON understood the concerns and presented a Past Noncompliance (PNC) document. During the onsite survey, PNC was cited after the facility implemented actions to correct the noncompliance which included: 1. The Smoking Guideline policy was reviewed by the Nursing Home Administrator (NHA) and DON and deemed appropriate. 2. IDT (Interdisciplinary team) and CNA (Certified Nurse Aide) staff were educated on the Smoking Guidelines policy. 3. CNA and Activity staff were educated on ensuring following residents smoking plan of care, how to locate the plan of care, and where supplies were located. 4. Smoking assessment audit was completed, reviewed, and updated as needed for all Residents who reside in the facility and smoke. 5. The NHA will audit residents on smoke breaks 5x (5 times) per week for 1 week, 3x a week for 1 month, and weekly thereafter until substantial compliance is determine/achieved to ensure resident smoking plan of care is being followed. 6. R21 is no longer allowed to smoke while at the facility. 7. Findings will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends and continued recommendations for process monitoring and improvement. The facility successfully demonstrated monitoring of the corrective action and maintained compliance by completing weekly audits of residents identified with unavailable medications or medication errors to ensure established protocol was followed. The PNC was granted with a Plan of Corrections (POC) date of 7/14/24.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview, and record review the facility failed to ensure monitoring of weight and following of physician orders in providing proper diets to prevent weight loss for two Residents (#66 and #67) of two residents reviewed for significant weight loss, resulting in potential for delayed treatment, continued weight loss and decline in function. Findings include: Resident #66 (R66) R66 was admitted on [DATE] with diagnoses including heart failure, malnutrition, thyroid disorder, and depression. Review of the MDS (Minimum Data Set) assessment for R66, dated 6/16/2024 revealed set up assistance was required for eating and had a baseline weight of 153 pounds (lbs.). Review of the Electronic Medical Record (EMR) for R66 on 7/16/2024 at 9:32 a.m., revealed the following recorded weights: 6/10/2024 at 11:01 p.m.: 153.0 lbs. 6/25/2024 at 2:08 p.m.: 118.6 lbs. (*Note- Weight was struck through with message entered by RN K on 6/26/2024 at 6:56 a.m. Incorrect Documentation. No follow-up weight was observed in the EMR.) 7/03/2024 at 1:28 p.m.: 114.0 lbs. It was noted R66's recorded weight of 114 lbs. on 7/03/2024 indicated a significant weight loss of minus 25 percent from her admission weight on 6/10/2024, 23 days earlier. No Nutrition/Dietary Note or reweigh was noted in the EMR for R66 for the weight struck out by RN K on 6/25/2024 until 7/3/2024. Further review of R66's EMR revealed the following: 7/03/2024 15:50 [3:50 p.m.] Nutrition/Dietary Note . Weight Warning: Value 114.0 [lbs.] Vital Date: [7/03/2024 1:28 p.m.] . 114 [lbs.], -25.5% . per most recent weight taken, triggers for significant weight loss as detailed above. This weight appears inaccurate and reweigh has been requested for verification . Review of R66's EMR on 7/16/2024 at 9:32 a.m., revealed no documented reweigh to verify whether R66's weight documented on 7/3/2024 was accurate. During an interview on 7/17/2024 at 11:40 a.m., Registered Dietician (RD) M reported he would expect a reweigh to occur and be reported within 24-hours of the request to allow for swift assessment to prevent further weight loss, if possible. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/17/2024 at 1:20 p.m., the Director of Nursing (DON) reported R66 had a reweigh that morning. The DON reported R66's current weight was 117.6 lbs., indicating significant weight loss of minus 23 percent since admission on 6/10/2024. The DON stated RD M and R66's physician were notified. Review of the facility policy titled Weight Monitoring Guideline, dated 6/7/2023, revealed the following, in part: Residents will be weighed, documentation with be recorded in [EMR] . Weekly for four weeks post admission and/or until the weight is determined to be stable . A reweight is indicated when there is a weight variance of [less than] or [greater than] 5 pounds based on medical condition(s) and resident baseline weight . A significant change in weight is defined as: 5% change in weight in 1 month (30 days), 7.5% change in weight in 3 months (90 days), 10% change in weight in 6 months (180 days) . Resident #67 (R67) R67 was admitted on [DATE] with diagnoses