STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235433	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Rehab and Nursing Center	3030 Greenfield Ave Royal Oak, MI 48073

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that resident's call light was within reach for one (R48) one of resident reviewed for call lights, resulting in the potential for unmet response for care needs or fall(s) etc. Findings include: R48R48 was a long-term resident of the facility, originally admitted to the facility on [DATE]. R48's admitting diagnoses included encephalopathy (Encephalopathy is a group of conditions that cause brain dysfunction. Brain dysfunction can appear as confusion, memory loss, personality changes and/or coma in the most severe form-source: https://my.clevelandclinic. org/health/diseases/encephalopathy), Chronic Obstructive Pulmonary Disease (COPD), abnormalities of gait and mobility and adjustment disorder with mixed anxiety and depressed mood. Based on Minimum Data Set (MDS) assessment dated [DATE], R48 needed supervision with toileting, transfers, and moderate assistance with dressing.An initial observation was completed on [DATE] at approximately 12:15 PM. R48 was not in their room. Based on the census list provided by the facility and observation, R48 did not have any roommate. R48's bed was positioned on the west (left) side of the room. A wardrobe (cabinet that contained clothes) was placed on the right side of the bed. There was no call light cord/access/port on the wall around the bed. At approximately 12:35 PM, R48 was observed sitting in the dining room, eating lunch. R48 had a palm protector (a device designed to prevent the fingers from digging into the palm, protecting the skin from damage and promoting healing. It's commonly used for individuals with finger contractures) on their left hand. On [DATE], at approximately 8:20 AM a follow up observation was completed. R48 was not in their room. The room set were the same as yesterday and there was no call light cord or port on the wall around R48's bed. A staff member (Certified Nursing Assistant - CNA) was passing water in the hallway. They reported that they were the assigned CNA for R48 and they worked for agency. They added that it was their first day working at the facility. Review of R48's care plan revealed that R48 had cognitive deficits, altered respiratory status, and was at risk for falls. R48's care plan also revealed that R48 did not offer verbal responses and nodded their head yes or no due to their cognitive deficits. An intervention dated [DATE] read call light within reach. Review of R48's behavior monitoring task list from [DATE] to [DATE] revealed that R48 did not exhibit any behavior symptoms.An interview with Unit Manager (UM) U was completed on [DATE] at approximately 9:05 AM in R48's room. UM U was queried about R48's call light and they were asked if they had one as the wall port and call light cord were not visible around the bed. UM U looked around the bed and reported that they did not see a call light cord. They added maybe R48 had a call bell. There was no call bell at the bedside, and they were notified of the concern and the unit manager reported that they understood the concern.On [DATE] at approximately 9:15 AM, facility administrator and unit manager (UM) U came into R48's room and checked for the call light cord. They moved the wardrobe and located the call light port and cord behind the wardrobe and they had rearranged R48's room setup. The administrator reported that R48 had some behaviors and might have placed the call light cord there. When queried how R48 with one hand function was able to move the wardrobe (that needed 2 individuals to move) and place the call light cord behind the wardrobe, they offered no further explanation was provided.A follow up interview with the facility administrator was completed on [DATE] at approximately 7:45 AM. They were notified of the concern and they reported that they understood the concern and added that someone had changed R48's room set up and they should have made sure that the call light was accessible.A facility provided document titled Call Light Accessibility and Timely Response dated [DATE] read in part, The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.GUIDANCE: Staff will be educated in the proper use of the resident call system, including how the system works and ensuring residents have access to the call light. Upon admission and periodically as needed, explain, and demonstrate the use of the call light to the residents. Each resident will be reviewed for unique needs and preferences to determine any special accommodation that may be needed for the residents to utilize the call system. Special accommodations will be identified on the residents' person-centered plan of care and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.) Staff will ensure the call light is plugged in, functioning, within reach of residents, and secured, as needed. The call system will be accessible to residents while in their room at bedside as well as in the bathroom and shower room. Staff will report problems with a call light or the call system to the

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to ensure the window air conditioning (AC) unit was properly sealed to maintain a safe, clean, comfortable environment for two (R15 and R77) of four residents reviewed for environmental concerns. Findings include:On 7/22/2025 at 10:58 AM, R15 was observed lying in bed. A window AC unit was observed to be poorly sealed, and the side and bottom of the unit had gaps that were open to the outside. A green insect with wings was observed on the pillowcase to the left of the resident's head.On 7/24/2025 at 10:33 AM, an observation of the 2 north unit was conducted with the Maintenance Director (Staff ‘R'). When asked about who maintains the facility's window AC units, Staff ‘R' reported they did. At that time, Staff ‘R' was requested to observe several resident rooms with the window AC units.On 7/24/25 at 10:36 AM, the room occupied by R15 and R77 was observed with Staff ‘R'. The window AC unit was observed to be in the same manner as observed on 7/23/25. When Staff ‘R' was asked about the lack of proper seal, they confirmed the same observation and reported they would correct that immediately. At that time, a similar green insect with wings was observed on the window sill and Staff ‘R' scooped it up with their hands to remove it.According to the facility's policy titled, Homelike Environment dated 9/21/23: .Residents are provided with a safe, clean, comfortable, and homelike environment .clean bed and bath linens that are in good condition.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for one (R93) of two residents reviewed for death by neglecting to adequately assess/monitor a resident with an identified change in condition, timely notify the physician of resident's status and timely transfer the resident to a higher level of care, resulting in a delay in identifying and treating the resident with a history of respiratory distress leading to death in the facility. The deficient practice resulted in the increased likelihood of serious harm, serious injury and /or death to occur. Findings include:The Immediate Jeopardy (IJ) began on [DATE] when the facility staff failed to adequately assess/monitor R93 who had an identified change in condition and timely notify the physician of the continued decline.The IJ was identified on [DATE] and the Administrator was notified of the Immediate Jeopardy on [DATE] at approximately 1:47 PM. A plan for removal was requested at that time to remove the immediacy.The surveyor team confirmed by Observation, Interview and Record review that the Immediate Jeopardy was removed on [DATE] based on the facility's implementation of an acceptable plan of removal. The noncompliance remains at an isolated event with the potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that