STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235439	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Allen Park	9150 Allen Rd Allen Park, MI 48101

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 Based on interview and record review, the facility failed to ensure proper completion of Advanced Directive information was in place for one (R8) of 19 residents reviewed for Advanced Directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time), resulting in the potential for a resident's preferences for medical care to not be followed by the facility or other healthcare providers. Findings Include: Review of an Electronic Health Record (EHR) revealed, R8 had a code status of Do Not Resuscitate/No code (DNR). R8's Do-Not-Resuscitate (DNR) Order was signed by the guardian on 6/15/23. The document was signed by the Physician on 6/26/23 and two witnesses on 6/28/23. Review of an Admission Record revealed, R38 admitted to the facility on [DATE] and readmitted on [DATE] with pertinent diagnosis which included dementia. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R8 had mild cognitive impairment with a Brief interview for Mental Status (BIMS) score of 13, out of 15. In an interview on 6/26/24 at 1:42 p.m., Social Worker (SW) K reported the Advance Directive form should be signed in front of two witnesses. SW K then reported the witness signature date should be the same as the resident's or guardian. Review of an Advance Directives - Code Status policy revised 10/5/23 documented, It is the policy of the facility that the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment . DNR must be documented on the Do-Not-Resuscitate (DNR) form for the DNR to be valid. Until the form is full filled out and signed by the resident or the resident's legal representative, two witnesses, and a physician, the resident will be a Full Code by default .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on interview and record review, the facility failed to complete an annual OBRA (Omnibus Budget Reconciliation Act) Level II Evaluation for one (R3) of seven residents reviewed for PASARRs (Preadmission Screen and Resident Review), resulting in the potential for unmet mental health services. Findings include: Review of the clinical record revealed Resident #3 (R3) was initially admitted into the facility on [DATE] and readmitted on [DATE]. R3's diagnoses included adjustment disorder with mixed anxiety and depressed mood, unspecified dementia, bipolar disorder, and major depressive disorder. A Minimum Data Set assessment dated [DATE] documented moderate cognitive impairment. The date of R3's most current Level II PASARR was 3/21/23. On 6/26/24 at 2:30 PM, a review of R3's most recent Level II PASARR, dated 2/20/23, was conducted with Social Worker (SW) K. SW K stated the local community mental health services modified the document on 3/21/23, and that we need to submit a new Level II. It was due 3/21/24. On 7/2/24 at 2:30 PM, the Nursing Home Administrator (NHA) stated he expects PASARRs to be completed upon admission, a change in condition, and annually. A review of the facility document titled, PASARR, dated April 2022, documented in part the following: The nursing facility is responsible for verifying that required PAS and ARR processes are completed appropriately and timely and documented in the resident's record. On 7/2/24 at 3:15 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information when asked.

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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** 47964 Based on observation, interview, and record review the facility failed to 1) provide wound care according to treatment orders for one (R49) of six residents reviewed for skin conditions, resulting in unmet skin treatment needs, 2) failed to follow-up on pharmacist recommendations in a timely manner, 3) consistently hold antihypertensive medication per physician's order, and 4) consistently check blood pressure prior to administration of antihypertensive medication for two (R104, R1) of 23 residents reviewed for quality of care resulting in unmet care needs. Findings include: R49 On [DATE] at 12:24 pm R49 was observed in bed with a bandage on his left forearm dated [DATE] and a bandage on his right hand dated [DATE]. When R49 was asked what happened to your arms R49 reported I fell and tore up my hand and arm. On [DATE] at 9:09 am R49's left forearm