including right humerus (upper arm bone) fracture, pelvic fracture, and malnutrition. Review of the MDS assessment for R67, dated 6/16/2024, revealed moderate cognitive impairment and R67 required set-up assistance for eating. Further review of the MDS assessment revealed R67 had a base weight of 108 lbs. An observation on 7/17/2024 at 9:50 a.m. revealed R67 seated in a wheelchair at the end of her bed with a meal tray positioned in front of R67 on a wheeled, tray table. R67 was not making any attempt to eat the foods on the meal tray. The meal tray contents included a brown ground meat, two pancakes, a four-ounce glass of orange juice, a four-ounce glass of apple juice, and a bowl of pureed oatmeal. Review of the meal card on the tray revealed the following: [R67]. Diet Order: Regular Diet, Fluids - Thin. Wed. [DATE]/24 [Wednesday, July 17, 2024] . Standing orders: 4 fl oz [fluid ounces] Apple Juice, [one-half] cup Oatmeal, 4 fl oz Orange Juice, [one-half] cup Steamed Rice (double portions W/A [when available]), 8 fl oz Water. It was noted R67's meal did not include one-half cup of steamed rice or a double portion of steamed rice per the Standing Orders. There was no staff present assisting R67 with her meal at the time of the observation. During an interview on 7/16/2024 at 10:12 a.m., CNA V reported R67 did not eat much of breakfast and stated, She [R67] didn't like it. When asked how much R67 ate at breakfast, CNA V reported R67 ate two bites of pancakes and a little bit of her pureed oatmeal. Review of the EMR for R67 revealed the following documented weights: 6/12/2024 at 11:26 a.m.: 108 lbs. 6/18/2024 at 1:50 p.m.: 103.5 lbs. 6/19/2024 at 12:53 p.m.: 103 lbs. 6/26/2024 at 3:49 p.m.: 100 lbs. 7/03/2024 at 1:37 p.m.: 97.2 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The documented weights revealed a 10 per cent (%) weight loss from her admission on 6/11/2024 based on the most recent documented weight on 7/03/2023, which was a time span of 22 days. Review of the EMR for R67 revealed the following active physician's orders: 6/13/2024 at 6:08 a.m.: Serve rice and oatmeal with meals - mod/max [moderate to maximum] assist with meals. 7/03/2024 at 10:23 a.m.: Needs assistance with feeding at all meals. Review of the care plan for R67 revealed the following, in part: [R67] has a nutritional risk [related to] advanced age . cultural dietary restrictions limit food and supplement options . new unstageable pressure ulcer to sacrum, spoke with family who approve adding supplements at this time. Date Initiated:6/25/2024 . Provide feeding/dining assistance as needed. Encourage oral intake of meals and snacks. Date Initiated: 6/25/2024 . Provide foods according to resident cultural preferences. Send rice with meals as available. Family encouraged to bring in food resident enjoys. Date Initiated: 6/25/2024 . Further review of the EMR for R67 revealed the following: 7/11/2024 at 3:17 p.m.: Weight Change Note. Weight Warning: Value 97.2 [lbs.] Vital Dated: 2024-07-03, 13:37 [7/03/2024 at 1:37 p.m.] . Triggering for significant weight loss - 10% x past 1 month vs admit [weight] of 108 lbs . variable [oral] intake . Receives assistance with meals. Food preferences obtained and tray card updated . Review of the lunch and dinner tray cards for R67 revealed she was to receive one-half cup of oatmeal and one-half cup of steamed rice (double portions when available) with each meal. During an interview on 6/17/2024 at 11:40 a.m., RD M reported he was unaware R67 was not receiving steamed rice and oatmeal with every meal per the physician's standing order and RD M's recommendation. RD M reported the weight loss for R67 was multifactorial and most likely related to age. RD M stated the cultural preferences for R67, limited oral intake, and providing R67's preferred foods were important to keep them interested in eating and assisting in prevention of further weight loss. An observation on 6/17/2024 at 1:20 p.m., revealed the lunch tray for R67 did not include one-half cup of oatmeal per the physician's standing order. On 7/17/2024 at 1:37 p.m., the DON reported the kitchen staff were confused by R67's diet orders and thought oatmeal was only to be served with breakfast and steamed rice was only to be served with lunch and dinner, not oatmeal and steamed rice with every meal per the physician's standing order.