has not been verified by the State Agency (SA).A review of R93's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: abscess of lung with pneumonia, COPD (chronic obstructive pulmonary disease) and type II diabetes. A Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was their own responsible party and noted as Full Code status.Continued review of R93's clinical record revealed, in part, the following:[DATE]: admission Evaluation: .R93.Clinical Evaluation.Mental Status: Alert. Orientation: Situation, Place, Person, Time.Clinical Evaluation Respiratory - Lung Sounds .that noted the resident did NOT (emphasis added) display any crackles.Stridor (high-pitched, noisy breathing sound that indicates a partial blockage or narrowing in the upper airway).and Wheezing in the upper/lower right and left lobes.Productive cough description: .coughing up clear mucoid secretions and had 02 running via a nasal canula. Interventions.monitored for signs and symptoms of respiratory distress and report to the MD (medical doctor) PRN (as needed)XXX[DATE]- Nursing Progress Note: Resident alert and responsive oriented X3 received no acute cardiac or respiratory distress 02 (oxygen) at 2L (liter).SP02 (blood oxygen saturation) 96% (normal levels run generally between 90%-100%).XXX[DATE] (late entry)- Physician Team: .visit for continuation of subacute rehab.presenting for continuation of subacute rehab due to.myelopathy (injury to spinal cord).denies SOB (shortness of breath.Medications.albuterol solutions .3ml inhale orally every 6 hours as needed for SOB.XXX[DATE]-Social Work: .her BIMS (brief interview for mental status) score is 14/15, indicating intact cognition.reported that she is on waiting list for subsidized apartments.goal to walk and complete ADLs (activities of daily living).XXX[DATE]: Social Work: .worker reported he spoke with resident. informed him that she plans to remain in the facility for placement until her functional mobility and health status improve.XXX[DATE]: Nursing Progress Note: .Resident returned to the facility from an appointment with (name redacted) in stable condition.No signs of distress.XXX[DATE] (12:06): Physician Team Note: . [R93].Chief Complaint: Upper back-left shoulder pain.respiratory difficulty.hospitalized for COPD.and bacterial pneumonia. reports shortness of breath requiring 2 liters of continuous oxygen.Assessment and plan:.history of COPD.hospitalization for COPD exacerbation with bacterial pneumonia.On physical exam, bilateral wheezes were noted with use of accessory muscles and poor air exchange. Patient is on 2 liters of continuous oxygen.Plan: Start scheduled albuterol nebulizer treatments every 4 hours.Decision made to initiate scheduled nebulizer treatments with albuterol every 4 hours in addition to existing PRN (as needed) inhaler. *It should be noted that following the physician visit on [DATE],no orders for scheduled nebulizer treatments were noted in R93's clinical record.A review of R93's MAR/TAR (Medication/Treatment Administration Record) showed no indication that Albuterol Sulfate was either administered as a PRN (as needed) or scheduled treatment for the entire month of [DATE]XXX[DATE] (1:07 PM): Nursing Progress Note: Resident said she was not feeling well, on assessment she had HR (heart rate) of 138 (average between 60-100 beats per minute), BP (blood pressure) 94/68, SPO2 of 89 with 2l via NC, her 02 was increased to 5L and the NP (nurse practitioner) was informed and she gave an order for .9% Nacl (sodium chloride used to maintain fluid balance) and labs ordered of bmp (basic metabolic panel and cbc (complte blood count) for Monday. (Authored by Nurse Y)[DATE] : Nursing Progress Note: Called Medical Director

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to report an injury of unknow origin to the State Agency (SA) for one R10 out of three residents reviewed for abuse. Findings include: On 7/2/25 at approximately 9:23 AM, R10 was observed sitting in a wheelchair near the main dining room. The resident was alert but unable to answer questions asked.A review of R10's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Epilepsy, Type II diabetes, recurrent falls and paranoid schizophrenia. A review of the resident Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 0/15 (severely cognitively impaired).Continued review of R10's clinical record revealed the following:4/3/25: Physician Team Progress Note: .seen for facial swelling and bruising, facial bruising and swelling noted on exam.? Recent injury/fall.check facial x-ray, ice compression as tolerated. *It should be noted that there were no notes prior to the physician note above that described the resident's face and/or when it was found.4/8/25: Nursing Progress Note: The physician consulted the patient today via video and confirmed that he reviewed the x ray indicating a chronic fracture of the nasal bone.A request was made for the IA (incident/accident report) pertaining to R50's fracture nose. The IA was provided, and the following was reviewed: Injury of Unknown Cause.Date: 4/3/25 (12AM). Resident: R10.Person Preparing the Report: Director of Nursing (DON).Incident Description: The resident's sister came to visit and stated that she had cleansed the resident's nose during care and the resident had some blood in his nose. The writer's assessment confirmed bruising of the nasal bone, bilateral eye lids and chicks<sic>. Resident unable to give description.Immediate action taken: The physician was called and the NP (nurse practitioner) was directed to assess the resident. The NP assessment was completed with orders for x-ray. Post Incident.Statement(s) . (Statement by Nurse H on 4/3/25): The resident's sister told me she cleaned blood in his nose, and I saw the bruise. R10 did not fall and no one has told me that he did nor has anyone seen the bruise in his face until his sister came in and told me.(Statement by R10's Sibling/Legal Guardian on 4/3/25): When I came in honey, I cleaned blood on R10's nose looks at his nose maybe something wrong. I asked him if he had pain and he said no, I asked him if he fell and he said no. Honey, I think maybe he hit his face on the night stand or in the sink in the toilet but he cannot say, you know. (Statement by Staff DD on 4/7/25 - 3 days after R10's bruising to their nose, eyelids and checks were observed): I saw the resident's face and I asked him R10 what happened to your face? He stated, I punched myself and bulged his fist, in demonstration .Notes (4/11/25).The wall outlet suspected of being the cause of the injury was fixed (authored by the DON). *It should be noted that during the Survey the DON (Director of Nursing) was not available for interview.On 7/24/25 at approximately 11:59 AM, an interview was conducted with the Administrator/Abuse Coordinator regarding the injury of unknow origin that was discovered by R10's family member on 4/3/25. The Administrator was asked why it was not reported to the SA. The Administrator noted that R10 was not competent and could not explain what had occurred but noted they would look into the issue and get back to the Surveyor.On 7/24/25 at approximately 1:28 PM, the Administrator, along with Staff DD came to the conference room to discuss R10. Again, the Administrator was asked why the injury of unknow origin was not reported to the SA. The Administrator had Staff DD report what they believed occurred and they stated that they did not believe it was an injury of unknown origin as when they saw the bruises on R10's face and asked them what happened, they reported that they punched themselves. Again, it should be noted that the same statement was made on 4/7/25, three days after the incident occurred.On 7/24/25 at approximately 2:09 PM, a phone interview was conducted with R10's sibling/legal guardian. R10's sibling/legal guardian stated that they did not think it was possible the resident could self-harm themselves in the face causing bleeding and bruising. They thought it possibly came from a fall, but again nobody could confirm what had happened.The facility policy titled, Abuse (5/24/23) was reviewed and documented, in part: .Policy Overview: Residents have the right to be free from abuse.Initial Reporting: The facility will ensure that all allegations involving abuse.Injuries of unknown source.are reported immediately to the Administrator and Reported to the State Survey Agency immediately but not later than two hours after the allegation is made.or results in serious bodily injury.Reported to the State Agency no later than 24 hours if the allegation does not involve abuse and does not result in serious bodily injury.Injury of Unknown Source: When all of the following conditions are met: The source of the injury was not observed by any person; AND The source of the injury could not be explained by the patient/resident; AND The Injury is suspicious because of the extent of the