and right-hand bandages were observed with dates of [DATE]. On [DATE] at 9:19 am Licensed Practical Nurse (LPN) V was interviewed and said R49's bandages and wound care should be performed daily. LPN V stated I forgot to change his bandages yesterday. I marked the treatment administration record that I provided the bandage change and wound care on [DATE] but I really didn't provide the wound care. It was my mistake. Record review of R49's Electronic Medical Record (EMR) revealed admission into the facility on [DATE] with pertinent diagnosis of Parkinson's Disease, falls. According to the Minimum Data Set (MDS) dated [DATE] R49 had moderately impaired cognition and moderate assistance with Activities of Daily Living (ADLS). On [DATE] at 9:41 AM R49's physician's orders and June Treatment Administration Record (TAR) were reviewed with Unit Manager D and revealed that wound care was to be provided daily and that LPN V performed wound care on [DATE]. Unit Manager D agreed the wound care entry for [DATE] was not accurate and said nurses should provide care first, then document. They should not document treatments that were not provided. On [DATE] at 9:09 AM the Director of Nursing (DON) was interviewed and agreed wound care should be performed per physician's orders and documentation should be accurate. 34901 Resident #1 - (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record for Resident #1 (R1) documented an initial admission into the facility on [DATE] and readmission on [DATE]. R1's diagnoses included moderate protein-calorie malnutrition (PCM), type 2-diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD), irritable bowel syndrome (IBS) without diarrhea, end state renal disease, and heart failure. A Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition. Chart review revealed R1 had multiple admissions and discharges from the facility, such as: admit: [DATE] and discharge: [DATE] admit: [DATE] and discharge: [DATE] admit: [DATE] and discharge: [DATE] admit: [DATE] and discharge: [DATE] admit [DATE] Review of monthly Medication Regimen Reviews (MMR) included the following pharmacist's recommendations: 1. MMR dated [DATE] - Order for Ranolazine ER 500 mg (given for chest pain) to give one tablet by mouth once daily. This medication is recommended to be dosed twice a day from the manufacturer. Please consider increasing to twice a day at this time. Physician agreed. - Order for Fluticasone-Salmeterol ,d+[DATE] (given for shortness of breath/COPD) to inhale 1 puff by mouth two times a day as a therapeutic interchange for Trelegy Ellipta once daily. Trelegy also contains a [NAME] (long-acting muscarinic antagonist - used to help control asthma long-term). Consider adding Incruse Ellipta 62.5 once daily to cover the [NAME] portion of a Trelegy inhaler. Physician agreed. 2. MMR dated [DATE] - Resident has an order for Ranolazine ER 500 mg to give one tablet by mouth daily. However, this medication is recommended to be dosed twice a day from the manufacturer. Please consider increasing to twice a day at this time. Physician agreed. 3. MMR dated [DATE] - Resident has an order for Fluticasone-Salmeterol ,d+[DATE] to inhale 1 puff by mouth two times a days as a therapeutic interchange for Trelegy Ellipta once daily. However, Trelegy also contains a [NAME]. Please consider adding Incruse Ellipta 62.5 once daily to cover the [NAME] portion of a Trelegy inhaler. Physician agreed. 4. MMR dated [DATE] (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident has an order for Fluticasone-Salmeterol ,d+[DATE] to inhale 1 puff by mouth two times a days as a therapeutic interchange for Trelegy Ellipta once daily. However, Trelegy also contains a [NAME]. Please consider adding Incruse Ellipta 62.5 once daily to cover the [NAME] portion of a Trelegy inhaler. Physician agreed. Per (physician) - add Incruse Ellipta once daily. Order placed in (electronic medical record). Dated [DATE]. During an interview and record review on [DATE] at 12:30 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), completed MMRs, containing the pharmacist's recommendations, are emailed to the DON. The MMRs are given to the Unit Managers to review. The Unit Managers are to contact the responsible physician for a decision regarding the pharmacist's recommendations. The MMRs are placed in the physician's folder for their signature. A review of R1's Medication Administration Records (MAR) revealed the following: 1. [DATE] MAR: confirmed no change in the orders for Ranolazine or Incruse Ellipta per pharmacist's recommendations and as agreed upon by the physician. 