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on observation, interview, and record review, the facility failed to provide fluids in the prescribed texture/consistency for two residents (Resident #14 and #37) of two residents reviewed for therapeutic diet orders. This deficient practice resulted in the delivery of fluid of inappropriate consistency resulting in the potential for decreased fluid intake, aspiration (accidental inhalation of food/fluid into the lungs), and associated respiratory complications. Findings include: Resident #14 (R14): Review of R14's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including dementia, dysphagia (difficulty swallowing), and chronic obstructive pulmonary disease (COPD). Review of R14's most recent Minimum Data Set (MDS) assessment, dated 4/27/24, revealed a Brief Interview for Mental Status (BIMS) score of 6, indicative of severe cognitive impairment. On 7/17/24 at 8:39 AM, R14 was observed laying in bed with a white foam cup dated 7/17/24 filled with water sitting on her bedside table. The observed water consistency was thin. Review of R14's physician orders revealed a diet order initiated on 3/20/24 which read, Regular diet, pureed texture, nectar-thick consistency. On 7/17/24 at 8:44 AM, an interview was conducted with Licensed Practical Nurse (LPN) P who verified R14 had an active order for nectar-thick liquids. LPN P was asked if R14's bedside water was thickened per orders. LPN P observed the water and stated, It doesn't look like it. LPN P then dumped the water in the sink and revealed the thickening agent had settled on the bottom of the cup. Resident #37 (R37): Review of R37's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including Alzheimer's Disease, nutritional deficiency, and failure to thrive. Review of R37's most recent Minimum Data Set (MDS) assessment, dated 6/21/24, revealed R37's cognitive skills for daily decision making were, severely impaired. Review of R37's physician orders revealed a diet order initiated on 3/10/23 which read, Regular diet, pureed texture, nectar-thick consistency. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 9:05 AM, an interview was conducted with Hospitality Aide Q who verified she had passed water to all residents on the unit the morning of 7/17/24. Hospitality Aide Q confirmed she had independently thickened and delivered water to both R14 and R37. When asked if she had received formal training on preparing fluids to the prescribed therapeutic consistency, Hospitality Aide Q stated, I've never gotten formal training, just some tips on how to make it easier like adding ice. Hospitality Aide Q stated she did not have access to a list of residents with an altered prescribed diet texture or fluid consistency and could only get this information from a floor nurse. On 7/17/24 at 11:05 AM, a white cup foam cup dated 7/17/24 filled with water was observed on R37's bedside nightstand. The observed water consistency was thin. On 7/17/24 at 11:12 AM, R37's bedside water consistency was observed with the Director of Nursing (DON). The DON verified R37 was prescribed an altered diet of nectar thickened liquids. The DON was asked if R37's water had been thickened to which she replied, I can't tell. The DON poured the water from the glass and revealed the thickening agent had settled to the bottom of the glass. When asked if separation of the thickening agent was safe or expected, the DON replied, No. The DON was asked if Hospitality Aides should be thickening liquids to which she replied, No. Hospitality Aides should not be thickening liquids, they have not been trained to do so. On 7/17/24 at 11:59 AM, an interview was conducted with Speech Language Pathologist (SLP) O regarding thickened liquid expectations. SLP O stated thickened liquids should not naturally separate if prepared appropriately. When asked the potential risks of not following a prescribed therapeutic diet, SLP O stated the risks include choking, aspiration, and subsequent increased likelihood of pneumonia, as well as potential weight loss, malnutrition, and/or dehydration. Review of a document titled Job Description, Hospitality Aide posted on the unit did not include thickening beverages as a duty/responsibility. Review of facility policy titled, Thickened Liquid Preparation, dated 2017 read, in part: .liquids may be thickened by food and nutrition services or by nursing services .