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set (MDS) Assessments were completed accurately for one (R68) of residents reviewed. Findings include:According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual. Link to the LTCF RAI User's Manual: https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf: .an accurate assessment requires collecting information from multiple sources .Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician . On 7/22/25 at 10:19 AM, R68 was observed lying in bed. R68's left hand appeared to be contracted with his fingers completely bent at the second knuckle and his fingertips were almost touching the upper most aspect of the palm. R68 was asked if he could open his hand. R68 explained he was not able to move any of his fingers on his left hand. R68 was asked if he could straighten his legs completely. R68 explained he only had one leg. It was observed R68 had an above the knee amputation (AKA) of his left leg.Review of the clinical record revealed R68 was admitted into the facility on 2/11/16 and readmitted [DATE] with diagnoses that included: acquired absence of left leg above knee, diabetes and bipolar disorder. According to the MDS assessment dated [DATE], R68 had a Brief Interview for Mental Status (BIMS) exam score of 15/15, indicating intact cognition. Further review of R68's MDS assessments identified the following inaccuracies:The Quarterly assessment dated [DATE] documented in Section G G0115. Functional Limitation in Range of Motion A. Upper extremity (shoulder, elbow, wrist, hand) was marked as 0. No impairment. The section was signed by Registered Nurse (RN) M.The Comprehensive assessment dated [DATE] documented 0. No impairment for A. Upper extremity and B. Lower extremity (hip, knee, ankle, foot). This section was signed by RN M.The Quarterly assessments dated 1/11/25, 10/11/24 and 7/11/24 all documented 0. No impairment for both upper and lower extremities. On 7/23/25 at 2:37 PM, R68's left hand was observed with the Restorative Aid revealed R68 was not able to extend the fingers of his left hand and expressed pain with any attempt by the Restorative Aide to actively extend the fingers. The Restorative Aide was asked how long R68's hand had been contracted. The Restorative Aide explained the left hand had been contracted for a long time.Review of R68's comprehensive care plan revealed a focus initiated 3/8/21 that read, RISK FOR IMPAIRED COMFORT r/t (related to) Arthritis, (L)LE (left lower extremity) Amputation and left hand related to arthritis, neuropathy.Review of an Occupational Therapy Evaluation dated 3/20/24 read in part, .LUE (left upper extremity) ROM (range of motion): .Hand = Impaired; .Index Finger = Impaired; Middle Finger = Impaired; Ring Finger = Impaired; Little Finger = Impaired. Contracture: Does Patient (Pt) Present with Contracture(s)? = Yes. Functional Assessment: Self Feeding = Independent (Pt continues to requires [sic] set up of tray opening [sic] containers. Pt eats mostly fingers [sic] foods but can use regular utensil with right ue . Pt needs lids with HOT LIQUIDS FOR SAFETY.). Evaluation Summary: .Assessment: # (number) of Performance Deficits = Assessment identified 3-5 deficits in areas of physical, cognitive, psychosocial skills resulting in activity limitation or participation restrictions.On 7/23/25 at 4:07 PM, Licensed Practical Nurse (LPN) L, who served as the MDS nurse, was interviewed and asked who was assessing the residents for their MDS assessments. LPN L explained she had only worked as a MDS nurse for about a month and was still in training. LPN L was asked who was signing the MDS assessments. LPN L explained it was RN M, who was the PRN (as needed) MDS nurse. When asked how often RN M was at the facility, LPN L explained RN M did not come to the facility she was offsite at another facility.Multiple attempts to call RN M on 7/23/25 and 7/24/25 were made with no return call.On 7/24/25 at 1:10 PM, Regional MDS N was interviewed and asked who had been doing the resident assessments since RN M did not come to the facility. Regional MDS N explained she had been doing the assessments; however, Section GG is completed as a chart review so it could be done offsite. When asked about the inaccurate assessment for R68, Regional MDS N explained she would look into the matter.On 7/24/25 at 2:28 PM, Regional MDS N explained that due to Occupational Therapy (OT) saying the contraction did not affect functional skills, no impairment was marked on the MDS. Regional MDS N was asked if even though R68 was not able to use his left hand but can feed himself with his left if that indicates there is no impairment of his upper extremities. Regional MDS N gave no answer. Regional MDS N was asked about R68 being admitted in 2016 with the LAKA, and the assessments were marked as no impairment. Regional MDS N explained they could go back and correct up to two years of assessments.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a care planning review in coordination with a significant change Minimum Data Set (MDS) assessment for one (R62) of one resident reviewed for hospice, resulting in the lack of opportunity for the resident, legal representatives, and hospice to participate in review of interventions which pertained to their care. Findings include:Review of the clinical record revealed R62 was admitted into the facility on 3/28/25, hospitalized on [DATE], readmitted on [DATE] and signed onto hospice on 6/19/25. Diagnoses included: encounter for palliative care, anemia, other asthma, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, other sequelae of cerebral infarction, type 2 diabetes mellitus without complications, obstructive sleep apnea, hyperlipidemia, depression, anxiety disorder, unspecified intracranial injury without loss of consciousness, and bilateral hearing loss.According to the significant Minimum Data Set (MDS) assessment dated [DATE], R62 had severely impaired cognitive skills for daily decision making, had long and short-term memory impairment, and received hospice care while a resident.Review of the available documentation in the clinical record for a care planning review conference revealed only one on 4/2/25. Further review of the clinical record revealed no documentation that a care planning review had been completed with the resident/legal representative, and interdisciplinary team, including hospice since the significant change MDS had been completed.On 7/23/2025 at 9:05 AM, an interview was conducted with the Social Work Director (Staff ‘F'). When asked about whether the facility had a care conference or a care planning review in coordination with the significant change MDS and R62 signing onto hospice services, Staff ‘F' reported they had not yet. When asked who was responsible for coordinating this, Staff ‘F' stated it was their responsibility but was behind in completing that.When asked to explain when the care planning review conferences should be conducted, Staff ‘F' reported they should be coordinated within a week or two of the date of the MDS assessments.On 7/23/2025 at 10:13 AM, a phone interview was conducted with Hospice Nurse ‘Q'. They reported they no longer were assigned to R62, and had not seen the resident for almost a week or so. When asked about whether they had been involved in any care planning review with the resident/legal representative and facility staff, they reported they did not. They did recall having a discussion with the Director of Nursing when the resident first signed onto hospice. According to the facility's policy titled, Care Conferences dated 3/10/2025: .It is the policy of the facility to offer Care Conferences to residents and authorized representatives on admission, quarterly, with a significant change condition, and any time the resident and/or authorized representative requests a care conference.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Rehab and Nursing Center	3030 Greenfield Ave Royal Oak, MI 48073

