STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235456	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtney Manor	1167 E Hopson Street Bad Axe, MI 48413

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on observation, interview and record review, the facility 1) Failed to ensure that call lights were answered timely, with dignity, were within reach and needs were met timely, 2) Failed to provide assistance with feeding in a dignified manner, 3) Failed to ensure that food was a palatable temperature, offered substitution of meal items, and ensure the opportunity to eat in the dining room, and 4) Failed to ensure that residents could go outside for a confidential group of residents and Residents (#3, #15, #16, #29, #37, #44 and #64), resulting in complaints of frustration, unhappiness, delayed care with a likelihood of overall decreased quality of life. Findings include: On 10/28/24, at 2:00 PM, During the Resident Council task, the following complaints were voiced regarding not have healthy snacks and food choices: No fresh greens no fresh veggies no fresh fruit I dream about a beautiful red fresh tomato I would love a fresh ear of corn the meals are food of carbs if you want to gain wait, just eat the processed foods here you get the same thing for breakfast every day we want fresh cinnamon rolls the little butter packets are margarine we want real butter (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	we don't want imitation cheese they run out of snacks they run out of honey buns you have to ask the CNA's for night time snacks and they say there isn't any The CNA's say they will go check for a snack but then they don't come back You have to go to the kitchen sometimes to get snacks you have to know who to go to, to get what you want we get a choice but you have to wheel your butt down there and make it you could tell your nurse or CNA but they're too busy to do it (referring to order slip for a different food choice They don't have time to little own do their job I can tell when my meds are late because I get tremors The following complaints were voiced regarding their care received and call light responses: I rang my buzzer. The girl that answered said, you listen, I'm doing the talking I want my meds on time, they're always late They don't have enough CNA's to take care of us adequately they pass the buck when they answer your call light they say well, I can't do that but let me get someone who can, and then they don't come back You end up having to put your call light back on after they cancel it because they don't come back sometimes, the CNA's work three sixteen hour shifts and we feel bad because they're tired They don't schedule enough CNA's They'll say just a minute or go on by the room You can hit the call light and wait 25 to 30 minutes, usually longer they come in and shut it off and say we'll be back in a minute and then they don't come back they rush in to turn it off (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the longest I've waited was 2 hours and I was sitting in soaked pants they say I don't have time right now they'll say I'm not qualified to do that but then still cancel the light If you can make it into the bathroom and pull the light down, that will get someone in there pretty quick there could be some improvements. You gotta wait a half hour to get to the bathroom A review of the facility provided . RESIDENT COUNCIL MEETING MINUTES FOR JULY 2024 revealed . As a group we discussed the call light times and all in attendance agreed that they have improved . A review of the . RESIDENT COUNCIL MEETING MINUTES FOR JUNE 2024 revealed no mention as to the complaints regarding call light wait times. A review of the . RESIDENT COUNCIL MEETING MINUTES FOR AUGUST 2024 revealed . Call light times. The majority agreed that they have improved and verbalized the understanding of times during meal times . A review of the . RESIDENT COUNCIL MEETING MINUTES FOR SEPTEMBER 2024 revealed . We discussed the call light times and staff answering them in a timely manner, all agreed that they have improved and the understanding of having to during meal times . On 10/29/2024, at 1:00 PM, Activity Director (AD) G was interviewed regarding the council minutes. AD G was asked why the minutes didn't mention the council members voiced concerns regarding call light wait times and AD G offered, the complaints were on different documents. The documents with the voiced concerns were not offered prior to exiting the survey. The following complaints were voiced regarding the ability to go outside and get fresh air: they lock the door when they don't want you to go out the front door is locked the door is screwed up and it's hard to get your wheelchair over the threshold The following complaints were made regarding the dining room being closed on the weekends: yes they do that often we're short staffed all the time on the weekends it's a problem because you have to eat in your room and when we get our room trays, they're cold yes. It's a problem when the dining room gets closed (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they could have told me the dining room was closed. I wheeled all the way down there to find out it was closed. I'm not real happy working on a skeleton crew On 10/27/24, at 11:35 AM, Anonymous facility staff H was interviewed regarding the dining room being closed for lunch. Anonymous Facility staff H was asked why the residents couldn't go to the dining room for lunch and Anonymous facility staff H offered, the dining room is closed because of low staffing. On 10/29/24, at 9:15 AM, the Director of Nursing (DON) was asked why the dining room was closed on day 1 (Sunday) of the survey for the lunch meal and the DON offered, that a nurse chose to close the dining room without calling management prior to making that decision. The DON was asked how often the dining room gets closed for meals and the DON offered, that the only time they will close the dining room would be if they had a music activity scheduled shortly after lunch time. On 10/29/24, at 12:57 PM, Activity Director (AD) G was interviewed regarding Resident Council complaints regarding not being able to go outside whenever they want to and that they complained the doors were often locked by maintenance. AD G offered the they thought door gets unlocked when the outside temperature was 70 or 72 degrees Fahrenheit. AD G planned to follow up with the residents to plan outside activities for cooler temperatures. On 10/29/24, at 2:48 PM, Certified Dietary Manager (CDM) I was interviewed regarding resident complaints of the facility provided food choices and items. CDM I was alerted of the complaints of no fresh fruit or veggies and CDM I offered the facility has celery and carrot snacks. CDM I was asked what fresh fruit the facility had in house for snacks and CDM I offered, bananas. CDM I denied having apples, oranges or grapes. CDM I was alerted of the complaints the facility didn't offer real butter and that the residents complained of the use of imitation cheese. CDM I offered I guess I haven't had anybody request real butter and that they do use Velveeta for the macaroni and cheese. 37771 Resident #15: A review of Resident #15's medical record revealed an admission into the facility on [DATE]. A review of the Minimum Data Set assessment revealed the Resident had moderately impaired cognition and needed setup or clean-up assistance with eating and oral hygiene and was dependent for other activities of daily living, mobility and transfers. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/27/24 at 12:23 PM, an observation was made of Resident #15 sitting up in bed with the head of the bed elevated. The Resident had a carrot in her left hand to help with contractures. When questioned the Resident said she can't use that hand. An observation was made of the call light positioned on the side of the left hand that had the carrot. When asked if she knew where her call light was, the Resident looked around and stated, I don't know where it is. When asked if the Resident used her left hand, the Resident reported she did not use that hand and did not raise the left hand when asked. The Resident was asked if she could reach over to get the call light that was positioned on the bed next to the lateral left hand. The Resident tried to reach for the call light but said she could not get it. The Resident was observed to have food on her clothing in the chest area and some food debris on her skin around her neck and there was food debris on her sheet that was across her abdomen. CNA P brought in the Resident's lunch tray, went to set the tray with the Resident and reported she would get a shirt protector, and change the Resident's sheet. When asked about the Resident's use of the left hand, the CNA reported the Resident did not use her left hand. When asked about the positioning of the call light by the outer aspect of the left hand, the CNA reported she had it clipped earlier to where the Resident could reach it and indicated the Resident must have moved it. The CNA went to get a shirt protector and reported she would change the Resident's sheet and clothing that was soiled from eating previously. Resident #16: A review of Resident #16's medical record revealed an admission into the facility on [DATE]. A review of the Minimum Data Set assessment revealed the Resident had intact cognition, needed setup or clean-up assistance with eating, supervision or touching assistance with oral hygiene and was dependent with most other activities of daily living, mobility and transfers. On 10/27/24 at 1:00 PM, an observation was made of Resident #16 lying in bed and had her meal tray on the overbed table next to her. The looked like it had not been eaten except for what was on a small dessert plate. The Resident was asked about the meal. The Resident stated, That looks horrible, I can't eat it. Why don't they have better things?! The Resident expressed frustration at some of the foods that were served and explained, they had fish and French fries on Friday, reported the fish and the fries looked good, but they put a glob of stewed tomatoes, which she reported she would not eat those and stated the stewed tomatoes ran into everything, made everything soggy. The Resident expressed that she would like to see more fresh fruits and veggies and stated, We live in a farm country they have access to fresh stuff, why can't they get fresh cucumbers even. During the interview with the Resident, staff came in to pick up the tray. The Resident explained to the staff that she could not eat it and that she only ate the pie but just couldn't bring herself to eat what was on the plate. The staff did not ask the Resident if she wanted something else to eat. After the staff left with the tray, the Resident was asked if they offer alternatives. The Resident expressed that they just get what is served, don't have any choices to what comes, it just comes on a plate what ever they are cooking. If you don't like it then it's too much of a hassle, they have to go all the way down there and back, they are too short staffed for that. The Resident explained that she did not want the staff to have get other food items and stated, It's too hard for them to ask for something else. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After the interview with the Resident, the staff that was picking up trays was approached. Dietary was asked why the Resident was not offered an alternative after she explained that she could not eat what was served. The Dietary staff reported that the Resident often declines but you are right, I should have asked her. The Dietary Staff returned to Resident #16's room and the Resident indicated she wanted a sandwich. Resident #29: A review of Resident #29's medical record revealed a reentry into the facility on [DATE]. A review of the Minimum Data Set assessment revealed the Resident had intact cognition, was independent with most activities of daily living, mobility and transfers, and needed partial/moderate assistance with ambulation and bathing. On 10/27/24 at 12:07 PM, an observation was made of Resident #29 eating lunch in his room. The Resident was dressed, in a wheelchair with their meal tray on the overbed table positioned in front of the Resident. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about any issues that they had with the care he received at the facility. The Resident reported they did not serve enough food, and he usually got more than this and indicated his meal tray. The Resident was asked if he was supposed to received larger portions. The Resident explained that he usually ate in the dining room, and he would ask for more of what he wanted. The Resident explained that the meal came up and he did not get larger portions. When asked why he did not go to the dining room to eat, the Resident stated, too short staffed, they said we had to eat in our room. The Resident reported that when he had to eat in his room that the food was not warm enough for his liking and stated, Food too cold that is an issue when we eat in our room. Resident #44: A review of Resident #44's medical record revealed an admission into the facility on [DATE]. The review of the Minimum Data Set assessment revealed the Resident had severely impaired cognition and needed setup or clean-up assistance with eating, substantial/maximal assistance with multiple areas of activities of daily living, was independent with roll left and right, and needed partial/moderate assistance with most other mobility and transfers. On 10/28/24 at 10:22 AM, an observation was made of Resident #44 lying in bed with the head of the bed elevated high up but not to 90 degrees. The Resident was sleeping and did not arouse with name voiced. The bed was in a low position. An observation was made of the call light on a bedside table. The call light was a push pad. The bedside table was up against the wall next to the resident's bed but was behind the raised head of the bed and not in reach for the Resident. The Resident was facing the wall with his face on a pillow that prevented him from having his face on the wall. The bed controller, that adjusted the height of the head of the bed, hung over the foot of the bed and not in reach for the Resident. Resident #64: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #64's medical record revealed an admission into the facility on [DATE] and readmission on 6/10/24 with diagnoses that included need for assistance with personal care, muscle weakness, difficulty in walking, and anxiety disorder. A review of the Minimum Data Set assessment dated [DATE] revealed the Resident had intact cognition and needed substantial/maximal assistance with most activities of daily living, transfers and mobility. On 10/27/24 at 12:32 PM, an observation was made of Resident #64 sitting in their room. The Resident was interviewed, answered questions and engaged in conversation. When asked about any issues the Resident had with the care received while a Resident at the facility, the Resident reported that the food served in the room was not hot enough and discussed how the eggs often came cold, the soup was often lukewarm and by the time you got your food, the coffee was cold. The Resident complained of not getting enough fresh items like fruits and vegetables. When asked about other issues with their care, the Resident complained of the call light not answered for 45 minutes. The explained that sometimes pretty quick, but other times you wait a long time! A review of facility policy titled, Resident Rights, revised 5/14/24, revealed, Policy: The facility protects and promotes the rights of each resident. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . Information: Residents have freedom of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules and regulations affecting resident conduct and those regulations governing protection of resident health and safety . A review of facility policy titled, Call lights, revised 2/15/22, revealed, Policy: Call lights will be place within the guest's/resident's reach and answered in a timely manner. Procedure: .3. When a guest/resident is in bed or confided to a chair be sure the call light is within easy reach of the guest/resident . Responding to a Call Light: 1. Identify the location and answer the guest/resident promptly . 5. When finished, turn the call light off and replace the call light within guest's/resident's reach . 22348 During the dining room observation on 10/29/24 at 11:28 AM, residents R3 and R37 were observed eating in the dining room area. Observation 1: On 10/29/24 at 11:30 AM, during meal observation in the main dining room, R37 was observed eating independently on the table with no staff supervising or assisting close by her at the time. R37 was observed eating, trying to scoop the pudding with her fork, which was dripping as she tried to put the fork with the pudding into her mouth. R37 also used the same fork to eat her taco sandwich but was unsuccessful, and pudding was caught on her garment protector (bib). At 11:45 AM, a male certified nursing assistant (CNA) came with a chair, sat beside R37, and started assisting R37 with the Taco meat on a bun. Resident #37 (R37): (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37 According to the facility's Electronic Medical Record (EMR), R37 was [AGE] years old and admitted to the facility on [DATE] with a diagnosis of Dysphagia in addition to other diagnoses. R37's Brief Interview for Mental Status BIMS Score dated 9/5/24 assessment was 02/15. A score of 0-7 indicates a patient's cognition is severely impaired. R37's Section GG of the MDS (Minimum Data Set), dated 9/5/24, indicated that R37 required set-up and clean-up assistance as the resident completed the activity. Section K for the MDS assessment on 9/5/24 was incomplete. R37 Care Plan for Eating and Nutrition indicated that R37 is a one-assist for meals. Assist to finish meals as needed. Provide diet as ordered. Observe and document food acceptance and offer substitutes as needed. Provide feeding/dining assistance as needed, including set-up, encouragement w/eating, and feeding PRN to optimize intake. R37 has a regular diet, mechanical soft texture, thin liquids: upright for all meals, alternate solids and liquids, check for pocketing, small bites, small sips, sippy cups, and scoop plate. It was updated on 10/29/24. Observation 2: On 10/29/24 at approximately 11:35 AM, R3 was sitting in his wheelchair and received feeding assistance with his lunch meal while the staff (MDS Nurse) was standing up, giving R3 a spoonful of food in his mouth. R3 was verified to receive the appropriate mechanical soft diet as ordered because of his diagnosis of Dysphagia. Resident #3 (R3): A review of R3's Electronic Medical Record revealed that R3 was [AGE] years old and admitted to the facility on [DATE], with the diagnosis of oropharyngeal Phase Dysphagia in addition to other diagnoses. R3's Brief Interview for Mental Status (BIMS) Score dated 10/2/2024 was 5/15. A score of 0-7 indicates a patient's cognition is severely impaired. Section GG of the MDS (Minimum Data Set) dated 7/3/24 indicated that R3 required supervision or touching assistance with eating (helper provides verbal cues or touching steadying assistance as the resident completes the activity. Section K for both MDS assessments for 7/3/24 and 10/2/24 were incomplete. On 11/29/24 at 2:00 PM, a review of R3's Care plan for Alteration in Nutritional Status r/t Dx of Oropharyngeal Dysphagia w/ needed for modified texture diet last revised on 7/8/24. It indicated for Staff will provide feeding and dining assistance, including a scoop plate, sippy cup, and soup spoon, to aid in self-feeding with setup. On 10/29/24 at 11:45 AM, it was verified by the Registered Dietician RD that RD observed the staff (MDS Nurse) was observed providing feeding assistance in an undignified manner, which is why she pulled a chair and placed it next to the staff to sit down when feeding R3. RD confirmed that the staff was standing up while feeding R3. The RD confirmed R3's name and the diet order status and identified the staff as the facility's MDS nurse.

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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** 22348 Based on observation, interview, and record review, the facility failed to follow up on advanced directives with the proper POA signature of DNR consent and ensure that the care planning matches the desired code status for 2 residents (Resident #47 and Resident #71) of 2 residents reviewed for code status resulting in lack of accurate assessment and documentation of code status and the potential for a resident to receive life-sustaining medical treatment against their wishes. Findings include: Resident #47(R47): Advance Directives According to the Electronic Medical Record (EMR) reviewed on [DATE] at 3:30 PM, R47 was admitted to the facility on [DATE] with the diagnosis of Unspecified Dementia, Psychotic Disorder with Delusions, General Muscle Weakness and the need for assistance with personal care in addition to other diagnoses. According to the face sheet, R47's daughter is the established Power of Attorney (POA). R47's Brief Interview for Mental Status (BIMS) Score is ,d+[DATE]. A ,d+[DATE] score indicates that the person has severe cognitive impairment. The Do-Not-Resuscitate Order Form was reviewed dated [DATE] for R47 was reviewed. A physician's signature was noted, dated [DATE]. However, the nurse wrote the co-advocate's name and noted phone date as [DATE]. There was no follow-up signature of the POA, and I was not given the right to sign the DNR papers. [DATE] 10:27 AM The DNR Order was not signed or validated by the guardian/POA. A Physician's order in R47's EMR dated [DATE], No CPR/DNR. (No Cardiopulmonary Resuscitation/Do-Not-Resuscitate) R47's care plan is a full code dated [DATE], which does not match the DNR Form. The care plan was never revised to match according to the DNR Order Form signed by the physician on [DATE]. The Care Plan's intervention was not followed: > Code status will be reviewed upon readmission, quarterly, significant change in condition, and at the resident's or responsible party's desire. (initiated and created on [DATE]) > The facility representative will attempt to contact the responsible party/emergency contact in emergencies. (initiated and created on [DATE]) > The facility will make attempts to sustain life in emergency situations. (initiated and created on [DATE]) Resident #71 (R71): (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Advance Directives A review of R71's EMR on [DATE] at 10:15 AM revealed R71 was [AGE] years old and admitted to the facility on [DATE], with a diagnosis of Alzheimer's Disease, Dysphagia, muscle weakness (generalized), and the need for assistance with personal care. BIMS score of ,d+[DATE] dated [DATE] Minimum Data Set Assessment. A ,d+[DATE] score indicates that the person has severe cognitive impairment. R71's Code Status Form was reviewed, and the DNR Order dated [DATE] (Do not resuscitate was selected. No signature was obtained from the healthcare legal decision maker, but the legal guardian's name was written and noted: phone consent dated [DATE], signed by witnesses (2 nurses) on [DATE]. The physician signed the order dated [DATE]. The Care Plan for R71 is a DNR initiated on [DATE] with the following interventions: c Advanced directives will be honored in emergency situations (Initiated and created on [DATE]) c Code status will be reviewed upon readmission, quarterly, significant change, and at the desire of the resident or responsible party. On [DATE] at 10:30 AM, the DON was queried on the DNR Process and obtaining an actual signature from the guardian. She stated she would check on how they obtain the actual signature by phone after the verbal. The DON was unsure how long the verbal authorization was valid per policy. She verified that both R71 and R47 had a discrepancy in the code or no code status and that verbal consent by phone was written on the form regarding Do Not Resuscitate. The DON validated that the DNR Order form did not have an actual signature by the Power of Attorney or Guardian. Advanced Directive Policy was reviewed on [DATE] at 3:30 PM. The Policy revealed: Title: Advance Directives- Michigan Effective Date: [DATE]. Policy:A. Recognition of Resident Self Determination. The Facility is committed to the promotion of the well-being of our Residents. We recognize each residents right to refuse treatment, to live a dignified life, and to self determination, which includes the right to refuse care and to formulate advance directive regarding future care . B. Non Descrimination. We will not descriminate against and Resident or potential Resident on the basis of race, sex, religion, age, handicap or because of a Resident's choice regarding cardiopulmonary resuscitation (CPR), or whether the Resident has signed an advanced directive . Procedures: Generally .B. Obtain Documents. Copies of Advanced Directives will be obtained from the Resident and or family and placed in the medical record. If applicable, A DNR Order will be signed and placed in the medical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Cognitively Impaired Resident Unable to Make Medical Decisions with a Duly Executed Advanced Directive and DNR . The facility shall: >Determine the legal healthcare decision maker (i.e. DPOA-HC or guardian) . >Complete a DNR form if necessary. >Place copies of all paperwork in the Resident's chart. Review the Resident's advance directives quarterly and capacity at least annually and with any significant mental status changes. > If a DNR was requested it is re-signed annually, if still requested . Definition: . D. Do-Not Resuscitate Order (DNR). A DNR is a written document in which the Resident expresses his/her wish that if his/her breathing and heartbeat cease, the Resident does not want to be resuscitated. Unlike DPOA and living Wills, under certain conditions DNRs may also be requested by a patient advocate or a guardian, as well as the Resident themselves. A DNR becomes effective upon signature.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview, and record review the facility failed to provide a clean, comfortable and home like environment to ensure that residents' rooms, were clean, uncluttered, and in good repair, resulting in an unhomelike physical environment, with electric razors plugged in and resting over the back of toilets, chairs in disrepair and residents' rooms with drywall gouges and holes in the walls. Findings Include: FACILITY Environment On 10/27/2024 at 12:35 PM, Resident room [ROOM NUMBER] was observed to have large gouges and holes in the wall. When a Confidential Resident was asked about the damaged wall, the resident stated, They were going to fix it and didn't. I've been here since the beginning of the year. The gouged and open areas were near the head of the bed behind the chair and on the other side of the room on the opposite wall. 39059 On 10/27/24, at 11:22 AM, an observation of room [ROOM NUMBER] was conducted. There was an approximate 1-foot square of chipped drywall. On 10/27/24, at 11:40 AM, An observation of room [ROOM NUMBER] revealed an approximate 10 inch by 2-foot area with chipped drywall. On 10/27/24, at 11:25 AM, an observation of room [ROOM NUMBER] revealed, Resident #66 was sitting in their chair. The fan was pointed toward the resident and was on. The fan had a large amount of dusty buildup. The room smelled of urine. The bathroom floor was dirty and sticky with dried urine. There was an electric shaver plugged in and resting on the back of the toilet. The cord was long and appeared to be able to reach the toilet water. On 10/28/24, at 9:18 AM, an observation of room [ROOM NUMBER] revealed the shaver remained plugged in and resting on the back of the toilet. Resident #66's fan was off and remained with dusty build up. On 10/29/24, at 10:07 AM, an observation of room [ROOM NUMBER] revealed an electric shaver plugged in resting on the back of the toilet in reach of the toilet water. CNA E was asked if they normally store the electric shavers plugged in so close to the toilet water and CNA E offered, we normally put them away but it was running out of battery. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided Resident's Personal Property Last Revised 9/22/2023 policy revealed . Residents are permitted to keep reasonable amounts of personal clothing and possessions for their use while residing in the facility. Residents' property will be kept in a safe location that is convenient to the resident .