2. [DATE] MAR: confirmed Ranolazine was give once daily between [DATE] and [DATE]. The order for Ranolazine was changed to give twice daily on [DATE]. Incruse Ellipta was not administered per pharmacist's recommendation and as agreed upon by the physician. 3. [DATE] MAR: confirmed Incruse Ellipta was ordered on [DATE]. The DON said a determination of the pharmacist's recommendation should be completed within seven days. Resident #104 - A review of the clinical record for Resident #104 (R104) documented an initial admitted [DATE] and readmitted [DATE]. R104's diagnoses included persistent atrial fibrillation, hypotension, chronic kidney disease-stage 3, diabetes mellitus-type 2, and peripheral vascular disease. R104 expired in the facility on [DATE]. A MDS assessment dated [DATE] documented severe cognitive impairment. Review of R104's Medication Administration Record (MAR) documented an order for Midodrine HCL oral tablet 5 mg. Give 1 tablet by mouth every 8 hours for hypotensive, hold for systolic blood pressure less then 130. Start date [DATE]. Stop date [DATE]. On [DATE] at 11:59 AM, Attending Physician H said Midodrine should be held for systolic blood pressure greater than 130. On [DATE] at 12:14 PM, Licensed Practical Nurse (LPN) I said that nurses should check a resident's blood pressure prior to administering the blood pressure medication. LPN I said Midodrine should be held for blood pressure above 130. On [DATE] at 11:52 AM, during an interview and record review with the DON and ADON, the following was confirmed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Midodrine should have been held when R104's blood pressure was greater than 130. Midodrine was incorrectly administered to R104 on: [DATE] at 10:56 AM with a blood pressure of ,d+[DATE] [DATE] at 7:50 AM with a blood pressure of ,d+[DATE] [DATE] at 9:42 PM with a blood pressure of ,d+[DATE] Midodrine was scheduled to be administered at 6:00 AM, 2:00 PM and 10:00 PM. The DON confirmed that R104's blood pressure should be taken prior to each administration of Midodrine. R104's blood pressure was not obtained prior to the administration of Midodrine on the following dates and times: [DATE] at 6:00 AM, [DATE] at 6:00 AM, [DATE] at 6:00 AM, [DATE] at 2:00 PM, [DATE] at 10 PM, and [DATE] at 10:00 PM. On [DATE] at 3:15 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information when asked.

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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 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** 34901 Based on observation, interview, and record review, the facility failed to consistently implement interventions to prevent the development of pressure wounds for one resident (R19) out of seven residents reviewed for pressure ulcers, resulting in the potential for the development of pressure wounds. Findings include: During an interview on 6/25/24 at 10:03 AM, Licensed Practical Nurse (LPN) O was identified as the wound care nurse. LPN O said Resident #19 (R19) had a facility acquired pressure ulcer on their left lateral leg. On 6/25/24 at 1:45 PM, Resident #19 (R19) was observed lying in bed. The heel of R19's left foot was lying directly on the sheeted mattress. R19 offered minimal response when greeted. On 6/28/24 at 10:38 AM, during an observation, interview, and record review with Licensed Practical Nurse (LPN) U, R19's left heel was resting directly on the bed. Only one heel lift boot was located in R19's room. LPN U said R19 does not like to wear the boots. A review conducted with LPN U of R19's Treatment Administration Records and CNA tasks revealed no stipulation for the R19 to wear heel lift boots. Additionally, there was no documentation that there were attempts made to put a boot on R19 and he refused. On 6/28/24 at 10:44 AM, Certified Nurse Aide (CNA) J said R19 was good with wearing the boots and had them on the other day. On 7/2/24 at 8:10 AM, during an observation and interview in the presence of LPN L, R19 said his foot hurt. R19's left foot was observed resting directly on the sheeted mattress. LPN L stated, (R19's) foot needs to be elevated so it's not on the mattress. LPN L examined R19's left foot and stated, It seems like the heel is dented in. It is either heeling