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure showers and/or nail care were provided to one (R50) of four residents reviewed for activities of daily living (ADL's). Findings include:On 7/23/25 at approximately 10:05 AM, R50 was observed lying in bed. The resident was alert and able to make needs known. The resident was asked about care provided in the facility and reported that they were upset they had not yet seen a doctor per their request the day prior. They also reported that they had not had a shower since being admitted to the facility as the facility told them they did not have a chair large enough for them to fit in the shower room. R50 reported they were admitted from a sister facility. A review of R50's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Type II diabetes, chronic pulmonary disease and COPD (chronic obstructive pulmonary disease). A review of the R50's MDS noted the resident had a BIMS score of 13/15 (7/2/15) and further review noted the resident needed a two person assist via a mechanical lift for all transfers. Notes for Nutrition/Dietary dated 6/28/25 noted the resident's usual body weight was 362-375 pounds. A review of R50's Kardex on 7/24/25 showed no instructions as to bathing. A 30 day look back on the Task element of the Kardex for Bathing noted that R50 received only bed baths on the following dates: 6/30/25, 7/10/25, 7/14/25, 7/17/25, 7/21/25. There was no indication that showers were either provided and/or refused. A review of R50's care plan provided no information that pertains to R50's shower and/or shower concerns. The ADL portion of the care plan only noted that R50 required a two-person assist via a Hoyer lift for transfers. On 7/24/25 at approximately 2:46 PM, an interview was conducted with Wound Nurse E. When asked about the lack of R50 receiving showers, Nurse E noted that they believed the facility did not have a chair that was large enough to provide a shower to R50 and thus they received only bed baths. Following the interview with Nurse E, ADON C was asked about the lack of R50 receiving showers. ADON C noted that they believed the shower chair most likely would not have fit through the shower door, however they noted that they had a shower bed that might have worked but believed R50 refused it. *It should be noted that there was no documents in R50's record that noted they refused a shower. No further information was provided by the facility prior to ext. Review of a facility policy titled, “Activities of Daily Living (ADL)” revised 12/7/23 read in part, “…Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene…”

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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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. Based on interview and record review, the facility failed to ensure the Activity Director had the minimum qualifications to perform duties of the position affecting all residents in the facility. Findings include:On 7/24/25 at 9:16 AM, the facility was requested to provide license/certification for several employees, including the Activity Director (Staff 'D') that had a hire date of 7/31/24.Review of the employee documentation provided by the facility revealed no license/certification for Staff 'D'.On 7/24/25 at 3:30 PM, an interview was conducted with the Administrator. When asked about whether there was any license/certification for Staff 'D', the Administrator reported they didn't have any. When asked about Staff 'D's prior work experience, the Administrator reported they previously worked as an activity assistant and recently took on the role as Activity Director. When asked about the requirements for that role, the Administrator offered no further explanation.On 7/24/25 at 3:48 PM, the Administrator was requested to provide Staff 'D's work experience for the last five years.On 7/24/25 at 4:03 PM, the Administrator reported via email, 07/31/2024 to Present [current facility name] No other work experience.On 7/24/25 at 4:12 PM, the Administrator was requested to provide the job description for the role of Activity Director. Review of the facility's job description for the Activity Director role documented, in part: .MINIMUM QUALIFICATION STANDARDS.LICENSE: Licensed or registered in the State of Michigan and eligible for certification as Therapeutic Recreation Specialist or as an Activities professional by a recognized accrediting body; OR 2 years experience in a social or recreational program within the past 5 years, with 1 year full-time employment in a patient Activities program in a health care setting; OR Qualified as an Occupational Therapist or Occupational Therapy Assistant OR Satisfactory completion of an approved training course in the State of Michigan.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #'s 1214456 and 2569467. Based on observations, interviews and record reviews, the facility failed to timely and accurately assess, treat and follow up with a medical provider for change in condition for one resident(R83) of one resident reviewed for a change in condition,resulting in R83 being transferred to the hospital for a cellulitic scalp wound. Findings include: R83 On 7/23/25 a complaint submitted to the State agency was reviewed which alleged R83 had been transferred to the hospital for an infected wound on their head. On 7/23/25 the medical record for R83 was reviewed and revealed the following: R83 was initially admitted to the facility on [DATE] and transferred to the hospital on 7/14/25. A review of R83's MDS (minimum data set) with an ARD (assessment reference date) of /8/25 revealed R83 was dependent on facility staff with most of their activities of daily living. R83's BIMS score (brief interview for mental status) was 15 indicating intact cognition. A review of R83's admission Evaluation dated 5/2/25 did not reveal any skin abnormalities. A weekly Skin assessment dated [DATE] did not reveal any new skin impairments. A review of R83's July 2025 MAR (medication administration record) indicated that a skin assessment was completed on 7/12/25 but no documented weekly skin assessments completed by Nursing staff (documenting the presentation of R83's skin) were present in the record after the assessment on 7/5/25. A review of R883's progress notes revealed the following: 7/14/2025- Nursing - Progress Note- Pt (patient) reported sore area on the back of her head, red and warm to touch, scant yellow drainage noted to hair roots. NP (Nurse Practitioner) at facility new order for cephalexin 250mg po (by mouth) q6hrs (every six hours) stop 7/24/25. Pt notified. 