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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** 22348 Based on observation, interview and record review, the facility failed to ensure comprehensive revised care plans for four residents (#26, #47, #53 and #68) out of five residents reviewed for care planning, resulting in unassisted unsafe ambulation, unassessed nutritional needs with the likelihood of unmet care needs and code status and the potential for a resident to receive life-sustaining medical treatment against their wishes. Findings include: Resident #26: On [DATE], at 9:24 AM, Resident #26 ambulated from the bathroom to their bed. Resident #26 was not assisted, was not wearing shoes and was not using any Assistive device. Resident #26 leaned forward and grabbed the foot of the bed. They used the bed for support to ambulate around to the right side of the bed where they sat down. On [DATE], at 11:04 AM, a record review of Resident #26's electronic medical record revealed an admission on [DATE] with diagnoses that included Diabetes, History of falling, legally blind and Urostomy. Resident #26 required assistance with Activities of Daily Living. A review of Kardex as of [DATE] revealed no mention as to how much assistance Resident #26 required for ambulation and transfers. A review of the care plans revealed no intervention listed as to what assistance or any Assistive device the resident required for ambulation and transfers. Resident #53: On [DATE], at 12:57 PM, an observation of Resident #53 in their room. There was an electronic machine on their nightstand. There was a sticky note attached with certain cardiac information listed. On [DATE], at 11:00 AM, a record review of Resident #53's electronic medical record revealed an admission on [DATE] with diagnoses that included Paroxysmal Atrial Fibrillation, Diabetes and Left bundle branch block. A review of the care plan Focus (the resident) is at risk for cardiac complications r/t multiple cardiovascular diseases: Heart Failure, CAD, HTN, Pacemaker, Atrial Fibrillation, Lymphedema Date Initiated: [DATE] . Goal (the resident) will be free from s/sx of cardiac complications through the review date . There was no mention as to the pacemaker [NAME] machine at the bedside. On [DATE], at 2:20 PM, Resident #53 offered they weren't sure the name of their cardiologist and that the machine was for their pacemaker. Resident #53 offered that they had a cardiac ablation and that if they called their wife she would have all the information needed for the machine and the heart doctor. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #47(R47): Care Plan Advance Directives According to the Electronic Medical Record (EMR) reviewed on [DATE] at 3:30 PM, R47 was admitted to the facility on [DATE] with the diagnosis of Unspecified Dementia, Psychotic Disorder with Delusions, General Muscle Weakness and the need for assistance with personal care in addition to other diagnoses. According to the face sheet, R47's daughter is the established Power of Attorney (POA). R47's Brief Interview for Mental Status (BIMS) Score is ,d+[DATE]. A ,d+[DATE] score indicates that the person has severe cognitive impairment. The Do-Not-Resuscitate Order Form was reviewed dated [DATE] for R47 was reviewed. A physician's signature was noted, dated [DATE]. However, the nurse wrote the co-advocate's name and noted phone date as [DATE]. There was no follow-up signature of the POA, and I was not given the right to sign the DNR papers. [DATE] 10:27 AM The DNR Order was not signed or validated by the guardian/POA. A Physician's order in R47's EMR dated [DATE], No CPR/DNR. (No Cardiopulmonary Resuscitation/Do-Not-Resuscitate) R47's care plan is a full code dated [DATE], which does not match the DNR Form. The care plan was never revised to match according to the DNR Order Form signed by the physician on [DATE]. The Care Plan's intervention was not followed: > Code status will be reviewed upon readmission, quarterly, significant change in condition, and at the resident's or responsible party's desire. (initiated and created on [DATE]) > The facility representative will attempt to contact the responsible party/emergency contact in emergencies. (initiated and created on [DATE]) > The facility will make attempts to sustain life in emergency situations. (initiated and created on [DATE]) Resident# 68 (R68): Care Plan Wound Management A review of the Electronic Medical Record EMR on [DATE] at 3:30 PM revealed that R68 was [AGE] years old and admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease with Early Onset Type 2 Diabetes Mellitus and Major Depression. R68's Brief Interview for Mental Status BIMS score was ,d+[DATE] and assessed on [DATE]. His Care Plan for at-risk for impaired skin integrity was last revised on [DATE]. One of the interventions specified: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	> Observe skin with showers/care. Notify the nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, or discoloration noted during bath or daily care. > Conduct weekly head-to-toe skin assessments and document and report abnormal findings to the physician. During the tour observation on [DATE] at 02:11 PM, R68 complained about his bedside chair being in disrepair and needed to be replaced. R68 revealed he asked more than a week ago, and the reason why was he had cuts all over the left forearm due to the broken part on the chair (observed that a piece of the handle broke with an exposed metal sticking out) of the arm of the chair. He stated, It has a sharp edge and cuts my arm. On [DATE] at approximately 3:30 PM. R68 was found sitting in a wheelchair after a shower in front of the nurses' station with at least six other residents around him. It was noted that his left forearm was bleeding, dripping from a scabbed open area. The new nurse orientee was alone, passing pills. When alerted, she confirmed the area was bleeding and said she would take care of the bleeding arm immediately. During the interview with DON the following morning, [DATE], at 09:28 AM, the surveyor inquired with the Director of Nursing DON regarding R68's bleeding arm. The DON discovered after a review of records from yesterday, [DATE], that: 1. There was no record of assessment or nursing note documented related to the left forearm bleeding/cut of R68 found on [DATE] at 2:30 PM. 2. There is no incident report or investigation as to the cause of the cut and bleeding. 3. No treatment order was documented for R68 from yesterday's date [DATE]. 4. No care plan related to skin impairment was updated When the treatment started on [DATE], there was NO documentation of any wound assessment, and treatment in place No care plan update or revision was noted on [DATE] as conformed with the DON on [DATE] at 10:30 AM. The nurses' notes were reviewed on [DATE] at 4:01 PM, and the nurses' notes were entered on [DATE] at 10:55 AM. Note Text: Assessed area Left arm. Noted to have a scabbed area that is intact. No s/s of infection. Resident denies pain or discomfort at this time. A wound treatment order was entered on [DATE] at 1900. The new order was to Cleanse the scabbed area to the left posterior arm with normal saline. May cover with dry dressing if drainage is present. Monitor for s/s of infection. The facility's Skin Management Policy was requested on [DATE] at 10:30 AM and was reviewed at 4:00 PM. It indicated that Residents with wounds and or pressure injury and those at risk for skin compromise are identified, evaluated, and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest resident outcomes. 39059

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 37771 Based on observation, interview and record review, the facility failed to ensure that professional standards of care were followed during medication administration of nebulizer treatment for one resident (Resident #82) and supervision of medication administration for one resident (Resident #50), of seven residents reviewed for medication administration, resulting in Resident #82 not observed during the administration of nebulizer medication, a lack of getting the prescribed amount of nebulizer medication, and the likelihood of medication not administered as prescribed/scheduled for Resident #50 and the exacerbation of medical conditions, Findings include: Resident #82: On 10/29/24 at 8:42 AM, the Medication Administration task of the survey was started. The following were observed: -At 9:42 AM, Nurse T was observed to prepare Resident #82's medications by removing the pills from the blister packets. Nurse S was observed to prepare the insulin. Nurse S uncapped the needle of the syringe, inserted the needle into the insulin vial, extracted the insulin and when completed with getting the amount needed from the vial, the Nurse recapped the insulin syringe with the cap that was between her 5th digit and palm of her hand. The Insulin syringe had a guard that could be extracted to cover the needle without having to recap the needle. -Nurse S gave the medications that were prepared by Nurse T to Resident #82. -Nurse S put the nebulizer medication, Ipratropium-Albuterol inhalation solution, for Resident #82 into the medication chamber of the nebulizer handheld apparatus, gave instructions to the Resident on how to turn on the machine, and pulled the curtain. The Resident was unable to turn on the machine and the Nurse opened the curtain, showed the Resident how to turn on the machine and pulled the curtain around the Resident. The Resident had been asking for help to get her shirt off. The Nurse left the room. The Resident could be heard from the hallway saying, Oh Please, and asking for help. Nurse S had not returned to ensure the Resident was doing the breathing treatment. An observation was made of the Resident sitting on the side of the bed and the nebulizer on the bed next to the Resident. Nurse T who was at the medication cart, was told the Resident was not using her nebulizer treatment. Nurse S returned to the medication cart and reported to Nurse T that the Resident wanted her shirt off but had to finish the breathing treatment. The Resident was told to continue the breathing treatment, neither Nurse S, nor Nurse T stayed with the Resident to observe if the Resident had completed the remainder of the nebulizer treatment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Once the first nebulizer was completed for Resident #82, the Nurses did not listen to the Resident's lung sounds, monitor oxygen saturation, respirations or heart rate. The Resident was observed to be sitting on the side of the bed, appeared to be short of breath, asked for a breathing treatment and requested to have her shirt taken off due to it being tight. The Resident had a gown on, which she had a shirt on before that had been changed. Nurse S told her she had her gown on, and the shirt was changed. Nurse S was given the Resident's second medication for nebulizer treatment, Nurse S was not the Nurse who checked the medication record for the Resident or signed out the medication from the medication cart. Nurse S did not listen to lung sounds, monitor oxygen saturation or heart and respiratory rate. -At 10:00 AM, Resident #82 was given the second breathing treatment, Budesonide Inhalation Suspension, administered by Nurse S. The Nurse put the medication into the medication chamber of the nebulizer, instructed the Resident on how to turn on the machine. The Resident reported she could not turn it on, the Nurse showed her again how to turn it on, pulled the curtain and the Resident turned on the machine. The Nurse left the Resident to do the breathing treatment on her own without supervision. -After the second nebulizer was completed at 10:10 AM for Resident #82, Nurse S instructed the Resident to shut off the nebulizer. The Resident had not been observed during the administration of the medication. Nurse S listened to the Resident lungs at this time and got the oxygen saturation. On 10/29/24 at 2:20 PM, an interview was conducted with the Director of Nursing (DON) regarding concerns observed during the medication administration task of the survey. The nebulizer treatments for Resident #82 were reviewed of the Nurses not watching the Resident while administration of the medication. The DON was asked if the Resident had an evaluation to administer her own medication. The DON reviewed the Resident's medical record and reported the Resident did not. The DON indicated that the Nurse should observe the Resident getting the nebulizer treatment until completion. When asked about nebulizer treatment policy on assessment, the DON reported the Nurse was to check the lung sounds, pulse oxy (oxygen saturation), and pulse/respirations before and after the nebulizer treatment. A review of the facility policy received titled, Nebulizer therapy, small volume, revealed, .Obtain the patient's vital signs, assess the respiratory status, as ordered . As needed, assist the patient with applying the mouthpiece of mask, depending on the delivery system and patient-related factors, such as age and physical and cognitive ability .Remain with the patient and continue the treatment until the nebulizer begins to sputter. After treatment, obtain the patient's vital signs, assess the respiratory status, as instructed . 39059 Resident #50: On 10/27/24, at 12:03 PM, Resident #50 was sitting their wheelchair in their room. There was a plastic medication cup with numerous white pills in it sitting on their over bed table. Resident #50 moved about in their wheelchair toward the table, picked up the medication cup and took the medications. There was no nurse nor staff in the room. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/27/24, at 12:10 PM, Nurse F was standing at the medication cart down the hallway. Nurse F was asked if they were aware that Resident #50 had a cup of medications in their room that they consumed and Nurse F stated, Yeah. I just gave them to him. On 10/28/2024, at 11:30 AM, a record review of Resident #50's electronic medical record revealed an admission on 11/15/2022 with diagnoses that included Heart failure, chronic kidney disease and heart attack. A review of the care plans revealed no care planned intervention for self-administration of oral medications. On 10/29/24, at 9:15 AM, the Director of Nursing (DON) was alerted of the medication observation of Resident #50 on 10/27/24. The DON was asked to provide the medication administration policy. A review of the facility provided policy Medication Administration Last Revised 10/17/2023 revealed . Self-administration of medication will be reflected in the resident care plan along with any special considerations . 7. Observe that the resident swallows the oral medications. Do not leave medications with the resident to self-administer unless the resident is approved for self-administration of the medication .