from what was there previously or something is about to occur. R19 made a painful sound and grimaced when his foot was touched. R19 stated, I will ask if we can put a dry patch on his heel so it won't get worse. On 7/2/24 at 8:20 AM, during an observation and interview with CNA M, only one heel lift boot was located in R19's room. CNA M stated R19 only has one boot and it's for his right leg. On 7/2/24 beginning at 10:15 AM, during an observation and interviews with Wound Nurse, LPN O, bilateral heel boots were observed on R19. A red area was noted on R19's left heel with dry, flaky surround skin. The skin appeared fragile and blanchable. R19 grimaced when the left heel was touched. LPN O reported this was a reoccurring issue with the left heel. LPN O reported R19 had a previous pressure sore on the left heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record revealed an initial admission into the facility on [DATE] and readmission on 8/10/23. R19's diagnoses included dysphagia following cerebral infarction, vascular dementia, personal history of transient ischemic attack (TIA) and unspecified severe protein-calorie malnutrition. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment, nutrition support was given via a feeding tube, resident identified at risk of developing pressure ulcers, and resident had one unhealed Stage 3 pressure ulcer. Review of R19's care plans document in part the following: 1. Anticipated skin breakdown related to: history of deep tissue injury to bilateral heels, History of pressure sore, incontinence, total dependent of care, fragile skin that tears/bruises easily. Dated 10/29/23. Interventions included: Heel life boot to bilateral feet while in bed as tolerated. Dated 8/28/23. 2. At risk for alteration in skin integrity related to: contractures, impaired mobility, incontinence, disorder of muscle, total dependent, hypertension, transient ischemic attach, post-traumatic stress disorder, peg tube use, scarring on buttocks, bilateral red heels, history of deep tissue injury to bilateral heels, foam wedge, anticipated skin break down related to previous wounds. Dated 8/18/23. Interventions included: Elevate heels as able. Dated 7/5/22. Heel lift boots on while in bed as tolerated. Dated 5/11/23. 3. Pressure injury at left lateral calf related to impaired mobility, disorder of muscle, and malnutrition. Dated 2/1/24. Interventions included: Elevate heels as able. Dated 1/23/24. Skin and Wound Evaluation of 4/2/24 documented in part the following: Pressure wound, stage 3 full thickness skin loss, left lateral calf, in house acquired, 1/23/24. Weekly wound care rounds completed with wound care nurse practitioner. Wound appears to be improving. wound has moderate amount of serosanguinous drainage .(R19) has positioning wedge, and heel lift boots in place. Nursing progress note of 7/2/24 at 8:28 AM documented: Writer examined resident heels with the state surveyor the writer observed L(left)-heel indented in; writer reported to wound care nurse. Writer applied dry patch with Prevlon boots (heel protection boots for pressure relief). On 7/2/24 at 11:33 AM during an interview and record review, the Director of Nursing (DON) said R19's foot should not be lying directly on the bed if he has vascular problems, and then acknowledged that R19's history of TIA could indicate vascular concerns. R19 was assessed for pressure ulcer risk on 6/3/24 and 6/29/24, resulting in a Braden Scale score of 12, and deemed to be a high-risk for pressure ulcer development. The DON stated, I would have his foot elevated because he is high risk. A review of R19's care plan provided no documentation or interventions related to refusals to elevate feet or wear protective boots. A review of the facility policy titled, Skin and Wound Guidelines, dated 3/20/24, documented in part the following: - The Braden Scale is the clinically validated tool used to identify potential levels of risk for pressure injury development. A Braden Scale of 10-12 is considered High Risk. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Pressure Injury: Localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical or other device. Can be present as intact skin or an open ulcer and may be painful. Injury occurs because of intense and or prolonged pressure or pressure in combination with shear and is classified by stage. On 7/2/24 at 3:15 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.