7/14/2025- Nursing - Progress Note- Received report from out-going nurse that patient has small opening at the back of the head. Upon assessment, noticed small superficial opening, with purulent drainage, notified NP of the Facility. NP already ordered Cephalexin 250mg q (every) 6 hours for 10 days. Notified patient and her son who was with patient at the time. Patient's son insisted the patient be sent to the hospital. NP was called to see the patient, and assured patient and son to allow patient to stay on Facility. Patient's son insisted patient goes to the hospital. Patient's son called 911, EMS (emergency medical system) arrived, and patient was sent to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An emergency department evaluation dated 7/14/25 revealed the following: Chief Complaint-Wound Problem .Active Problems: Cellulitis of scalp wound - foul smelling purulent discharge - ongoing for the past few weeks - no leukocytosis - blood cultures and wound cultures pending - unclear if patient is diabetic or not at baseline, last A1c 2 years ago 6% - on vancomycin and zosyn (antibiotics)- MRSA (Methicillin-resistant Staphylococcus aureus) nares pending . An infectious disease note dated 7/17/25 revealed the following: .brought to the hospital for concerns of infected wound. Patient notes that for about a week prior to admission she'd complained of pain in the back of her head and some drainage/blood on her pillow Culture Data: .Wound (7/14) - Many Staph aureus, Many Proteus mirabilis .Impressions- .Scalp wound culture with Proteus & Staph aureus, adequately covered with current antibiotics . On 7/23/2025 at approximately 4:12 p.m., the facility Administrator was interviewed pertaining to R83's head wound. The Administrator indicated that they believed R83 had hematoma on the back of their head and that R83's family member had a concern regarding wound care at the facility after they had it evaluated at the hospital. The Administrator indicated that R83 did not want to come back to the facility due to the lack of wound care. On 7/23/25 at approximately 4:30 p.m., Regional Clinical Service Director P (RCSD P) was queried regarding R83's head wound and indicated that they believed it was from the family braiding their hair. RCSD P was queried as to why the wound was not identified before 7/14 with CNA (Certified Nursing Assistant) morning care and they indicated they did not know but acknowledged the concern and indicated that the facility had done education on resident observations and reporting anything to Nursing staff. On 7/24/25 at approximately 9:16 a.m., during a conversation with the Assistant Director of Nursing (ADON), the ADON was queried regarding the facility staff not identifying R83's head wound and they reported that they had been made aware of it the day they went to the hospital and had assessed it as a reddened area on the head approximately the size of a quarter with yellow drainage coming from it around the hair follicles. The ADON was queried regarding the approximate age of the wound, and they indicated it was not a new/fresh wound and should have been identified before the day R83 went to the hospital. The ADON was queried regarding the lack of weekly skin documentation in the medical record and they indicated that skin assessment should be done weekly and documented in the total body evaluation that indicates the presentation of the resident's skin and the CNA's should be checking every day when the assist with personal hygiene. The ADON reported that as a result of R83's scalp wound, a whole house audit was done to see if any other wounds were present that had not been identified by staff.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure timely interventions and treatments for one (R6) of three residents reviewed for pressure ulcers, resulting in R6 acquiring a Stage 3 (full-thickness skin loss) pressure ulcer. Findings include:On 7/22/25 at 10:08 AM, R6 was observed lying in bed. R6 was asked if he had any wounds or sores. R6 explained he wasn't sure.Review of the clinical record revealed R6 was admitted into the facility on 9/11/24 with diagnoses that included: dementia, heart disease and kidney disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R6 had severely impaired cognition. The MDS assessment also indicated R6 had one facility acquired Stage 3 pressure ulcer.Review of a Skin - Total Body Eval dated 6/14/25 by Licensed Practical Nurse (LPN) T read in part, .Does the resident have any skin abnormalities? 1. Yes. Site: wound to coccyx.Review of a Skin/Wound progress note dated 6/16/25 at 10:36 AM by LPN E, who served as the Wound Care Nurse, read in part, Upon assessment I observed open area to resident's sacrum. Physician notified and recommended that the area be cleansed with cleanser, Triad paste applied and covered with boarder dressing once daily and as needed. Pressure reducing mattress and seat Roho (pressure relieving) cushion for the wheelchair, frequent check and change to ensure resident remains clean and dry with frequent turning and repositioning while in bed and up in chair. All proper staff aware, and all orders implemented.Review of R6's June 2025 Treatment Administration Record revealed the following orders: CLEANSE SACRUM WITH DAKIN'S SOLUTION, APPLY MEDIHONEY AND CALCIUM ALGINATE, BOARDERFOAM COVERING DAILY AND AS NEEDED. One time a day -Start Date- 06/18/2025. Dakins (1/4 strength) External Solution. Apply to SACRUM topically one time a day for WOUND HEALING -Start Date- 06/18/2025. LOW AIR LOSS MATTRESS every shift -Start Date- 06/17/2025.Review of a Wound Rounds progress note dated 6/17/25 at 9:17 AM by the contracted Wound Provider read in part, .Sacral region stage III pressure injury measurements 2 cm (centimeters) x 1. 1cm x 0.3 cm removed loose slough (non-viable tissue) with 4 x 4 now 100% pink granular base, moderate serosanguineous (blood serum and red blood cells) drainage.On 7/23/25 at 1:20 PM, LPN T was interviewed by phone and asked about R6's skin assessment on 6/14/25. LPN T explained she reported the wound to LPN E and put a dressing on it. LPN T was asked what the wound looked like. LPN T explained it was a small slit like wound, it was not bleeding. When asked if she had written a progress note or called the doctor for wound treatment orders, LPN T explained she thought she had written a progress note. On 7/24/25 at 9:37 AM, LPN E was interviewed and asked about the delay in treatment orders and interventions for R6's sacrum wound. LPN E explained 6/14/25 was on a Saturday and she did not work on weekends, so when she came in on 6/16/25 she got the treatment orders and put the interventions in place, then on 6/17/25 the Contracted Wound Provider saw the resident. On 7/23/25 at 1:37 PM, the Assistant Director of Nursing (ADON), who was serving as the Acting Director of Nursing, was interviewed and asked if the delay of treatment orders and interventions for R6 between 6/14/25 when the wound was first identified contributed to the wound documented as a Stage 3 pressure ulcer by the Contracted Wound Provider on 6/18/25. The ADON acknowledged the concern. Review of a facility policy titled, Skin and Wound Guidelines revised 3/20/24 read in part, .identify prevention techniques and interventions to assist with the management of pressure injuries and skin alterations.