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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** 39059 Based on observation, interview and record review, the facility failed to provide Activities of Daily Living (ADL) care for two residents (Resident #23, Resident #74) of 18 residents reviewed for ADL care, resulting in soiled hands, unkempt appearance, and a lack of showering/bathing. Findings include. Resident #74: On 10/29/24, at 10:51 AM, Resident #74 was in their room. They had a large amount of brown residue to their right-hand nails and nail beds. On 10/29/24, at 2:26 PM, an observation along with CNA E was conducted of Resident #74's nails. CNA E observed the brown residue and offered, oh yeah it didn't get done. CNA E shortly returned into Resident #74's room with supplies to provide nail care. A review of Resident #74's electronic medical record revealed an admission on 01/15/2024 with diagnoses that included Dementia, Heart Failure and kidney disease. Resident #74 had severely impaired cognition and required assistance with all ADL's including PERSONAL HYGIENE: Resident (requires one assist Date Initiated: 12/06/2023 . A review of the Kardex as of 10/29/2024 revealed Keep fingernails trimmed and clean. 37771 Resident #23: A review of Resident #23's medical record revealed an admission into the facility on [DATE] with diagnoses that included chronic kidney disease, muscle weakness, need for assistance with personal care, obesity, and dependence on renal dialysis. A review of the Minimum Data Set assessment revealed the Resident had intact cognition and needed substantial/maximal assistance with shower/bathe self. On 10/27/24 at 1:31 PM, an observation was made of Resident #23 sitting in her recliner chair and was dressed. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about ADL care and showering. The Resident reported she did not get her shower on Saturday, indicated she got a shower twice a week. The Resident expressed frustration and stated, They said I refused it because my daughter was coming. I would never have said that. My daughter would have waited for me. Now I don't get one until Tues. When asked why they won't give her one today (Sunday), the Resident explained that it does not fit into their schedule. The Resident was asked if they offered to come back and do it another time or reschedule it, the Resident reported that did not offer. The Resident reported it was her word against mine, and that it was not offered to do it at another time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #23's medical record of the shower/bathing task revealed the Resident was marked as refused for the shower task on 10/25/24. Further review of the medical record revealed a lack of a progress note to identify that the nurse was notified, why the resident refused, and a plan for the refusal. On 10/28/24 at 2:54 PM, an interview was conducted with the Director of Nursing (DON) regarding the lack of a shower for Resident #23. The task for the refusal of the shower on 10/25/24 was reviewed with the DON. The DON was asked about facility policy of refusal of care. The DON indicated staff were to offer three times and let the nurse be aware the resident refused, and the nurse can adjust everything accordingly. When asked if that would be setting up another time, the DON reported yes, it would be up to the Resident when they wanted to shower, it would be the Resident preference. The CNA was not working this day and the Nurse on during that time, the DON reported she worked evenings. When asked about documentation, the DON indicated the Nurse should be documenting the resident refused and the plan moving forward. When asked if they can take showers on other days including the weekends, the DON stated, Yes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 Based on observation, interview, and record review, the facility failed to ensure ambulation supervision and ensure that a safety care plan was followed for two residents (Resident #71 and Resident #38) at risk for falls, and prevent/assess/document an injury from furniture in disrepair for one resident (Resident #68), of 4 residents reviewed for falls and safety, resulting in the potential for serious harm or injury from a fall and a delay in treatment for R#68's forearm cut from a sharp edge of broken furniture. Findings include: Resident #38 (R38): Accidents During the observation tour conducted at the 200 Hall on 10/27/24 at 1:00 PM, R38 got out of bed and was observed walking with an unsteady gait out in the hallway. The staff was busy and not in sight because they were attending to another resident in the other room. The surveyor called for the nursing assistant's (CNA F) attention, and CNA F immediately took R38 back to her room. CNA F confirmed that R38 needed supervision when ambulating and will need her wheelchair for safety. CNA F explained that the other CNA in the unit is on lunch break, so she is by herself. It is just her, the nurse, and the housekeeper right now. On 10/29/24 at 09:42 AM, a review of R38's fall on 6/4/2024 at 7:12 AM revealed that R38 was observed on the floor with no reported injuries or complaints of pain. R38 got up with the staff and ambulated back to her room with no difficulty. R38 was sent to a nearby urgent care center for an X-ray, evaluation, and treatment. R 38 returned on the same day, 6/4/24, with no injury. On 10/29/24 at 3:19 PM, R38's Electronic Medical Record revealed that R38 was [AGE] years old and admitted to the facility on [DATE] with a diagnosis of dementia, major depression, and anxiety disorder in addition to other diagnoses. R38 Brief Interview for Mental Status Score dated 8/13/24 was 3/15. A BIMS score of 0-7 indicates that the patient has severe cognitive impairment. The minimum data set (MDS), dated [DATE], ambulates independently, and the R38 Care Plan for at-risk elopement/exit seeking and wandering and for fall was reviewed. R38 was at risk for falls related to injury, confusion, and poor safety awareness. Resident #71 (R71): Accidents On 10/27/24 at 01:18 PM, R71 was observed walking in the hallway without assistance, such as a walker or wheelchair, for safe ambulation. R71 walked slowly in the hallway outside her room, unsteady and wobbly. The housekeeping staff helped walk R71 to her room and sat her in the wheelchair. The housekeeping staff spoke gently and was helpful to R71. The surveyor found the nurse attending to another resident across the hall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R71's EMR on 10/28/24 at 10/15 AM revealed R71 was [AGE] years old and admitted to the facility on [DATE], with a diagnosis of Alzheimer's Disease, Dysphagia, muscle weakness (generalized), and the need for assistance with personal care. A review of R71's Fall incident reports revealed that there were multiple falls that had caused various injuries, from no injuries to minor abrasions and lacerations up to fractures of the humerus and sacrum.: Fall 1: #1 Fall Incident Report dated 8/2/23 at 10:23 AM revealed that staff was in the hallway and heard someone yelling for help. Upon entrance into the room, resident was in front of the bathroom door, lying on the right side with legs out straight with slight bend in knees . The resident was yelling and screaming out in pain r/t shoulder pain. Resident was noted to have a cut on the right eyebrow and left knee. Resident was sent to nearby urgent care for further evaluation and treat. Resident sustained a skin tear on the right knee and face. 8/4/24 Post Fall Notes: Indicated R71 was sent to the hospital post-fall and returned with a humerus fracture. Fall 2: #2 Fall Incident Report dated 6/12/2024 at 01:50 AM. Revealed: CNA heard a loud noise upon entering room observed res. Sitting on the floor, legs outstretch, bare feet. Roommate witnessed the fall. Resident was not wearing gripper socks or slippers. Stated pain to buttocks. A review of the hospital radiology report dated June 18, 2024, revealed that R71 was sent to the nearby Urgent Care post-fall due to a complaint of pain after a fall. Results indicated a nondisplaced fracture of the sacrum at the anterior cortex of the S2 vertebral body. Fall 3: #3 Fall Incident Report occurred on 6/27/24 at 12:25 AM. R71 was found lying on the floor in the room on her back . The resident was pleasantly confused. Abrasion noted to Rt. Elbow . Res. c/o pain to the pelvic area and said, a little pain to the left shoulder. Fall 4: #4 Fall Incident Report dated 8/16/2024 at 5:15 AM revealed R71 was observed sitting on knees on the floor facing the hall in front of the other resident's bed. Pants down to knees, with urine on the floor . Res. said she was trying to go to the bathroom. Self-transferring, no injuries, no complaints of pain. Denied hitting head. R71 on 8/16/24 fall did not have injuries. R71's at-risk-for-fall care plan was reviewed on 10/29/24 at 3:15 PM, gripper socks were not put in place when the resident fell on [DATE]. R71 sustained a sacral fracture on 6/12/24. All four falls were unwitnessed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview CNA F assigned to R38 and R71 on 10/27/25 at 1:16 PM. She explained that the second CNA was on lunch break and taking care of other residents, so she could not supervise other residents, and there were too many residents all at once. The fall policy was requested on 10/29/24 at 10:30 AM and reviewed at 4:00 PM. The facility's Fall Management Policy was reviewed and indicated, The policy will identify hazards and resident risk factors and implement interventions to minimize falls and risk of injury related to falls, Each resident is assisted in attaining and maintaining his or her highest practical level of function by providing the resident adequate supervision, assistive devices, and or functional programs as appropriate to minimize the risk for falls . The policy was last revised on 9/22/2023. Resident# 68 (R68): A review of the Electronic Medical Record EMR on 10/28/24 at 3:30 PM revealed that R68 was [AGE] years old and admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease with Early Onset Type 2 Diabetes Mellitus and Major Depression. R68's Brief Interview for Mental Status BIMS score was 8/15 and assessed on 8/8/24. His Care Plan for at-risk for impaired skin integrity was last revised on 8/24/24. One of the interventions specified: > Observe skin with showers/care. Notify the nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, or discoloration noted during bath or daily care. > Conduct weekly head-to-toe skin assessments and document and report abnormal findings to the physician. During the tour observation on 10/27/24 at 02:11 PM, R68 complained about his bedside chair being in disrepair and needed to be replaced. R68 revealed he asked more than a week ago, and the reason why was he had cuts all over the left forearm due to the broken part on the chair (observed that a piece of the handle broke with an exposed metal sticking out) of the arm of the chair. He stated, It has a sharp edge and cuts my arm. On 10/28/24 at approximately 3:30 PM. R68 was found sitting in a wheelchair after a shower in front of the nurses' station with at least six other residents around him. It was noted that his left forearm was bleeding, dripping from a scabbed open area. The new nurse orientee was alone, passing pills. When alerted, she confirmed the area was bleeding and said she would take care of the bleeding arm immediately. During the interview with DON the following morning, 10/29/24, at 09:28 AM, the surveyor inquired with the Director of Nursing DON regarding R68's bleeding arm. The DON discovered after a review of records from yesterday, 10/28/24, that: 1. There was no record of assessment or nursing note documented related to the left forearm bleeding/cut of R68 found on 10/28/24 at 2:30 PM. 2. There is no incident report or investigation as to the cause of the cut and bleeding. 3. No treatment order was documented for R68 from yesterday's date 10/28/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. No care plan related to skin impairment was updated When the treatment started on 10/28/24, there was NO documentation of any wound assessment, and treatment in place No care plan update or revision was noted on 10/29/24 as conformed with the DON on 10/29/24 at 10:30 AM. The nurses' notes were reviewed on 10/29/24 at 4:01 PM, and the nurses' notes were entered on 10/29/24 at 10:55 AM. Note Text: Assessed area Left arm. Noted to have a scabbed area that is intact. No s/s of infection. Resident denies pain or discomfort at this time. A wound treatment order was entered on 10/29/24 at 1900. The new order was to Cleanse the scabbed area to the left posterior arm with normal saline. May cover with dry dressing if drainage is present. Monitor for s/s of infection. The facility's Skin Management Policy was requested on 10/29/24 at 10:30 AM and was reviewed at 4:00 PM. It indicated that Residents with wounds and or pressure injury and those at risk for skin compromise are identified, evaluated, and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest resident outcomes.