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 40383 Based on observation, interview, and record review, the facility failed to determine and honor food preferences for five residents (R6, R5, R17, R20, R27) and additional residents in a confidential group meeting. This deficient practice resulted in resident complaints of their food choices being ignored, extended wait times for alternate food choices, decreased meal enjoyment, and the potential for weight loss and nutritional decline. Findings include: On 7/15/24 at 11:31 AM, R17 was in his room and stated the food could be better. He said the only things he really could not eat were broccoli and cauliflower. He said somehow, he gets these vegetables all the time and he had a medical condition in which prevented him from eating them. On 7/16/24 at 1:06 PM, R17 was in the north dining room and was finally served lunch. The other two residents at his table had finished their meal. R17 said he lived at the end of the hall, so he had to wait for the third food cart and his tablemate's trays were on the first cart. R17 received mixed vegetables with broccoli and cauliflower included. His meal card states, Dislikes: broccoli, cauliflower. R17 asked for a replacement and had to endure an additional wait time for his meal. On 7/16/24 at 12:59 PM, a resident who wished to remain anonymous stated, I requested a sandwich every lunch and again I got mashed potatoes, meat, and vegetables. The resident was sitting and waiting for the sandwich. This resident went on to say there was no salt, syrup, jam, or mayonnaise and . every meal we have to send for the stuff and have to wait even more. This resident said, Those are little things. We don't worry about the little things. We just want to eat. This resident expressed a desire for confidentiality adding, I am not going to tell you anymore because I will get in trouble. Certified Nurse Aid (CNA) R was assisting with lunch. CNA R stated she had filled out a request for this resident for a tomato or bacon sandwich with extra mayonnaise earlier in the day, but when the lunch tray came out of the kitchen this resident did not get it. CNA R had returned to the dietary department and had requested a bacon or tomato sandwich. At 1:21 PM, CNA R had gone to check on the sandwich and returned to let the resident know they are out of tomatoes. The Resident replied, I am tired of it. I told them I would like either tomato or a bacon sandwich with extra mayonnaise. At 1:30 PM, a small plate with two slightly toasted pieces of white bread and two slices of bacon arrived. The bacon sandwich had 4 packets of mayonnaise on the side of the plate. The resident had to request help to open the packets. On 7/16/24 at 1:15 PM, R20 stated, They do not listen to us in the kitchen. This morning, I asked for a biscuit with jelly, and they would not give that to me. They sent a biscuit with eggs and cheese. My (meal) card says no eggs. I am waiting for a grilled cheese now. That is what I wanted but did not get. At 1:45 PM, R20's grilled cheese arrived. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/24 at 1:26 PM, a staff member came to the dining room to take R27 to an activity. As the staff member prepared to wheel R27 away, the resident and those at his table exclaimed R27 had not yet eaten. At 1:40 PM a regular meal tray arrived for R27, but he had requested the alternate of a bratwurst. R27 stated he could not eat bread, pasta, mashed potatoes, or gravy. He said he got mashed potatoes and there was gravy on the meat. He said he could not chew the meat. He continued to wait for the alternate as requested. At approximately 1:50 PM, R27 received 2 hot dogs on a plate for lunch. The mealtimes were posted on the Dietary Department's door and for lunch hours which read as follows: Lunch Served: South 12:00-12:20 North: 12:30-12:40 The facility policy titled, Food Preference and Portions implemented 9/1/2021 was reviewed and read in part: . Food allergies, food intolerance, food dislikes, and food and fluid preferences will be entered into the resident profile in the menu management software system . The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies & intolerances, and preferences . Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value . The alternate meal and/or beverage selection will be provided in a timely manner. The facility policy titled, THE DINING EXPERIENCE dated 2017 was reviewed and read in part: .The food offered takes into account the client's food preferences. Substitutes of similar nutritive value are offered to clients who refuse food being served. Meals are served at approximately the same time to all the clients sitting at a table. Clients are spoken to politely. Clients' requests are responded to in a timely manner. 