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #1214313Based on interview and record review the facility failed to provide proper care for one (R87) out of three residents reviewed for falls, resulting in R87 being transferred to the hospital and examined for injuries. Findings include:A complaint was filed with the State Agency (SA) that alleged the facility staff failed to ensure R87, a noted two-person assist for bed mobility, was properly changed resulting in a fall with injury requiring hospitalization. Hospital (name redacted) records were reviewed and documented, in part: .7/8/25.ED (Emergency Department) Provider Note:.R87 presents with a fall and right arm pain.Fall and associated injuries- Experienced a fall in a rehabilitation facility when only one person was assisting, despite requirement for two-person assist.most likely during midnight shift.Right arm pain localized to the proximal humerus following fall.Mild head pain.x-rays significant for a possible nondisplaced medial humerus fracture.CT (Computed Tomography) -negative for fracture.A review of R87's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Sepsis, Urinary Tract Infection (UTI), muscle weakness and type II diabetes.Further review of R87's clinical record revealed the following:admission Evaluation: R87.Date: 7/4/25.ADL (activities of daily living) Care Plan:. Intervention.ADL assist of 2 staff.Care Plan: Focus: ADL (Activities of Daily Living) Date initiated: 7/3/25. Interventions: ADL assist of 2 staff.Focus: Resident has an ADL self-care performance deficit.Interventions: Bed Mobility: 2 person assist.A review of R87's Kardex (dated 7/23/25) revealed the following: .ADL (activities of daily living) assist of 2 staff.Bed Mobility: 2 person assist.Transferring: Requires Mechanical Lift with 2 PA (person assist) .7/8/25: Note: Summoned to patient's room, observed patient lying on the floor. The CNA (certified nursing assistant) was cleaning patient's <sic> up and patient fell out of bed. Patients daughter was notified and she was so mad and said we should send patient to hospital.7/8/25: Note: .upon my arrival the midnight nurse notified writer that patient had fallen. During breakfast patient's daughter arrived.Daughter called 911 to have R87 transferred out to the hospital.A request was made for any investigation documents pertaining to R87's fall on 7/8/25. Documents were provided and reviewed and revealed the following:7/8/25: This re-education is being provided today to reinforce the importance of accuracy when updating the [electronic medical record] care plan and Kardex. As discussed, it is critical not to create duplicate care plans, as this may cause confusion.in a recent incident the patient (R87), a duplicate care plan was created and the care plan status did not align with the assessment status. Despite the patient being totally dependent, the care plan incorrectly indicated one-person assist for toileting. Based on the inaccurate information, staff followed the incorrect care directive, which resulted in a patient fall.Statement by CNA FF: I (CNA FF) went in about 4:45 (AM) to check on R87 she said she had a BM (bowel movement). I went and got supplies to change her.I went to roll her she just rolled on the floor.I went to get help. One-on-One In-Service Record: Employee Name: CNA FF.Inservice Topic: Falls prevention.When providing care always check the Kardex to ensure you know the patients level of care.When moving residents in bed make sure to roll the resident towards you if the person requires x1 assist.Residents requiring x2 assist both staff should be at the bedside before care is provided. Nurses and CNAs should work together to ensure call lights and ADL care is provided in a timely manner. (Signed by CNA FF and ADON/Assistant Director of Nursing C on 7/8/25).On 7/23/25 at approximately 4:43 PM, a phone interview was conducted with CNA FF. CNA FF reported that they had been employed by the facility for about two months and had been a CNA for almost 20 years. CNA FF was asked about the incident that occurred with R87 on 7/8/25. They reported that they were assigned to R87, who was new to the facility, and went to their room to change the resident. CNA FF noted that they believed R87's Kardex noted that they were a one-person assist for toileting and tried to change the resident's brief. They noted that they rolled R87 over and they rolled off the bed. CNA FF reported that following the incident they were educated on how to roll a resident towards them when doing brief changes and also, informed that the resident required two people for all ADLs, including bed mobility.On 7/24/25 at approximately 11:00 AM, an interview was conducted with ADON ‘C regarding R87's fall on 7/8/25. ADONC reported that they were aware of the fall and noted that R87 was a new resident and there was an error in the care plan interventions and the Kardex. They noted that CNA FF was also educated on how to change a resident via one-person assist. ADON C reported that the facility identified the concerns and completed a Past Non-Compliance (PNC). The Administrator provided the documentation(s) for review (see below):The facility policy titled, Fall Management Guidelines (12/13/23) was reviewed and documented

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations interview and record review the facility failed to ensure that oxygen was administered according to physician's orders for one resident (Resident #39) of one reviewed for respiratory care. Findings include:On 7/22/25 at 9:54 AM, Resident #39 was observed lying in bed with a nasal cannula in their nose. Resident #39, was asked, did they normally use oxygen and how many liters where they on. Resident #39 reported that they used oxygen and that it should be on 2 liters. An observation of the concentrator in room was on , but set to administer 0 liters of oxygen. There was no audible sound coming from the concentrator to indicate that it was running. On 7/22/25 at 10:00 AM, Nurse A, was asked to come to Resident #39's room and observed the oxygen concentrator. Nurse A was then asked was Resident #39 supposed to be on oxygen and if so, why wasn't the concentrator working. Nurse A reported that Resident #39 was to be on oxygen and that the concentrator was not plugged in. Nurse A then plugged in the concentrator and asked Resident #39 if they were okay. A review of the record revealed that Resident #39 was readmitted to the facility on [DATE] with the medical diagnosis of shortness of breath, obstructive sleep apnea and chronic obstructive pulmonary disease (COPD). Resident #39 had a Brief interview for mental status score (BIMs) of 15 indicating no cognitive impairment. A review of the medication administration record had an order for Resident #39 to be on 2 liters(L) of oxygen via nasal cannula at a continuous setting. On 7/22/25 at 12:56 PM, an interview was conducted with Respiratory Therapist (RT) S. RT S, reported that, Resident #39 used oxygen for comfort, but it was not really needed. RT S was then asked, why was there an order for 2L nasal cannula continuous in the computer and not an as needed order (PRN). RT S reported that the facility did not like the use of PRN orders but if it was in the orders, it should have been carried out as such and stated that they were going to re-evaluate Resident #39 oxygen needs. No additional information was provided by the exit of survey.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Concern with facility staffing has the potential to affect to all residents Based on interview and record review facility failed to ensure sufficient nursing staff were available to meet the needs of residents. Findings include: Facility submitted data to Centers for Medicare and Medicaid Services (CMS) for time period between 1/1/25 to 3/31/25 revealed that facility’s nursing staffing on weekends were “excessively low”. Review of Staffing sheets (and sign in sheets) for the following dates revealed multiple nursing staff call offs across multiple shifts with facility’s attempt to fill in the call offs: 1/3/25 to 1/5/25; 1/24/25 to 1/26/25; 2/7/25 to 2/10/25; 2/21/25 to 2/23/25; 3/14/25 to 3/16/25; and 3/21/25 to 3/23/25. An interview with Certified Nursing Assistant (CNA) “V” was completed on 7/23/25 at approximately 4:20 PM. They reported that they were full-time and had been at the facility for about 6 months. They were queried about facility staffing levels and whether they were able to provide the care needed for their residents. CNA “V” reported that they were “short staffed” on most days and they added that they tried to do their best for their residents. They added that recently the facility was trying to get help through a staffing agency if they could get someone. When queried how they managed on days/shifts when they did not have enough staff, CNA “V” reported that they had to do bed baths instead