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on observation, interview and record review, the facility 1) Failed to ensure that urostomy appliance changes were ordered timely, completed per physicians' orders, and there was a completion of a comprehensive bladder elimination care plan and 2) Failed to obtain a physician's order for a urinary indwelling catheter for two residents (Resident #23, Resident #26), resulting in delayed and missed urostomy appliance changes, unmet care needs with the likelihood of further missed care needs, infection and complications from an indwelling urinary catheter. Findings include: Resident #26: On 10/28/24, at 11:04 AM, a record review of Resident #26's electronic medical record revealed an admission on 06/20/2024 with diagnoses that included Diabetes, History of falling, legally blind and Urostomy. Resident #26 required assistance with Activities of Daily Living. A review of the TREATMENT ADMINISTRATION RECORD 6/1/2024-6/30/2024 revealed no ostomy appliance changes from admission on 06/21/2024 through the end of the month. A review of the TREATMENT ADMINISTRATION RECORD 7/1/2024-7/31/2024 revealed no ostomy appliance changes until Mon 8 (7/8/24). A review of the TREATMENT ADMINISTRATION RECORD 8/1/2024 - 8/31/2024 revealed an order Change ostomy appliance and bag q (every) week and prn (as needed) every day shift every 7 day(s) for ostomy care -Start Date- 07/08/2024 revealed the day Mon 5 was not completed for both the ostomy appliance change and ostomy care. A review of the PRN for the corresponding day revealed no appliance change nor ostomy care for Mon 5. A review of the TREATMENT ADMINISTRATION RECORD 10/1/2024-10/31/2024 revealed a missed ostomy appliance change for Mon 14. On 10/29/24, at 12:30 PM, Resident #26 was resting on their bed in their room. They offered that at times they do their own ostomy care. An observation of the ostomy barrier/wafer revealed additional plastic tape which bordered the entire barrier. There was an area to the right side that was not adhered and the skin was creased. Resident #26 was asked who placed the tape and Resident #26 offered, that they do that themselves and that his wife brings the tape in from home. On 10/29/24, at 1:21 PM, Nurse C was interviewed regarding Resident #26 ostomy and if they were aware that the resident reinforces the barrier dressing and has done his own ostomy care while in the facility and Nurse C offered, they rely on the nurses for the smaller assessments. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24, at 1:24 PM, an observation along with Nurse C of Resident #26's ostomy and barrier dressing was conducted. The ostomy dressing remained bordered with the plastic medical tape. There was a crease in the skin to the 3 o'clock area. Resident #26 explained to Nurse C that they reinforce the barrier with their home brought tape. A further review of the care plans revealed Focus (the resident) is at risk for potential complications R/T: urostomy . Interventions Observe stoma site and surrounding skin . Ostomy care as ordered and PRN. Date Initiated: 06/21/2024 There was no mention the resident at times does his own care and that they use tape from home to reinforce the border dressing. 37771 Resident #23: A review of Resident #23's medical record revealed an admission into the facility on [DATE] with diagnoses that included chronic kidney disease, muscle weakness, need for assistance with personal care, obesity, and dependence on renal dialysis. A review of the Minimum Data Set assessment revealed the Resident had intact cognition and needed substantial/maximal assistance with shower/bathe self. On 10/27/24 at 1:31 PM, an observation was made of Resident #23 sitting in her recliner chair and was dressed. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about urinary issues. The Resident explained that at this time she had a Foley catheter that collected the urine. The Resident explained that they collected urine four times to get a 24-hour collection and reported the last one collected was a couple days ago since there was one specimen that got lost or spilt after it had left the facility. The Resident reported that they didn't take out the catheter because they didn't want to keep taking it in and out and they were going to wait for the results, so they left it in. When asked if she had issues with her bladder, the resident indicated she did not, but they wanted the 24-hour specimen and they didn't think the collection was accurate with voiding on her own and reported that was why she had the catheter placed. The Resident reported that she had the collection a couple days ago and they were waiting for results to come back before they took the catheter out. A review of the medical record revealed a progress note dated 10/27/24 at 5:00 AM, This RN contacted (lab services) and spoke with tech re: whether they had received and were processing a 24 hrs Urine collection done by us for (name of dialysis center) on 10/25/24? (Name of Lab) Tech stated that he didn't find any documentation for urine. This RN will continue to maintain Foley to dependent drainage bag system currently in place since 10/24/25(24) placement for 24 hr urine collection . The order for urinary collection was dated 10/23/24, Insert Foley cath 16 French 10 cc (cubic centimeters) balloon this evening. Leave in place until 24 hour urine obtained per (Physicians name) request. One time only for 24 hr urine collection for dialysis for 1 Day. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 2:59 PM, an interview was conducted with the Director of Nursing (DON) regarding the collection of urine for testing for Resident #23. The DON reviewed the medical record and reported the last time the urine was collected was on 10/24, with the order written on 10/23 for the 24-hour urine collection. The DON was asked if the urinary catheter was to be left in after the collection of urine. The DON stated, They should have gotten an order to leave it in or what ever he wanted to do. A review of the medical record revealed no order to have the catheter left in after the collection of the urine and no documentation that the practitioner had been notified. The DON was unsure if the physician had been notified and called Nurse S on the phone to asked if they had notified the physician. Nurse S answered the phone and reported she had left a message Friday (10/25) evening but had not received a message back and that the Resident had wanted the catheter continued until the laboratory results were back. The DON indicated a note should be documented regarding the physician notification and an order should have been received if the urinary catheter was to be continued.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review the facility failed to assess, monitor and ensure that interventions were enacted to promote nutrition and prevent weight loss for one resident (Resident #139) of 5 residents reviewed for food or nutrition, resulting in Resident #139 lacking nutritional assessments to aid in the identification of nutritional needs. Findings Include: Resident #139: Nutrition On 10/27/2024 at 2:38 PM, Resident #139 was heard yelling out and moaning. He was observed sitting in bed with his lunch tray at the bedside. The lid was on it and the resident said he did not feel like eating. He said after a while they would take his meal tray. He said he wished they wouldn't take it. A record review of the Face sheet and medical record indicated Resident #139 was admitted to the facility on [DATE] with diagnoses: acute respiratory failure, COPD, metabolic encephalopathy, weakness, need for assistance with personal care, diabetes, end stage kidney disease, acute kidney failure, need for dialysis, Addison's disease, hypothyroidism, hypertension, mild cognitive impairment, and unstageable pressure ulcers left and right heels. The Minimum Data Set/MDS assessment was not yet completed. A review of the Tasks eating documentation for Resident #139 from admission on 10/23/2024 to 10/28/2024 indicated the resident had food intake at 3 meals since admission: 0-25% on 10/27/2024 at supper, 26-50% on 10/26/2024 at supper and 76-100% on 20/26/2024 at lunch. All other meals were documented as Resident Refused/ 7 times or Resident Not Available/ 5 times. On 10/25/2024 there was no documentation for supper. A review of the Kardex for Resident #139 revealed, Eating: Resident requires assist; Provide diet as ordered. Observe and document food acceptance and offer substitutes as needed. A review of the Weight Summary for Resident #139, revealed 2 weights: 244.5 lbs. on admission on 10/23/2024 and 234.5 lbs. on 10/28/2024. The resident had lost 10 lbs. in 5 days. A review of the physician's orders identified the following: Vital signs and weights monthly, dated 10/23/2024. Renal diet, Regular texture, Thin consistency, dated 10/23/2024. Resident receives dialysis . on M-W-F at 545 AM . dated 10/24/2024. A review of the Care Plans for Resident #139 indicated the following: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident is at risk for Nutritional decline r/t (related to), date created and initiated 10/24/2024. There were no details or reason why the resident was at risk for nutritional decline. There were no goals. There were no interventions. The Care Plan was blank and not specific to Resident #139's nutritional needs. On 10/29/2024 at 12:45 PM, Registered Dietitian/RD L was interviewed. She said she had worked at the facility for 3 months as a Corporate RD. She said she was filling in at the facility and also had 3 additional facilities that she was responsible for. The RD said the facility was trying to hire a permanent dietitian. Registered Dietitian L said she was at the facility once a week, on Mondays to assess the residents. During the interview with RD L on 10/29/2024 at 12:45 PM, she was asked about Resident #139 and she stated, He is newly admitted and on dialysis. When I went in yesterday, he was sleeping. I have not assessed him yet. I haven't assessed him, so I don't know. The RD was asked who performed the nutritional assessments and she said the Registered Dietitian performed the assessments. Reviewed with the RD that Resident #139 had eaten almost nothing since admission and from 10/23/2024-10/28/2024 and had lost 10 lbs. The Registered Dietitian said she had not seen Resident #139's weights or Food Acceptance and did not know his nutritional needs. Reviewed with the RD that Resident #139's Nutritional Care Plan was blank, and she said she had not yet assessed the resident and that was why it was blank. The RD was asked why Resident #139 had not been assessed since he was diabetic, receiving dialysis and not eating. She said she was trying to assess other residents that were admitted before him. Reviewed with the RD that as of the time of the interview, there were no additional interventions for the resident to aid in promoting nutrition and there were no additional dietary notes. On 10/29/2024 at 1:00 PM, Physician M was interviewed about Resident #139, he said the resident was being transferred to the hospital for a change of condition. He said the resident had heart issues and Addison's disease along with being diabetic and receiving dialysis. He said the resident had an episode earlier that day where he was not responsive. Reviewed with Physician M that Resident #139 had been heard yelling out and moaning on several occasions and he had almost no food intake since admission. The Physician said the resident was very ill. On 10/29/2024 at 2:22 PM, Unit Manager C was interviewed about Resident #139's poor food intake and weight loss. The Unit Manager C said she had sent a Communication Form to RD L on 10/24/2024 related to Resident #139 having wounds on both heels. The RD responded on 10/28/2024. Unit Manager/UM C said when a resident was identified to have wounds, she would send the Registered Dietitian/RD a Communication Form to ensure the RD was aware and the resident would receive the necessary nutrition to promote wound healing and prevent further breakdown. A review of the facility policy titled, Nutritional Services Documentation, date originated 9/1/2013 and revised 9/19/2024 provided, . Each resident will receive a comprehensive nutritional evaluation upon admission, annually, and when a resident is identified as having a significant change in status . The nutritional evaluation encompasses the medical data, physical condition and examination, nutritional history, social history, and nutrient assessments . The Certified Dietary Manager/Registered Dietitian uses the Nutritional Evaluation form to complete an assessment of each resident's nutritional status, problems, need and capabilities on admission, readmission, annually and with a significant change of condition. A new Nutritional Risk Screening Score form is completed on all residents within five days of admission .