41978 Resident #5 (R5) An observation on 7/16/2024 at 3:28 p.m. revealed R5 sitting in her bed with a lunch tray positioned in front of her on an over-bed table. R5 reported she was finished eating. Further observation revealed R5's plate still contained a large portion of ground white meat, cooked cauliflower, and carrots. R5 reported the food tasted bland and she could not eat the remaining foods on her plate without salt. R5 stated she was going to ask her son to bring her in a saltshaker since she never received any salt with her meals at the facility. Further observation revealed no salt included with R5's lunch tray. Review of EMR for R5 revealed the following order: (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/10/2023 at 10:16 a.m.: Regular diet. Mechanical soft texture. Thin liquids. It was noted in review of the diet order for R5, there was no restriction of salt included in the order. 49397 On 7/16/24 at 2:29 PM during resident group meeting, resident #6 (R6) and confidential residents, stated that the kitchen is often out of items including, yogurt, onions, brown sugar, maple syrup, and tomatoes. The residents indicated they are not getting the food they order, and were receiving foods they requested not to have. The residents also stated they do not get enough salt, pepper, and condiments with their meals. R6 stated nightly snacks are either chips or crackers, and the confidential residents stated they would prefer more fresh fruit options for snacks and during meals. A review of the resident council meeting notes for 6/17/24 revealed a grievance was filed as a result of a resident reporting being upset they had gotten a meal of very dry chicken that was cold and difficult to cut. A review of the grievance from 6/17/24 indicated the dietary department was notified and the NHA requested dietary seek a different method of cooking to avoid dryness. The NHA also directed dietary to page overhead for all meals to help with timely passing of food trays. A review of a second grievance from 6/17/24 revealed a complaint of yogurt not being available for the resident's meals but was being passed during snack time. The confidential resident stated they were told yogurt was not available during each meal they had requested it.

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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** 13791 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among any and all 77 residents. Findings include: On 7/15/24 at approximately 10:15 AM, three pans of leftover food were observed in the upright refrigerator in the kitchen and included (as labeled) a pan of Chicken pot pie, Chicken parmesan, cheese soup. An interview with Kitchen Manager (KM) A was conducted. KM A was requested to produce documentation for the proper cooling for the leftover food. KM A stated that they did not complete cooling logs for leftover food. Immediately following the interview with KM A, an interview was conducted with the Regional Dietary Manager (RDM) F who stated leftovers were not supposed to be saved, pursuant to company policy. On 7/16/24 at approximately 7:15 AM, a flat pan, on a wheeled cart was observed in the walk-in cooler (WIC) with large chunks of uncovered meat. An interview was conducted with [NAME] B who identified the meat as turkey which had been cooked the evening before. At approximately 7:35 AM, an interview was conducted with RDM F who stated there was not a cooling log for the product, that the product had not been planned to be cooked, and the cook who prepared it had gone cowboy to prepare it. The meaning was not explained further. 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); P and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. On 7/15/24 at approximately 10:20 AM, three containers of horseradish were observed in the WIC with expiration dates of 4/27/24. These were shown to KM A who disposed of them. On 7/17/24 at approximately 7:20 AM, a package of slice bologna was observed in the upright freezer in the dry storage room. The package had a facility printed label of [DATE], affixed to the outside, with a manufacturer's expiration date of 4/02/23. An interview was conducted with [NAME] B at this time who explained the affixed label was printed with a dating gun but could not explain what the date actually meant or for what year the [DATE] referred to. An interview with KM A was conducted at approximately 7:55 AM while holding and showing the package. KM A stated they had no explanation for the package and had only been at the facility for less than two weeks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/15/24 at approximately 10:35 AM, wiping cloths were observed being stored in buckets around the kitchen, including one at the three-compartment sink. RDM F was requested to demonstrate how the solution was tested to ensure that the proper concentration of sanitizer was present. RDM F pulled a 3 strip from the QT 40 test strip dispenser, dipped and swirled