of showers. An interview with an agency (contract) CNA “W” was completed on 7/23/25 at approximately 4:30 PM. They reported and acknowledged the facility had a staffing challenge. They added that they had enough help and they were able to complete their assignment because of the survey that was currently going on (, indicating the facility staffed because of the survey, otherwise they usually work short). An interview with Registered Nurse (RN) “BB” on 7/23/25 at approximately 4:40 PM. They reported that they had been working at the facility for approximately 6 years and worked full time at the facility. They were queried about the facility’s staffing. RN “BB” reported that facility had staffing challenges, more with CNAs than nurses. They added that the facility had recently started using agency staff (employed by a third party) to cover CNA shortages. They added that issue was with staff call offs and not showing up to work. An interview with CNA “J” was completed on 7/23/25 at approximately 4:45 PM. CNA “J” reported that they worked part time at the facility. They agreed that the facility had staffing challenges because of staff not showing up to work. They added that the facility tried to get help from the agency when they were short-staffed and if they were unable to get staff to fill in the open shift, they were doing their best they could for the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235433	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Rehab and Nursing Center	3030 Greenfield Ave Royal Oak, MI 48073

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with Licensed Practical Nurse (LPN) “H” was completed on 7/24/25 at approximately 10:30 AM. They were queried about the facility staffing. LPN “H” reported that the facility’s “staffing could be better”. They added that the facility was short of CNAs, and they had one CNA on their side. When queried about residents who needed 2-person assistance, LPN “H” added they (nurses) were helping the CNAs. When queried about the weekend staffing, they reported there were no change. If they had a call off on the weekends it would get even harder. An interview with facility scheduler “CC” was completed on 7/25/25 at approximately 8 AM. They reported they were newer to the facility, had taken the role a few months ago. They were queried about nursing staffing and the call-offs. Scheduler “CC” reported that the staffing was getting better, and they had a lot of call offs. They added that their challenge was with CNAs more than nurses and they were trying their best to fill in the shifts that were not covered or if they had call ins. When they were queried further, they added the challenge was due to staff call ins and open positions An interview with the facility administrator was completed on 7/25/25 at approximately 7:45 AM. They were notified of the low weekend staffing on the facility submitted staffing report for 2nd quarter and interviews about staffing concerns. The administrator reported that they were trying to fill the staffing gaps with the agency staff recently (two weeks ago). They added that the challenge was staffing retention, and they understood the concerns. Review of the facility assessment dated [DATE] read in part, “The facility’s staffing is based on the resident population and acuity”. On 7/23/25 at 11:00 AM, a confidential resident group interview was conducted with 10 residents. When asked about whether they had any staffing concerns such as delayed response to call lights, or not receiving showers as scheduled, three of the 10 residents voiced their concerns. These included: “Sometimes we have to wait a long time (over 30 minutes).” “Weekends are worst and midnights.” “I’ve had to miss several showers because we only have one aide and they tell you that too. ”

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the timely acquisition and administration of medication for one (R13) of one resident reviewed for pharmacy services. Findings include:Review of the clinical record revealed R13 was admitted into the facility on 8/10/23, and readmitted on [DATE] with diagnoses that included: Alzheimer's disease, adjustment disorder with mixed disturbance of emotions and conduct, dementia with agitation, and anxiety disorder.According to the Minimum Data Set (MDS) assessment dated [DATE], R13 had severe cognitive impairment and received antipsychotic medication on a routine basis.Review of the current physician orders included two separate orders for quetiapine (Seroquel - an antipsychotic medication). One order started on 1/31/25 to have 25 MG (Milligrams) one tablet by mouth at bedtime; and the second order started on 5/14/25 to have 0.5 MG tablet by mouth one time a day (scheduled for 2:00 PM).Further review of the Medication Administration Records (MARs) included:An entry on 7/21/25 at 1:49 PM by Nurse ‘G' read: SEROquel Oral Tablet 25 MG Give 0.5 tablet by mouth one time a day for agitation/combative Medication on order. The MAR documented a check mark on 7/22 and 7/23 which meant the medication had been administered.On 7/24/25 at 10:30 AM, Nurse ‘H' who had been assigned to R13 on 7/23 and 7/24 was asked about the resident's 2:00 PM Seroquel. Nurse ‘H' reviewed their documentation and reported they did give it yesterday. At that time, when asked to review the medication cart, Nurse ‘H' reported there was no card (blister pack which contains the medication) for the Seroquel medication. When asked if there was no medication in the cart, did they remove any Seroquel medication on 7/23 to be able to administer that to R13, Nurse ‘H' reported they weren't sure if they did or not. On 7/24/2025 at 11:00 AM, an interview was conducted with the Assistant Director of Nursing (ADON) who also functioned as the Infection Preventionist and acting Director of Nursing for this survey. When asked about what the facility's process was for when medications needed to be re-ordered and/or if there was a delay in obtaining from the pharmacy, the ADON reported it usually takes six to eight hours to get the medication from pharmacy once re-ordered. The ADON was informed of the conflicting documentation of medication being on order on 7/21, but documented as administered on 7/22 and 7/23 and the observation with Nurse ‘H' of the medication not being available in the cart to administer and inability to recall if the medication had been pulled from the back-up supply. The DON reported they would attempt to contact pharmacy for documentation and follow-up.On 7/24/25 at 11:30 AM, the ADON reported they also reviewed the cart and saw no medication card for the Seroquel and contacted the pharmacy.On 7/25/25 at 7:25 AM and 10:18 AM, the facility was requested via email of any follow-up regarding R13's Seroquel medication as discussed with the ADON on 7/24/25.On 7/25/25 at 11:33 AM, the Administrator reported the information requested was placed into the survey folder.Review of the documentation uploaded revealed there was no documentation for July 2025. There was also no documentation of any medication pulled from the back-up supply.On 7/25/25 at 11:43 AM, a phone interview was conducted with the Regional Clinical Service Director (Nurse ‘P'). At that time, Nurse ‘P' was informed of what had been requested and what had and had not been provided for review. Nurse ‘P' reported they would follow-up.According to the medication back-up inventory list, there were 10 tablets of Quetiapine (Seroquel) 25 MG and 10 tablets of Quetiapine 100 MG tablets available for use.On 7/25/25 at 12:29 PM, a phone interview was conducted with Nurse ‘P'. Nurse ‘P' reported they pulled the pharmacy [name of back-up medication unit] for July and there were no Seroquel medications pulled at all for July and they were waiting on documentation for any other packing slips. They also reported they had R13's medication card which showed the Seroquel was delivered on 7/24 (which had been on order since 7/21/25).