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to assess, monitor, and provide pain management for two residents (Resident #138, Resident #139) of 6 residents reviewed for pain management, resulting in the residents' verbalizations of unrelieved pain, frustration and helplessness. Findings Include: Resident #138: Pain Management A record review of the Face sheet and electronic medical record (EMR) for Resident #138 indicated the resident was admitted to the facility on [DATE] with diagnoses: pancreatic cancer, right upper quadrant abdominal swelling, mass and lump, anemia, diabetes, anxiety, depression, malignant ascites (fluid build up in abdomen), heart disease, right buttock Stage 2 pressure ulcer, left buttock Stage 3 pressure ulcer and GERD (gastroesophageal reflux disease). The resident was receiving Hospice services and died on [DATE]. On [DATE] at 11:30 AM, Resident #138 was heard moaning loudly from his room. Upon entry into his room, the resident was observed lying in bed and moving around. The resident said he was uncomfortable and had pain. He said he had pancreatic cancer and a lot of abdominal pain and motioned to his abdomen. The resident was asked if he had pain medication and he said he did, but was not sure if it was working. On [DATE] at 11:45 AM, Nurse N was observed in the hall preparing medications for another resident. Resident #138 could be heard moaning loudly. The nurse was asked about Resident #138. She said the resident had cancer and was having pain. She said he had received something for pain. Nurse N said she was also assigned to another unit (400 Hall) in the middle of the building. It was not visible from the Resident's unit and hallway, and she could not hear the resident when he was calling out. On [DATE] at 3:30 PM, Resident #138 had multiple instances of yelling out and moaning in pain during the day. A record review of the Pain Level Summary documentation for Resident #138 from [DATE] to [DATE] revealed Pain assessments were being routinely completed for the resident in the evening and early morning (usually before 7:00 AM). There were 3 mid- morning pain assessments: 8:10 AM on [DATE], 8:29 AM on [DATE] and 11:22 AM on [DATE]. All but 2 of the pain assessments were completed by the night shift nurse. The resident was not being assessed for pain during the day/afternoon. The pain scores ranged from ,d+[DATE]. A record review of the physician's orders for Resident #138 on [DATE] revealed the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Oxycodone HCl capsule 5 mg, give 1 capsule by mouth every 6 hours as needed for moderate to severe pain, start date [DATE]. Omeprazole DR 20 mg capsule, Give 1 capsule by mouth one time a day for GERD, start date [DATE]. Meclizine HCl oral tablet 25 mg, Give 1 tablet by mouth every 8 hours as needed for Nausea or vertigo, start date [DATE]. Morphine sulfate solution 20 mg/ml, Give 0.5 ml by mouth every 4 hours as needed for Pain or shortness of breath, start date [DATE]. Oxycontin oral tablet ER 12 HR (Abuse-Deterrent) 10 mg (Oxycodone HCl), Give 1 tablet by mouth every 12 hours for pain, start date [DATE]. A record review of the [DATE] Medication Administration Record/Treatment Administration Record (MAR/TAR) for Resident #138 indicated the resident had received the following: 6 doses of Oxycodone from admission on [DATE]-,d+[DATE]. He was provided the medication sporadically: No doses were provided on [DATE]; 2 doses (at 5:45 AM and 10:44 PM) on [DATE]; 1 dose (at 11:50 PM) on [DATE]; 1 dose (at 6:47 AM) on [DATE]; no doses on [DATE]; 2 doses on [DATE] (at 2:05 AM and 8:10 AM). Omeprazole was received daily at 6:00 AM from [DATE]- [DATE]. Meclizine for nausea was not administered. Morphine was not administered from [DATE]-[DATE]. Oxycontin: The resident did not receive the medication on [DATE] at 9:00 PM (Hold), [DATE] 9:00 AM (not available), [DATE] 9:00 AM (not available). On [DATE], Resident #138's pain was rated at a 6 from a ,d+[DATE] scale (with 10 being the highest amount of pain) at 8:10 AM, he received Oxycodone and Oxycontin as ordered at that time and continued to yell out in pain at 11:45 AM. Further review of the Pain assessments for Resident #138 from [DATE] revealed the resident's pain had increased and was repeatedly rated from ,d+[DATE]. There were multiple instances that the resident's pain was a 10. Further review of the physician's orders indicated the Morphine and Oxycodone orders were adjusted on [DATE] due to the increased pain. Oxycodone HCl ER tablet 12 hour Abuse-Deterrent 20 mg, Give 1 tablet by mouth every 12 hours for moderate to severe pain, start date [DATE]. Morphine Sulfate solution 20 mg/ml by mouth every 2 hours as needed for Pain or shortness of breath, start date [DATE]. (continued on next page)

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	235456	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtney Manor	1167 E Hopson Street Bad Axe, MI 48413

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On [DATE] the resident had routine and as needed orders for Oxycodone and as needed orders for Morphine. The Oxycontin was discontinued. A review of the Care Plans for Resident #138 identified the following: (Resident #138) is at risk for pain and/or has (specify: acute/chronic) pain rt: Ascites, secondary to pancreatic cancer, date created and initiated on [DATE] with Interventions that included: Anticipate resident's need for pain relief PRN (as needed) and respond immediately to any complaint of pain, date created and initiated [DATE]; Notify physician if interventions are unsuccessful . dated [DATE]. The Pain Care Plan did not specify what type of pain, acute or chronic the resident had. The interventions were not followed. (Resident #138) is at risk for decline in condition, pain . (related to) terminal prognosis . date created and initiated [DATE] with Interventions that included: Observe resident closely for signs of pain, administer pain medication as ordered, and notify physician immediately if there is breakthrough pain . date created and initiated [DATE]. On [DATE] at 2:45 PM, Unit Manager C was interviewed and she said the Resident #138 also had a paper Hospice chart in a binder at the nurses' desk. She said each resident had their own Hospice chart. A review of the paper Hospice chart for Resident #138 was made. There were 2 visits documented in the chart: [DATE] and [DATE] by a nurse. It was noted the resident had verbalized to the Hospice nurse that he was not getting relief from the pain medication. The Hospice Care Plans were reviewed and the Pain Care Plan included Provide Hospice booklet Managing Pain. It was unclear who the booklet was provided to. Resident #139: Pain Management On [DATE] at 2:38 PM, Resident #139 was heard yelling out Help Me and moaning. He was observed sitting in bed. The resident was asked if he was having pain and he said he didn't feel well all over. On [DATE] from 11:30 AM to 4:00 PM, Resident #139 repeatedly yelled out Help Me and was heard moaning. A record review of the Face sheet and medical record indicated Resident #139 was admitted to the facility on [DATE] with diagnoses: acute respiratory failure, COPD, metabolic encephalopathy, weakness, need for assistance with personal care, diabetes, end stage kidney disease, acute kidney failure, need for dialysis, Addison's disease, hypothyroidism, hypertension, mild cognitive impairment, and unstageable pressure ulcers left and right heels. The Minimum Data Set/MDS assessment was not yet completed. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of the Pain Level Summary for Resident #139 from [DATE] the day of admission, to [DATE] revealed there were 9 pain assessments: [DATE] and [DATE] each had 1 assessment. The pain scores were either 0 for no pain or 7 moderate pain. 7 of the assessments were early in the morning prior to 7:00 AM or in the evening or night. 1 assessment was at 8:35 AM and 1 assessment at 4:25 PM. There were no assessments in the late morning or early afternoon. A review of the Physician's orders for Resident #139 on [DATE] at 2:00 PM, identified the following: Zofran oral tablet 4 mg, Give 1 tablet by mouth every 6 hours as needed for nausea/vomiting, start date [DATE]. The resident had no order for pain medication until [DATE] at approximately 2:00 PM: Tylenol Extra Strength oral tablet, Give 500 mg by mouth 3 times a day for pain, dated [DATE]. A review of the Nurses notes for Resident #139 revealed he had fallen 2 times at the facility: [DATE] at 11:25 PM and [DATE] at 1:45 AM. After the fall on [DATE] the resident complained that his right knee was hurting. The nurse applied ice and there was no additional mention of the resident's right knee. On [DATE] at 2:11 PM, Resident #139 was heard repeatedly yelling out for help and moaning. Resident #139 was transported to dialysis at 4:45 AM on [DATE]. He returned approximately 2:00 PM and was yelling out in discomfort, asking to lay down in bed. On [DATE] at 2:13 PM, the staff assisted the resident to lay down and he stopped yelling. Resident #139's sister Confidential Person O was visiting, and she said she went to dialysis with the resident and the dialysis staff had difficulty accessing his catheter. She said they couldn't start dialysis until they removed a clot. Confidential Person O said it took about 1.5 hours. She said it also took longer to have the resident picked up after dialysis and the resident was very uncomfortable. On [DATE] at approximately 11:50 AM, the resident had an episode of unresponsiveness. On [DATE] at 12:30 PM, Physician M was interviewed about Resident #139. He said he was transferring the resident to the hospital. He said the resident had several medical issues including Addison's disease (a chronic condition where the body does not make enough cortisol and aldosterone), kidney failure and an abnormal heart rhythm. Reviewed with the physician that the resident had been yelling out for several days, moaning and calling for help. Also reviewed the resident had 2 falls. The Physician said he had ordered Tylenol the day before. On [DATE] at 2:15 PM, Unit Manager C was interviewed about Resident #139 yelling out all day on [DATE] and after returning from dialysis on [DATE]. Review of the resident's pain assessments were usually completed by the night shift nurse and there was a lack of documentation related to the resident's discomfort and repeated moaning and Help me. The Unit Manager said the resident was confused and pain should always be considered when someone repeatedly yelled out. She reviewed the resident had Tylenol ordered on [DATE] and had not received any. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of the Care Plans for Resident #139 identified the following: (Resident #139) is at risk for pain (related to) Addison's disease and impaired mobility, dated initiated on [DATE] and revised [DATE] with 2 Interventions created and initiated on [DATE]: Encourage/Provide non-pharmacological interventions to prevent/manage pain . and Notify physician if interventions are unsuccessful . There were no additional interventions and there were none prior to [DATE]. A review of the facility policy titled, Pain Management, origination date [DATE] and revised [DATE] provided, The facility will evaluate and identify residents for pain, determine the type, location and severity and develop a care plan for pain management . The International Association for the Study of Pain (IASP) defines pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Persistent pain is defined as pain that continues for a prolonged period of time and that may or may not be associated with a well-defined disease process . In residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors such as: Calling out for help, pained facial expressions, refusing to eat, striking out when moved or touched, increased confusion .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to ensure that orders from the dialysis center were communicated to the practitioner for 2 residents (Resident #23 and Resident #139) of two residents reviewed for dialysis care, resulting in the potential for missed medication regimen, treatment and complications of dialysis care. Resident #23: A review of Resident #23's medical record revealed an admission into the facility on [DATE] with diagnoses that included chronic kidney disease, muscle weakness, need for assistance with personal care, obesity, and dependence on renal dialysis. A review of the Minimum Data Set assessment revealed the Resident had intact cognition and needed substantial/maximal assistance with shower/bathe self. On 10/27/24 at 1:31 PM, an observation was made of Resident #23 sitting in her recliner chair and was dressed. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about dialysis and reported she went to dialysis a couple times a week and was waiting to see if she had to continue after the results of the 24-hour urine test was completed. On 10/28/24 at 2;24 PM, a review of Resident #23's dialysis communication documents were completed. The facility document titled, Hemodialysis Communication Form, dated 10/18/24, revealed the section to be completed at the dialysis unit had the Medication Changes Recommended: Start Lasix 40 mg (milligrams) BID (twice a day). A review of the medication orders revealed no order for Lasix 40 mg BID. The communication form was not initialed by the physician or practitioner and a review of progress notes revealed no documentation that the physician had been notified of the medication change recommendation from the dialysis center and no documentation of rational of why the Lasix medication change recommendation was not to be followed. The Hemodialysis Communication Form dated 9/23/24 revealed documentation in the completed at the dialysis unit area Patient is having anxiety, please give something prior. The form was initialed by the practitioner. Vistaril 25 mg, give 1 capsule by mouth every 24 hours as needed for Panic Attacks for 14 days, with a start date 9/23/24 was ordered. The medication had not been given. A review of the progress notes revealed a lack of documentation if the Resident was offered the Vistaril prior to dialysis and the dialysis communication forms did not include why the Resident had not taken the Vistaril. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 2:41 PM, an interview was conducted with the Director of Nursing (DON) regarding facility communication with the dialysis center for Resident #23. The dialysis communication of recommendations to start Lasix twice a day was reviewed with the DON. The DON reviewed the medical record and reported she did not see that the Lasix was ordered and there was a lack of documentation that the physician had been notified of the recommendation nor was there documentation of rational of why the recommendation was not followed. The DON indicated that when the Resident came back from dialysis, the recommendation should have been communicated with the physician. When asked if the Vistaril was offered prior to dialysis treatments, the DON reported she saw that it had been ordered but the Resident had not been given the medication and with the lack of documentation was uncertain why the Resident had not taken the medication and stated, It would be up to (Resident #23's name) whether she wanted it or not, and indicated she would have to ask the Resident. When asked if the order was communicated to Nursing staff to give prior to dialysis, the DON indicated that communication was lacking in the order. Regarding the recommendations for the Lasix, the DON indicated the physician should have been contacted with the recommendation and a rational if the doctor did not approve of the recommendation. A review of facility policy titled Hemodialysis, revised 9/23/23, revealed, Policy: Residents receiving hemodialysis will be assessed pre and post treatment, and receive necessary interventions . Documentation: Hemodialysis communication form, Progress notes . 