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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 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** 34901 Based on observation, interview, and record review, the facility failed to obtain weekly weights and perform timely nutrition reviews for two residents (R1 and R19) who were determined to be at high nutritional risk, resulting in the potential for compromise in nutrition status to go undetected. Findings include: Resident #1 - Review of the clinical record for Resident #1 (R1) documented an initial admission into the facility on [DATE] and readmission on 5/14/24. R1's diagnoses included moderate protein-calorie malnutrition (PCM), type 2-diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD), irritable bowel syndrome (IBS) without diarrhea, end state renal disease, and heart failure. A Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition. Nutritional evaluation for R1 dated 5/28/24 documented in part the following: - Resident has a fluctuating weight history due to extreme swelling upon admission in February, was discharged and had fluid removed, currently in house that fluctuate 158-166 - Pertinent Diagnoses: moderate PCM, gout, sepsis, chronic pulmonary edema, major depression, angina, anxiety, IBS, type 2 DM, chronic respiratory failure, COPD, dysphagia, hyperlipidemia, heart failure. - Resident used to be on dialysis, no longer on it and may experience weight fluctuations. - Resident is at nutritional risk related to history of moderate PCM, chronic pulmonary edema, anxiety, IBS, type 2 DM, heart failure, history of swelling and weight fluctuations - Interventions: Weekly weight with monitoring x 1 month. Review of weight documentation on R1 revealed one weight was obtained between 5/28/24 to 6/25/24. Review of R1's care plan documented in part the following: Inadequate oral intake related to dislike of food as evidenced by variable oral intake, verbal report of food dislike. 5/2024- poor oral intake since return from hospital, evidence of skin breakdown buttocks, declines enteral feeding per hospital notes. The resident has a chewing problem related to lack of teeth, however she and her guardian wish for her to be on a regular texture diet. Dated 4/6/24. Interventions included: Weekly weights. Dated 4/15/24. Resident #19 - (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record revealed an initial admission into the facility on [DATE] and readmission on 8/10/23. R19's diagnoses included dysphagia following cerebral infarction, vascular dementia, personal history of transient ischemic attack (TIA) and unspecified severe protein-calorie malnutrition. A MDS assessment dated [DATE] documented severe cognitive impairment and nutrition support was given via a feeding tube. Quarterly Nutrition Review for R19, dated 3/27/24, documented in part the following: Diagnosis of vascular dementia with dysphagia, reliant of enteral for 100% of his needs. Recent complaints of gassy stomach. No edema, no wasting noted. (R19) is able to eat independently yet refused lunch today, only drank juice, does not want chocolate milk with meals any longer. Stage 3 left lateral calf (wound), no new labs. Current body weight 191.6#. Resident remains dependent on enteral feeding for nutrition and hydration needs. Continue mechanical soft regular diet, served in bowls, with built up utensils. Adjust food preference per request. Facility RD changed formula to Osmolite to lower fiber. Nutrition is following. Add nutritional juice bid for enhancement as resident enjoys juice beverages. Review of R19's care plan documented in part the following: Moderate malnutrition as evidenced by reliance on supplemental PEG tube feedings (Percutaneous Endoscopic Gastrostomy - a tube inserted into the stomach to provide a means of feeding), adjustment disorder with anxiety, PTSD (post-traumatic stress disorder), epilepsy, dysphagia, depression, psychotic disorder with delusions, hallucinations, traumatic brain injury, diagnosis of severe protein calorie malnutrition/adult failure to thrive, variable oral intakes with mechanically altered diet, difficulty feeding self/food spillage, vascular dementia, language deficit. Weight gain x 180 days. Dated 3/24/24. During an interview beginning on 6/28/24 at 12:12 PM, Registered Dietitian (RD) S stated she performs a nutrition assessment on all new admissions to the facility in order to determine who is at nutrition risk. RD S said all residents determined to be at high nutritional risk are to be reviewed monthly because they can deteriorate easily, and it is good to capture that before it happens. R1 was considered at high nutritional risk due to diagnosis of end stage renal disease and history of poor intake. RD S said weekly weights were recommended for R1 on 5/28/24 because her weights were all over the place. The order for weekly weights was