the strip in for approximately 6 seconds, then looked at it and began to discard it. When asked what concentration she understood the quat (sanitizing solution) to be from the test conducted, RDM F stated, about 400. RDM F was then requested to read the directions on the dispenser to which they acknowledged the strip was to be dipped and held in the solution for 10 seconds and the temperature range was to be 65 F to 75 F. The temperature had not been measured prior to the reading and when measured was found to be 107 F. When the limitations and restrictions of the QT 40 strips used for testing Quat solutions was explained, RDM F stated, I've never heard that before. The FDA Food Code 2017 states: 2-102.11 Demonstration. Based on the RISKS inherent to the FOOD operation, during inspections and upon request the PERSON IN CHARGE shall demonstrate to the REGULATORY AUTHORITY knowledge of foodborne disease prevention, application of the HAZARD Analysis and CRITICAL CONTROL POINT principles, and the requirements of this Code. The PERSON IN CHARGE shall demonstrate this knowledge by: (11) Explaining correct procedures for cleaning and SANITIZING UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT On 7/16/24 at approximately 7:51 AM, observations of the morning meal service were made. Two pans of scrambled eggs were observed in hotel pans in the steam table. The temperature of each was measured with a metal stem probe Super Fast digital thermometer. The measured temperatures ranged between 113 F and 129 F. [NAME] B was asked when the eggs had been placed in the steam table, to which they replied, about ten minutes ago. A pan of sausage patties was observed in the steam table and the temperature measured the same as above. Temperatures of the sausage ranged between 115 F and 133 F. The FDA Food Code 2017 states: 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401. 11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54 C (130 F) or above On 7/16/24 at approximately 11:40 AM, KM A was observed pushing a cart of heated plates from the dish room into the kitchen and placing it next to the steam table, readying for the noon meal. The electrical cord was observed dragging along the floor while the cart was being pushed. When the cart was placed next to the steam table, KM A picked up the cord from the floor and plugged it into a wall electrical socket. KM A then resumed his position across from the steam table, preparing residents' trays without washing his hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/16/24 at approximately 8:30 AM, KM A was observed dropping a paper towel on the floor, picking it up and throwing it out, then returning to the back of the steam table to assist with food preparation without washing his hands. On 7/16/24 at approximately 11:30 AM, [NAME] C was observed without a hair restraint over his long facial hair preparing and cutting fresh vegetables. [NAME] C went to the beard restraint dispenser, removed one, held it at his side, walked around the kitchen for approximately 20 seconds, turned his head and placed the restraint on. [NAME] C then returned to his cutting board and resumed cutting celery, green pepper, and onion without washing his hands. KM A and [NAME] C were observed multiple times throughout the survey walking through the kitchen without facial hair restraints, and multiple times with the restraints pulled up onto their heads, then returning the restraints to their faces when realizing they were being observed by a surveyor. On 7/16/24 at 1:50 PM, [NAME] C was observed preparing a grilled cheese sandwich at the griddle with his facial hair restraint pulled up onto his head, exposing the long facial hair. On multiple occasions [NAME] C was observed touching his face with his gloved hands and returning to food preparation duties without hand washing or glove changes. The FDA Food Code 2017 states: 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301. 12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (E) After handling soiled EQUIPMENT or UTENSILS (I) After engaging in other activities that contaminate the hands. 