37666 Resident #139: On 10/27/2024 at 2:38 PM, Resident #139 was heard yelling out and moaning. He was observed sitting in bed with his lunch tray at the bedside. The lid was on it and the resident said he did not feel like eating. He said he went to dialysis 3 times a week and was going the next day. A record review of the Face sheet and medical record indicated Resident #139 was admitted to the facility on [DATE] with diagnoses: acute respiratory failure, COPD, metabolic encephalopathy, weakness, need for assistance with personal care, diabetes, end stage kidney disease, acute kidney failure, need for dialysis, Addison's disease, hypothyroidism, hypertension, mild cognitive impairment, and unstageable pressure ulcers left and right heels. The Minimum Data Set/MDS assessment was not yet completed. On 10/28/2024 at 9:30 AM, a 24-Hour urine container was observed sitting on the nurses desk near Resident #139's room; it was empty. Resident #139 was at the dialysis center. On 10/28/2024 at 10:45 AM, during a review of Resident #139's medical record, it indicated he went to dialysis outside of the facility on Monday, Wednesday and Friday each week and he left for dialysis at 4:55 AM. On 10/28/2024 at approximately 2:30 PM, the resident was observed returning from dialysis. He was yelling out in discomfort and said he wanted to lay down in bed. A family member was with the resident and said he had experienced issues with his dialysis catheter at the dialysis center as it had a clot and then after the clot was removed the dialysis started. She said he finished later because of it. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Hemodialysis Communication Form for Resident #139 dated 10/25/2024 identified an entry by the dialysis nurse, Additional Comments: 24-hour urine to bring Monday 10/28/24. A review of the physician orders for Resident #139 indicated there was no order to obtain the 24-hour urine as requested by the dialysis center on 10/25/2024. On 10/29/2024 at 1:55 PM, Unit Manager/UM C was interviewed about the dialysis center request for a 24-hour urine as documented on the 10/25/2024 Hemodialysis Communication Form. She said she had contacted Physician M on 10/28/2024 after the resident returned from dialysis that day. She said the 10/28/2024 dialysis communication form requested a 24-hour urine and dialysis sent the jug for it and when it was full a nurse would keep it on ice and send it back with the resident to dialysis. She said in addition, she had a question about the resident's Foley (indwelling urinary catheter). She wanted to know when they could remove it. Reviewed with UM C that the 10/25/2024 dialysis form for Resident #139 also requested a 24-hour urine and to return the urine jug on 10/28/2024 when the resident went to dialysis. The UM C reviewed the 10/25/2024 dialysis form for Resident #139 and stated, It does say to do a 24-hour urine and bring to dialysis 10/28/2024. Reviewed the 10/28/2024 Hemodialysis Communication Form with the UM C it was compared to the 10/25/2024 Hemodialysis Communication Form and she stated, It wasn't done and dialysis put the information again on the 10/28/2024 form. During the interview with UM C on 10/29/204 at 1:55 PM, the physician orders were reviewed. There was an order dated 10/28/2024: May leave Foley catheter in until 24- hour urine is collected for nephrology (kidney doctor). When completed discontinue Foley . 24-hour urine is to begin Tuesday at 0001 am (10/29/2024). Complete at 2400 Wednesday. Urine collection to go with resident to dialysis on Wednesday morning (10/30/2024). The Unit Manager said Resident #139 had been transferred out to the hospital earlier that day (10/29/2024) due to a change in condition.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 22348 Based on observation, interviews and record review, the facility failed to ensure sufficient nursing staff were available for a timely and adequate resident care for eight residents (R29, R38, R41, R61, R64, R80, R138, and Resident in room [ROOM NUMBER]B), of eight residents reviewed for adequate staffing resulting in long call light responses, unmet resident care needs, and late medication administration. Findings include: On [DATE] at 3:30 PM, a record review of Daily Staffing Assignment from [DATE] to [DATE] was reviewed with the staffing coordinator. Although there were daily call ins by staff, records and punch cards revealed that there was minimal staff assigned to each of the units because staff go through mandation or by volunteer for staffing coverages. For example, while accounting for staffing schedule per units, there was a daily trend of nurses filling some of the staffing shortages seen on days where there were call ins for license nurses. Some nurses work full their full shift (12.0 hours) plus another half a shift (6.0 hours) equivalent to 18. 0 hours to cover or fill some call-ins for that day. Some Certified Nursing Assistants (CNA) work for 16 hours straight (2 shifts of 8.0 hours back-to-back) has been noted to cover some CNA shortages. Interview with the Staffing Coordinator on [DATE] at 11:05 AM revealed that the facility recently hired nurses. The shortage is due to the fact that five nurses quite at the same time. The staffing coordinator explained that the facility had to mandate nurses to stay extra more hours and have CNA stay another shift. Sometimes nurses stay for 18 hours and CNA's stay a double shift (16.0 hours). Daily shortage are covered by requiring them to stay over. Some nurses stay over and work as aides as needed. Resident #38 (R38): During the observation tour conducted at the 200 Hall on [DATE] at 1:00 PM, R38 got out of bed and was observed walking with an unsteady gait out in the hallway. The staff was busy and not in sight because they were in another room attending to another resident. The surveyor called for the nursing assistant's (CNA F) attention, and CNA F immediately took R38 back to her room. CNA F confirmed that R38 needed supervision when ambulating and will need her wheelchair for safety. CNA F explained that the other CNA in the unit is on lunch break, so she is by herself. It is just her, the nurse, and the housekeeper right now. A newly hired nurse who wished not to be identified was interviewed on [DATE] at 3:30 PM, stated that the ratio of 25 residents to one nurse is exhausting and heavy for 12 hours/shift providing medication, treatments, wound care, and other necessary special care need is jeopardized. We could not provide the quality of care especially the psychosocial aspect that the residents need as part of their daily care need. The residents deserve better care. 37666 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staffing Resident #80: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #80 was admitted to the facility on [DATE] with diagnoses: infected right knee after knee replacement, IV antibiotics, heart disease, anemia, GERD, and COPD. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities and needed assistance with care related to decreased mobility of the right leg. On [DATE] at 1:08 PM, Resident #80 was interviewed and she stated, The weekend staffing is bad; especially this weekend. They had 2 call ins. That is my only complaint; it takes a long time for them to answer your light. The resident said it was sometimes an hour before her light was answered. Resident #138: A record review of the Face sheet and electronic medical record/emr for Resident #138 indicated the resident was admitted to the facility on [DATE] with diagnoses: pancreatic cancer, right upper quadrant abdominal swelling, mass and lump, anemia, diabetes, anxiety, depression, malignant ascites (fluid buildup in abdomen), heart disease, right buttock Stage 2 pressure ulcer, left buttock Stage 3 pressure ulcer and GERD (gastroesophageal reflux disease). The resident was receiving Hospice services and died on [DATE]. On [DATE] at 11:30 AM, Resident #138 was heard moaning loudly from his room. Upon entry into his room, the resident was observed lying in bed and moving around. The resident said he was uncomfortable and had pain. He said he had pancreatic cancer and a lot of abdominal pain and motioned to his abdomen. Resident #138 was asked about the care he was receiving, and he stated, There's not enough staff. Sometimes it takes an hour for someone to come in; nights is worse. On [DATE] at 1:50 PM, Confidential Staff R said staff had called in over the weekend and it made it difficult to answer the call lights. Some of the staff working were trying to help on other halls in the building and were not available to care for their own assignments. 37771 An observation was made on [DATE] during the medication administration task of the survey of late medications administered and an interview regarding medications that had not been administered to Residents. The following interactions and observations included: -On [DATE] during medication administration observation, Nurse S and Nurse T were observed to be working together to administer morning medications to the Residents in the 500-hall unit. When asked, Nurse S indicated they were from the night shift and were asked to work over until staff came in. Nurse S was asked about how they accomplished the medication pass. Nurse S stated, one will pop (take out the medications from the bubble packaging) and one will deliver. The person signing for the meds does the popping, the other delivers the med. Helps to go faster. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE] at 10:05 AM, Nurse S reported she had stayed over on the 400-Hall until the Nurse came in for that hall and then came to help on the 500-Hall where Nurse T was staying over from the night shift until Nurse F came in for the day shift. When asked how often that happens that they are asked to stay over, Nurse S stated, They lost some Nurses and it left holes. -At 10:25 AM, Nurse F was observed during the medication administration task. Resident #78 had been given 11 medications with 8 of those medications given late that were scheduled at 8:00 AM. -At 10:33 AM, an observation was made of Resident #34 who approached the medication cart and informed Nurse F that she did not get her nasal spray and inhaler medication. Nurse F gave the Resident the Fluticasone nasal spray and the Wixela inhalation powder. On the computer, the Nurse had checked the Resident's list of medication, and the medication was documented as already given. When questioned, Nurse F reported that they were marked as given but knew the Resident and reported the Resident would know if she did or did not receive the medications. The medications were given late. -At 10:34 AM, an observation was made of Resident #75's medication administration by Nurse F. The Resident received 10 medications late that were scheduled at 9:00 AM and one medication, Miralax, that was not given to the Resident. -At 10:58 AM, Nurse F was questioned about the late medications. The Nurse indicated she had come in late, and the nightshift Nurse had stayed over. When asked how many Residents she had left to pass medication on that had late medications, the Nurse opened the computer screen and counted 12 Residents that were colored in red. The Nurse stated, 12 late meds right now. An interview with Confidential Staff was conducted regarding staffing issues. The Staff revealed that the facility does not have enough staff and nursing staff get mandated. When asked how often you get mandated, the staff replied, more then we should, and expressed concern of Nurses doing 12 hour shifts then asked to stay over to cover the next shift. When asked how long the Nurses were working, the Confidential Staff reported they would have to wait until someone else came in with variable times of up to 6 hours. The staff indicated there was holes in the schedule that were not filled and issues when someone calls in. The Confidential staff indicated issues with medications not passed timely and Nurses working too many hours and too many days in a row. Residents' concerns with long call light response times and insufficient staffing. Resident #29: On [DATE] at 12:07 PM, an observation was made of Resident #29 eating lunch in his room. The Resident was dressed, in a wheelchair with their meal tray on the overbed table positioned in front of the Resident. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about any issues that they had with the care he received at the facility. The Resident reported they did not serve enough food, and he usually got more than this and indicated his meal tray. The Resident was asked if he was supposed to received larger portions. The Resident explained that he usually ate in the dining room, and he would ask for more of what he wanted. The Resident explained that the meal came up and he did not get larger portions. When asked why he did not go to the dining room to eat, the Resident stated, too short staffed, they said we had to eat in our room. The Resident reported that when he had to eat in his room that the food was not warm enough for his liking and stated, Food too cold that is an issue when we eat in our room. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #41: On [DATE] at 12:43 PM, an observation was made of Resident #41 sitting in a chair with Family member U assisting with Resident eating. The Resident and Family Member were interviewed, answered questions and engaged in conversation. The Resident and Family Member were asked about any concerns related to care received by the facility. The Family Member indicated long call light wait times and stated, she has had to wait more than a half an hour, at times and reported insufficient staffing, short of help especially on the weekends. Resident #64: On [DATE] at 12:32 PM, an observation was made of Resident #64 sitting in their room. The Resident was interviewed, answered questions and engaged in conversation. When asked about other issues with their care, the Resident complained of the call light not answered for 45 minutes. The explained that sometimes pretty quick, but other times you wait a long time! Resident #61: On [DATE] at 11:55 AM, an interview was conducted with Resident #61. The Resident was asked about any concerns they had about the care received at the facility. The Resident reported a concern with insufficient staffing and stated, They are so short staffed, they quit and don't hire more. When asked about call light wait times, the Resident reported two hours was the longest, usually its about 20 minutes, sometimes more then 30 minutes. The indicated needing assistance with getting cleaned up and changed.