entered on 6/23/24. RD S said, That's a little bit late. RD S acknowledged that recommendations for weekly weights for R1 were not followed and stated, That's something I need to follow-up on. RD S indicated R19 was considered at high nutritional risk because he was on a tube feeding. RD S acknowledged that the last nutrition assessment/progress note for R19 was completed on 3/27/24. RD S said there should have been monthly follow-up on R19 because of high-risk status and there was not. On 7/2/24 at 12:06 PM, the Director of Nursing (DON) said the RD was expected to see patients timely and that weight measurements for R1 should have been done. On 7/2/24 at 3:15 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 Based on observation, interview, and record review the facility failed to administer medications accurately for one resident (R38) out of three residents during medication pass, resulting in a medication error rate of 7. 41%. Findings include: In an observation on 6/26/24 at 9:45 a.m., Licensed Practical Nurse (LPN) E prepared medications for R38. Medications included Flonase (nasal spray) and Symbicort (inhaler). In an observation on 6/26/24 at approximately 9:47 a.m., LPN E entered R38's room and performed hand hygiene. LPN E administered two sprays of Flonase in each of R38's nostrils and gave the inhaler. R38 requested to receive a PRN (as needed) breathing treatment. LPN E then exited the room and documented the medication administration. In an interview on 6/26/24 at 9:49 a.m., LPN E reported R38 administer the breathing treatment and has a PRN order is being requested. In an observation on 6/26/24 at 9:50 a.m., R38 began the breathing treatment with Albuterol. Review of an Admission Record revealed, R38 readmitted to the facility on [DATE] with pertinent diagnosis which included chronic obstructive pulmonary disease (COPD) chronic respiratory failure with hypoxia (CRF), dementia, and asthma. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R38 had no cognitive impairment with a Brief interview for Mental Status (BIMS) score of 14 out of 15. Review of Physician orders revealed R38 had an order for Flonase Allergy Relief Nasal 1 spray in both nostrils one time a day for allergy. R38 did not have a PRN Albuterol order. In an observation and interview on 6/26/24 at 11:04 a.m., LPN E reviewed R38's orders and confirmed R38 did not have a PRN order for Albuterol. In an interview on 6/26/24 at 11:08 a.m., Unit Manager D reported R38 does not have a current order for a PRN breathing treatment. In an interview on 6/26/24 at 11:22 a.m., LPN E reported R38 acknowledged that she gave R38 two sprays in each nostril and R38 should have received one in each nostril. In an interview on 6/27/24 at 2:20 p.m., the Director of Nursing (DON) reported nurses should look at the MAR (Medication Administration Record) to see what medications are due or if the resident has an order. The DON then reported the nurse should give the correct dose and should not give a medication without an order. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Medication Administration policy issued 8/7/23 documented, To safely and accurately prepare and administer medication according to physician order, professional standards of practice, and resident needs . Medications are administered in accordance with the following rights of medication administration: Right resident Right medication Right Dose Right time and frequency .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on observation, interview, and record review, the facility failed to ensure that a proper sanitizing product was used to kill Clostridium difficile (C. diff - a bacteria that can cause diarrhea) resulting in the potential spread in infection and disease, potentially affecting all residents who resided in the facility. Findings include: On 6/25/24 at 9:50 AM, Licensed Practical Nurse (LPN) I indicated the resident in room [ROOM NUMBER] was on transmission-based precautions because of a C. diff. infection. On 6/26/24 at 11:08 AM, signage outside of room [ROOM NUMBER] documented that staff were to used transmission-based precautions upon entering and exiting the room. On 6/26/24 at 11:16 AM, Housekeeper F was observed entering room [ROOM NUMBER] without donning PPE (personal protection equipment) with the exception of gloves. Housekeeper F mopped the floor in room [ROOM NUMBER]. Upon exiting the room, Housekeeper F took the gloves off, removed the mop bottom, and put it in a bag. Housekeeper F then used hand sanitizer. On 6/26/24 at 11:20 AM, Housekeeper F said she just wet mopped the floor in room [ROOM NUMBER] using product, Xcelente (a multi-purpose cleaner), mixed with water. Housekeeper F explained that at the end of the shift, the bag with the dirty rags is put with the dirty linen without any special designation that the mop used to clean the room of a resident diagnosed with