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the facility assessment staffing was revised upon the reopening of a previously identified closed unit. This has the potential to affect all 87 residents. Findings include:Observations made from 7/23/25 to 7/25/25 revealed the facility had all units being utilized (residents assigned to rooms), including the 2 South unit.Review of the revised Facility assessment dated [DATE] documented under the section for staffing plan ratios by unit as the 2 south unit as not being staffed d/t (due to) census.Page 14 of 14 of the Facility Assessment had a section for Review and Update after Significant Changes - Any changes made within the facility assessment after the initial completion will be initialed and dated at the area of the change as well as documented below. The most recent revision signature was 4/1/25 by the current Administrator. This assessment was not updated to reflect the staffing plan for 2 South now that it was actively being utilized.On 7/24/25 at 10:07 AM, the Administrator was requested to provide the date of when the 2 South unit re-opened.On 7/24/25 at 10:11 AM, the Administrator reported All our private rooms got dual certified for medicare/medicaid on 4/1/25.On 7/24/25 at 10:20 AM, the Administrator was asked to clarify their response of what date they opened the 2 south unit and they reported they thought it was around that same timeframe. When asked why this was not reflected in the assessment dated [DATE], the Administrator reviewed and acknowledged the same and reported they would have to revise the facility assessment.

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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** Based on observation, interview and record review, the facility failed to follow infection control practices related to implementation of enhanced barrier precautions (EBP) upon identification of a new wound for one (R62) of three residents reviewed for pressure ulcers. Findings include:On 7/22/2025 at 10:19 AM, the hallway outside of R62's room had a cart with some personal protective equipment (PPE), however there was no signage posted to indicate if anyone in the shared room was on any infection control precautions. Other rooms throughout the hallway were observed to have signage that indicated they were on EBP. Upon entering the room, R62 was observed lying in a bed with a low air loss mattress. The resident did not wake up when approached.Review of the clinical record revealed R62 was admitted into the facility on 3/28/25, hospitalized on [DATE], readmitted on [DATE] and signed onto hospice services on 6/19/25. Diagnoses included: encounter for palliative care, anemia, other asthma, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, other sequelae of cerebral infarction, type 2 diabetes mellitus without complications, obstructive sleep apnea, and unspecified intracranial injury without loss of consciousness. According to the Minimum Data Set (MDS) assessment dated [DATE], R62 had severely impaired cognitive skills for daily decision making, had long and short-term memory impairment, and received hospice care while a resident.Further review of the clinical record included physician orders for a newly identified pressure ulcer on 7/14/25 and a care plan initiated by the Wound Care Nurse (Nurse ‘E') on 7/14/25 which documented, Documented Pressure Ulcer Documented Pressure Ulcer TO LEFT GLUTEUS.Further review of the clinical record revealed R62 had a newly identified pressure ulcer on 7/14/25 with subsequent wound care orders for the sacrum area implemented by Wound Care Nurse (Nurse ‘E').A progress note documented by Nurse ‘E' on 7/14/25 at 11:45 AM documented, Upon brief change I observed open area upon resident's left gluteus.it is recommended for treatment of Triad cream daily and as needed, low air loss mattress, frequent turn and reposition and frequent check and change daily. Wound care team has been consulted for evaluation.Review of the physician orders revealed there were no EBP precautions implemented upon identification of the new wound on 7/14/25.On 7/23/25 at 3:40 PM, Nurse ‘E' was asked to observe R62 who was lying in bed. At this time, there was no PPE cart outside the room or signage that indicated the resident was on EBP. When asked about the lack of EBP implemented for the resident who was identified as having a new wound on 7/14/25, Nurse ‘E' reported they were on EBP. When asked given the lack of signage, PPE cart, physician order, or cart, how would staff know to use that, Nurse ‘E' confirmed the same and reported they would implement that now (after it was brought to their attention).On 7/24/2025 at 11:00 AM, an interview was conducted with the Assistant Director of Nursing (ADON) who also performed as the facility's Infection Preventionist and acting Director of Nursing for this survey. When asked about facility's process for implementing EBP for a newly discovered pressure ulcer, the ADON reported they were never informed of the resident's new wound and normally the nurse who found the wound or the wound care nurse would be the one to implement the EBP. The ADON further reported R62 had a roommate that recently discharged that was on EBP for an indwelling device and the signage and cart might've been pulled when they discharged .According to the facility's policy titled, Enhanced Barrier Precautions dated 3/28/24: . Wound - in relation to enhanced barrier precautions wound .refers to more chronic wounds with skin opening(s) that require a dressing .Residents admitted to the facility with or during their stay at the facility acquire a wound .will be placed in enhanced barrier precautions .A physician order is obtained .Enhanced Barrier Precautions signage will be posted on the door or wall outside of the resident's room. Gown and gloves will be available outside the resident room .