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE SERVICE and SINGLE SERVICE USE ITEMS. On 7/15/24 at approximately 11:45 AM, observations were made during the noon meal preparation and service. When the steamer was opened, a large volume of steam exited and emerged from under the exhaust hood. The steam rolled up to the ceiling and spread around and above the food preparation and service areas. An interview was conducted with [NAME] B at that time and was asked if the exhaust hood was on, to which she replied, No. They told us to turn it off. This same observation was made again on 7/15/24 at approximately 4:20 PM and again on 7/16/24 at 7:50 AM. On 7/15/24 at approximately 1:30 PM, an interview was conducted RDM F who also stated the kitchen staff was instructed to turn the exhaust hood off due to heating and cooling issues. On 7/17/24 at approximately 8:15 AM, an interview was conducted with Maintenance Supervisor (MS) G and RDM F in the kitchen. MS G stated that no one was instructed to leave the exhaust hood off during cooking operations. The FDA Food Code States: 6-304.11 Mechanical. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	If necessary to keep rooms free of excessive heat, steam, condensation, vapors, obnoxious odors, smoke, and fumes, mechanical ventilation of sufficient capacity shall be provided. 40383 On 7/16/24 at 8:12 AM, Staff H was observed placing paper placemats on the north dining room tables for the breakfast meal service. Staff H dropped the stack of paper placemats on the floor, gathered them together, picked them up, and continued to place them on the remaining tables. When asked about this practice, Staff H acknowledged the paper placemats placed on the tables were in contact with the floor. Staff H stated the paper placemats could be used as they did not touch the food but were only there to protect the tables. On 7/16/24 at 12:49 PM, the residents were observed in the north dining room waiting for lunch service. The paper placemats on the table were wrinkled with water marks and appeared to be the same placemats from the breakfast meal. Resident 17 (R17) remarked the placemats on the table were the same ones that were on the table this morning for breakfast. Another resident who wished to remain anonymous confirmed the paper placemats were from breakfast and had not been removed after the breakfast meal. The FDA Food Code States: - 4-904.13 Preset Tableware. (A) Except as specified in (B) of this section, TABLEWARE that is preset shall be protected from contamination . - 3-304.16 Using Clean Tableware for Second Portions and Refills. (A) Except for refilling a CONSUMER'S drinking cup or container without contact between the pouring UTENSIL and the lip-contact area of the drinking cup or container, FOOD EMPLOYEES may not use TABLEWARE, including SINGLE-SERVICE ARTICLES, soiled by the CONSUMER, to provide second portions or refills.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 34568 Based on interview and record review, the facility failed to report Payroll Based Journal (PBJ) information to CMS (Centers for Medicare and Medicaid). This deficient practice resulted in inaccurate reporting of staffing levels with the potential to affect all 77 residents. Findings include: Review of the CMS PBJ Staffing Data Report FY (fiscal year) Quarter 2 2024 (January 1- March 31) revealed the metric Excessively Low Weekend Staffing Triggered with daily infractions from 1/1/24 to 3/31/24. An interview was conducted with the Nursing Home Administrator (NHA) on 7/17/24 at 1:05 p.m. The NHA stated corporate is responsible for submitting the data to the CMS PBJ report. The NHA confirmed they used agency staffing to meet the needs of the residents. A review of the Facility assessment dated , undated, revealed, .Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies: Staff type: Identify the type of staff .that are needed to provide support and care for residents. Potential data sources include staffing records, organization chart, and Payroll-Based Journal reports .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on observation, interview, and record review, the facility failed to correctly identify, label and use personal protective equipment (PPE) for Enhanced Barrier Precaution (EBP) rooms per standards of practice for infection control measures according to the Centers for Disease Control and Prevention's (CDC) guidelines. This deficient practice resulted in the potential transmission of infectious agents to all 77 vulnerable residents in the facility. Findings include: Resident 18 (R18): Review of R18 Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnosis of a pressure-induced deep tissue damage of the right heel and sacral region diagnosed on [DATE] and a pressure-induced deep tissue damage of unspecified site on 6/14/24. Review of the facility's Facility Matrix CMS Form-802 revealed R18 was marked as S (suspected deep tissue injury) in category 5 for Pressure Ulcer(s). On 7/15/24 at 2:18 p.m., during an observation and interview with R18, it was observed that there was no signage posted on R18's door indicating EBP nor any PPE available