C. diff. On 6/27/24 at 12:19 PM, Housekeeper F said the only product used on the floor in room [ROOM NUMBER] was the Xcelente. Housekeeper F said she was told today that she needs to use bleach water to adequately clean room [ROOM NUMBER]. Housekeeper F stated, I didn't know. On 6/28/24 at 3:22 PM, Infection Preventionist (IP) G stated bleach was required to clean C. diff. because It kills the spores. IP G added it was a concern that the correct cleaning product was not used because C. diff. could spread to other residents. On 7/2/24 at 1:38 PM, Housekeeping Supervisor A said Xcelente should not have been the only product used to clean and sanitize room [ROOM NUMBER]. Housekeeper Supervisor A said Housekeeper F went in and cleaned the floor with a regular cleaning product and there was a concern that C. diff. could spread. On 7/2/24 at 1:42 PM, the Nursing Home Administrator said he expects cleaning staff to use the proper products to disinfect and kill C. diff. On 7/2/24 at 3:15 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information when asked.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on interview and record review, the facility failed to ensure two residents (R37 and R60) out of five residents reviewed for immunizations, were provided influenza and/or pneumococcal vaccination and education resulting in the potential for the development and spread of influenza and pneumonia among vulnerable residents in the facility. Findings include: On 6/28/2024 at 10:04 AM the Infection Preventionist (IP) G was interviewed and reported the following residents did not have documentation of a current influenza and/or pneumococcal immunization or refusal: -Review of the Electronic Health Record (EHR) for R37 admitted on [DATE] with diagnosis of Multiple Sclerosis and Parkinson's Disease. R37 did not have documentation to indicate that the influenza and/or pneumococcal vaccines were offered or was contraindicated. -Review of the EHR for R60 revealed admitted on [DATE] with a diagnosis of Heart Failure. R60 did not have documentation to indicate that the influenza and/or pneumococcal vaccines were offered or was contraindicated. On 7/2/2024 at 9:07 AM the Director of Nursing (DON) was interviewed and agreed both R37 and R60 and/or guardians should have been educated and offered the influenza and pneumococcal vaccine. Review of the facility policy titled Infection control Program revised 3/1/22 revealed in part . Residents will be offered the influenza vaccine each year between October 1 and March 31. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission. Documentation will reflect the education provided and details regarding whether the resident received immunizations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on interview and record review, the facility failed to ensure one resident (R37) out of five residents reviewed for immunizations, were provided a Covid 19 vaccination and education resulting in the potential for the development and spread of Covid 19 among vulnerable residents in the facility. Findings include: On 6/28/2024 at 10:04 AM the Infection Preventionist (IP) G was interviewed and reported the following resident did not have documentation of a current Covid 19 immunization or refusal: -Review of the Electronic Health Record (EHR) for R37 admitted on [DATE] with diagnosis of Multiple Sclerosis and Parkinson's Disease. R37 did not have documentation to indicate that the Covid 19 vaccine was offered or was contraindicated. On 7/2/2024 at 9:07 AM the Director of Nursing (DON) was interviewed and agreed R37 should have been educated and offered the Covid 19 vaccine. Review of the facility policy titled Infection control Program revised 3/1/22 revealed in part . Residents will be offered the Covid 19 vaccine. Documentation will reflect the education provided and details regarding whether or not the resident recieved the vaccince.

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F 0916 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident has a room at or above ground level. 32000 Based upon observation and interview the facility failed to provide resident bedrooms that are at, or above ground level in six of 70 rooms in the facility (rooms 101, 103, 105, 107, 109, and 111) resulting in the potential for water damage in resident living spaces. Findings include: On 6/25/24 at 1:42 PM, during an environmental tour of the facility six resident rooms (number's 101, 103, 105, 107, 109 and 111) were observed below grade level. The windows of the rooms had a visual line of sight that looked up and out, with the ground leveling out at the base of the windows. On 6/25/24 at 2:10 PM, an interview with the Housekeeping and Laundry Director, staff A, revealed the rooms had been like that for several years, but are no longer in use. During the survey no water damage was observed in these resident rooms.