for R18's room. On 7/16/24 at 1:00 p.m., during a wound care observation with R18, it was observed that there was no signage posted on R18's door indicating EBP nor any PPE available for R18's room. During this observation, Registered Nurse/Unit Manager (RN/UM) S and RN T did not don any PPE during wound care treatment. An interview was conducted with the Director of Nursing (DON) on 7/16/24 at 2:00 p.m. who stated she believed R18 should not be on EPB because the wound was not open. Review of R18's Skin and Wound Evaluation dated 7/9/24 read, in part, .Type: Pressure .Stage: Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration .Location: Right heel. Acquired: In-house Acquired .Exact Date: 5/22/24 .Staged by: (blank) .Wound Measurements: .8 cm2 (centimeters squared) by 1.3 cm by .9 cm .Wound bed: Eschar 100% . On 7/16/24 at 1:00 p.m. a wound observation was conducted with Registered Nurse/Unit Manager (RN/UM) S and RN T for R18's right heel. RN T removed R18's blue puffy boot to expose R18's right foot and heel. RN T then used a sterile cloth to wipe betadine over R18's right heel where the pressure ulcer was located. Near the bottom of the right heel R18 had an observed dark, thick purple scab approximately the size of a quarter, with bright pink tissue surround the scab. Review of the Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Ref: QSO-24-08-NH revealed, .CMS is issuing new guidance for State Survey Agencies and long-term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observation and interview, the facility failed to maintain a safe, functional, and sanitary environment, potentially exposing all 77 residents to unsafe and unsanitary conditions. Findings include: On 7/15/24 at approximately 12:30 PM, resident rooms [ROOM NUMBERS] were observed to have exposed pipes running along the floor at the east wall juncture. The pipes included 1 white plastic; 1/2 copper wrapped in black foam insulation, 3/4 electrical conduit and 1/4 copper. On 7/15/24 at approximately 1:30 PM, an interview was conducted with Maintenance Supervisor (MS) G, who identified the pipes as originating from the wall mounted air conditioning units located in the corridor outside each of the respective rooms. When asked why the piping had never been boxed in and sealed, MS G stated he did not know and agreed that they should be boxed in and sealed. On 7/16/24 between 2:00 PM and 3:30 PM, resident rooms on the South (300) and North (100) units were observed without functioning night lights. The south unit had a total of 16 resident rooms with recessed night light fixtures in each room. All were observed not working. No recessed wall night light fixtures were observed on the north unit. On 7/16/24 at approximately 3:45 PM, an interview was conducted with MS G who stated he was not aware of the night lights on the south unit or how they were to be activated. At approximately 4:30 PM, MS G stated the night lights were supposed to be on at all times (24/7) and all the ones on south were burned out. He stated he had two replacements and would have to order more to fix the lights. On 7/17/24 at approximately 8:10 AM, MS G explained the night lighting on the north unit was provided with small 1-[NAME] bulbs on the top of the wall mounted light fixtures above the resident's beds. MS G stated most of the lights did not work and the one which did, did not provide a functional level of lighting at night. On 7/17/24 between 8:30 AM and 9:30 AM, the clean utility rooms located on the north and south units were observed with plastic laminate counter tops (Formica) which were chipped and the laminate delaminating from the underlying particle board. This condition rendered these counter tops uncleanable and unable to be properly sanitized. These rooms were used for food storage and hand washing. At approximately 9:30 AM, MS G acknowledged the counter tops could not be adequately cleaned and sanitized. On 7/17/24 at approximately 9:35 AM, the Spa room on the north unit was observed to have missing ceramic floor tiles where a spa tub had been located previously. An interview with MS G at this time revealed the tub had been removed months prior, but the facility was unable to repair it or find a contractor willing to perform the work. 49397 (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/16/24 at 2:29 PM during resident council meeting, resident # 6 (R6) along with confidential residents stated they do not have night lights in their rooms. These confidential residents indicated that they were unable to see at night. The lack of light made the residents feel uncomfortable in their rooms at night.