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	235456	A. Building B. Wing	10/29/2024

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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** 37771 Based on observation, interview and record review, the facility 1) Failed to ensure that narcotic medication reconciliation was completed, 2) Failed to ensure that residents received medications timely, and 3) Failed to ensure that the medication administration standards of practice were followed for four residents (#34, #75, #78 and #82) of seven residents observed for medication administration, resulting in medications not given as scheduled with the likelihood of ineffective medication therapy, exacerbation of medical conditions, medication/narcotic diversion, and medication administration errors. Findings include: On 10/29/24 at 8:42 AM, the Medication Administration task of the survey was started. The following were observed: -At 9:42 AM, Nurse T was observed to prepare Resident #82's medications by removing the pills from the blister packets. Nurse S was observed to prepare the insulin. Nurse S uncapped the needle of the syringe, inserted the needle into the insulin vial, extracted the insulin and when completed with getting the amount needed from the vial, the Nurse recapped the insulin syringe with the cap that was between her 5th digit and palm of her hand. The Insulin syringe had a guard that could be extracted to cover the needle without having to recap the needle. -Nurse S gave the medications that were prepared by Nurse T to Resident #82. -Resident #82 did not receive Fenofibrate 67 mg (milligrams) as scheduled at 9:00 AM and did not receive Diclofenac external Gel 1% to affected area topically three times a day for pain, scheduled at 9:00 AM. When asked, Nurse S indicated the medication had not been sent by pharmacy and was not available in the back up medication supply. -At 10:05 AM, Nurse T left the medication cart and hall to give report to the oncoming Nurse F. The medication cart keys were retrieved by Nurse S to get the oxygen saturation monitor from the medication cart. The narcotic storage was in the medication cart and not counted prior to another Nurse getting the medication cart keys. -Nurse S and Nurse T were observed to be working together to administer morning medications to the Residents in the 500-hall unit during the medication administration task of the survey. When asked, Nurse S indicated they were from the night shift and were asked to work over until staff came in. Nurse S was asked about how they accomplished the medication pass. Nurse S stated, one will pop (take out the medications from the bubble packaging) and one will deliver. The person signing for the meds does the popping, the other delivers the med. Helps to go faster. -On 10/29/24 at 10:18 AM, Nurse F was about to start medication administration after getting report from Nurse T. The Nurse realized that she did not have the keys to the medication cart and went to retrieve them from Nurse S. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 10:25 AM, Nurse F was observed during the medication administration task. Resident #78 had been given 11 medications with 8 of those medications given late that were scheduled at 8:00 AM. -At 10:33 AM, an observation was made of Resident #34 who approached the medication cart and informed Nurse F that she did not get her nasal spray and inhaler medication. Nurse F gave the Resident the Fluticasone nasal spray and the Wixela inhalation powder. On the computer, the Nurse had checked the Resident's list of medication, and the medication was documented as already given. When questioned, Nurse F reported that they were marked as given but knew the Resident and reported the Resident would know if she did or did not receive the medications. The medications were given late. -At 10:34 AM, an observation was made of Resident #75's medication administration by Nurse F. The Resident received 10 medications late that were scheduled at 9:00 AM and one medication, Miralax, that was not given to the Resident. -At 10:45 AM, the Nurse was asked who she had received the medication cart/narcotic keys from. The Nurse reported she had gotten the keys from Nurse S. A review of the facility document titled, Controlled Substance Shift Inventory, was conducted with Nurse F. The Nurse signed the sheet at this time as 10A when asked if she had counted with the Nurse when she came in at 10:00 AM, the Nurse indicated she had not counted. When asked who had counted the narcotic count last, the Nurse indicated that Nurse T had counted last. The Nurse had gotten the narcotic keys and medication cart keys from Nurse S. -At 10:50 AM, Nurse S, who was still in the building, came to the 500-Hall medication cart and counted the narcotics with Nurse F. A review of the Nurses that had the keys was conducted with Nurse F of Nurse T who had the keys as observed during the beginning of the Medication Administration task, Nurse S had gotten the keys from Nurse T and Nurse F who received the keys from Nurse S, without ensuring the narcotic count was completed. Nurse T had counted the narcotics last, was the off going nurse and had not counted with the oncoming Nurse F. On 10/29/24 at 2:20 PM, an interview was conducted with the Director of Nursing (DON) regarding concerns observed during the medication administration task of the survey. The medication cart/narcotic keys exchanged between three nurses during medication administration and change of nursing staff and the lack of narcotic reconciliation with the change in nursing staff was reviewed with the DON. The DON reported that when the keys are given to another Nurse, the narcotic count should be completed. When asked about the nurse signing the narcotic sheet at 10 AM when the count had not been completed until 10:50 AM, the DON indicated the nurse should be signing when the narcotic count was completed. One nurse preparing the medication and the other nurse giving the medication to the Resident was reviewed. The DON reported the nurse preparing the medication should be the one giving them, since Nurse T had the keys to the cart, Nurse T should be getting the medication out and administering the medication. When asked what time Resident #82 had come back to the facility on [DATE], a review of the medical record was conducted and the DON indicated late afternoon about 3:45 PM. The two medications had not been received from the pharmacy, but the other medications had been received, leaving the two medications, Fenofibrate and Diclofenac Gel not available for the Resident to have but were scheduled for administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34 complained that she did not receive her inhaler and nasal spray, the Nurse administered the medication that had been signed out by another Nurse that the Resident received the medication was reviewed with the DON. The DON indicated the Nurse should have made sure by calling the Nurse that left to find out if they were given or not. It was reviewed with the Director of Nursing of a total of 23 errors that were observed during the medication administration task of medications that were not available and medications administered late. It was reviewed with the DON of the narcotic reconciliation not completed prior to the Nurse responsible for the narcotic keys leaving, medication signed out by one Nurse and given by another Nurse, medications signed out that were not given with another Nurse giving the medication late and not ensuring the medication had not been given. Review of facility policy titled Medication Administration, last revised 10/17/23, revealed, Resident medications are administered in an accurate, safe, timely, and sanitary manner . Self-Administration-residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with the guideline for self-administration of medication. A self-administration evaluation will be completed prior to the resident starting the self-administering process . a. Prepare medications immediately prior to administration . 6. Administer medications within 60 minutes of the scheduled time. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. For example, if the medication is ordered for 8:00 a.m., it must be given between 7:00 a.m., and 9:00 a.m. in order to be considered timely . A review of the facility document Controlled Substance Shift Inventory, revealed directions If a manager discovers that the reconciliation has note (not) been completed, the Nurse Manager will complete the count with the nurse that is working on the cart. The Nurse Manager will sign validating that the count has been completed with the nurse . A review of facility policy titled, Controlled Substances, revised 10/26/23, revealed, .Incomplete Medication Cart Reconciliation Guidelines 1. If it is discovered that the reconciliation has not been completed during shift change, the nurse manager will verify that the count in the cart is accurate with the nurse who is assigned to the cart. 2. Once the count is verified by the nurse who is assigned to the cart and the nurse manager, both individuals will sign the controlled substance inventory sheet in designated area .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review the facility failed to ensure a medication error rate of less than 5% when 23 medication errors were observed for four residents (#35, #75, #78 and #82) from a total of 69 opportunities, of seven residents observed for medication administration, resulting in an error rate of 33. 33% with the potential for adverse reactions related to the omission of medications and medications not administered timely with the potential of ineffective medication therapy and the exacerbation of medical conditions. Findings include: On 10/29/24 at 8:42 AM, the Medication Administration task of the survey was started. The following were observed: Resident #82: -At 9:42 AM, Nurse T was observed to prepare Resident #82's medications by removing the pills from the blister packets. Nurse S was observed to prepare the insulin. Nurse S uncapped the needle of the syringe, inserted the needle into the insulin vial, extracted the insulin and when completed with getting the amount needed from the vial, the Nurse recapped the insulin syringe with the cap that was between her 5th digit and palm of her hand. The Insulin syringe had a guard that could be extracted to cover the needle without having to recap the needle. -Nurse S gave the medications that were prepared by Nurse T to Resident #82. -Resident #82 did not receive Fenofibrate 67 mg (milligrams) as scheduled at 9:00 AM and did not receive Diclofenac external Gel 1% to affected area topically three times a day for pain, scheduled at 9:00 AM. When asked, Nurse S indicated the medication had not been sent by pharmacy and was not available in the back up medication supply. -Nurse S and Nurse T were observed to be working together to administer morning medications to the Residents in the 500-hall unit. When asked, Nurse S indicated they were from the night shift and were asked to work over until staff came in. Nurse S was asked about how they accomplished the medication pass. Nurse S stated, one will pop (take out the medications from the bubble packaging) and one will deliver. The person signing for the meds does the popping, the other delivers the med. Helps to go faster. Resident #78: -At 10:25 AM, Nurse F was observed during the medication administration task. Resident #78 had been given 11 medications with 8 of those medications given late that were scheduled at 8:00 AM. Resident #34: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 10:33 AM, an observation was made of Resident #34 who approached the medication cart and informed Nurse F that she did not get her nasal spray and inhaler medication. Nurse F gave the Resident the Fluticasone nasal spray and the Wixela inhalation powder. On the computer, the Nurse had checked the Resident's list of medication, and the medication was documented as already given. When questioned, Nurse F reported that they were marked as given but knew the Resident and reported the Resident would know if she did or did not receive the medications. The medications were given late. Resident #75: -At 10:34 AM, an observation was made of Resident #75's medication administration by Nurse F. The Resident received 10 medications late that were scheduled at 9:00 AM and one medication, Miralax, that was not given to the Resident. -At 10:58 AM, Nurse F was questioned about the late medications. The Nurse indicated she had come in late, and the nightshift Nurse had stayed over. When asked how many Residents she had left to pass medication on that had late medications, the Nurse opened the computer screen and counted 12 Residents that were colored in red. The Nurse stated, 12 late meds right now. On 10/29/24 at 2:20 PM, an interview was conducted with the Director of Nursing (DON) regarding concerns observed during the medication administration task of the survey. When asked what time Resident #82 had come back to the facility on [DATE], a review of the medical record was conducted and the DON indicated late afternoon about 3:45 PM. The two medications had not been received from the pharmacy, but the other medications had been received, leaving the two medications, Fenofibrate and Diclofenac Gel not available for the Resident to have but were scheduled for administration. Resident #34 complained that she did not receive her inhaler and nasal spray, the Nurse administered the medication that had been signed out by another Nurse that the Resident received the medication was reviewed with the DON. The DON indicated the Nurse should have made sure by calling the Nurse that left to find out if they were given or not. It was reviewed with the Director of Nursing of a total of 23 errors that were observed during the medication administration task of medications that were not available and medications administered late.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 39059 Based on observation, interview and record review, the facility failed to provide enough healthy snack choices for all residents, resulting in Resident Council-voiced complaints, missing and low snack list items, and feelings of decreased over all well-being and frustration. Findings include: On 10/28/24, at 2:00 PM, During resident council task, the following complaints were voiced regarding not have healthy snacks and food choices: No fresh greens no fresh veggies no fresh fruit I dream about a beautiful red fresh tomato I would love a fresh ear of corn the meals are food of carbs if you want to gain wait, just eat the processed foods here you get the same thing for breakfast every day we want fresh cinnamon rolls the little butter packets are margarine we want real butter we don't want imitation cheese they run out of snacks they run out of honey buns you have to ask the CNA's for night time snacks and they say there isn't any The CNA's say they will go check for a snack but then they don't come back You have to go to the kitchen sometimes to get snacks (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	you have to know who to go to, to get what you want we get a choice but you have to wheel your butt down there and make it you could tell your nurse or CNA but they're too busy to do it (referring to order slip for a different food choice They don't have time to little own do their job I can tell when my meds are late because I get tremors On 10/29/24, at 2:48 PM, Certified Dietary Manager (CDM) I was interviewed regarding resident complaints of the facility not having certain snacks items, food choices and that they often run out of certain snack items. CDM I offered they try to do a rotation of the sweet snack items. CDM I was alerted of the complaints of no fresh fruit or veggies and CDM I offered the facility has celery and carrot snacks. CDM I was asked what fresh fruit the facility had in house for snacks and CDM I offered, bananas. CDM I denied having apples, oranges or grapes. CDM I was alerted of the complaints the facility didn't offer real butter and that the residents complained of the use of imitation cheese. CDM I offered I guess I haven't had anybody request real butter and that they do use Velveeta for the macaroni and cheese. CDM I was asked what snack items they provide and CDM I offered, honey buns, cheese crackers, peanut butter crackers, yogurt, string cheese sticks, sandwiches, (rotate turkey, turkey and cheese, ham salad) and that they always have ham and turkey sandwiches. CDM I explained that everyone gets offered a snack and the kitchen staff stocks the kitchenettes on the nursing units. CDM I was asked what time of the day the kitchenettes get stocked and CDM I offered, they check it in the morning and stock them between 1:00 and 3:00 PM. CDM I was asked to provide the recipe for the macaroni and cheese. On 10/29/24, at 3:10 PM, an observation of the 400 hall kitchenette along with CNA J was conducted. There was 1 half sandwich, a few bags each of cheese puffs and Doritos. There was 1 package of peanut butter crackers and 1 honey bun, ice creams and sherbets. There was no cottage cheese, no string cheese, no yogurt, no fresh fruit and no fruit cups. CNA J offered, I've never seen string cheese for the residents. There was a large bag of yellow cheese sticks labeled with a resident name. On 10/29/24, at 3:29 PM, CDM I was alerted of the observation of the lack of snack items in the 400 hall kitchenette and CDM I offered, (dietary aide) is checking on them now. CDM I was asked to provide the kitchenette snack list for resident consumption. A record review of the facility provided Available Snack List revealed the following kitchenette items: Apple Nutri-grain Bars Peanut Butter Crackers Doritos Cheese Puffs (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Potato Chips Yogurt Turkey Sandwich Ham Sandwich Peanut Butter & Jelly Honey Buns Fruit Cups Pudding Ice Cream-Chocolate Marble, Strawberry: Sherbet-Orange String Cheese Stick Jello Applesauce Cottage Cheese On 10/29/24, at 4:01 PM, an observation of the 900 hall kitchenette snack items revealed: Doritios, 3 honey buns, peanut better crackers, nutri-grain bars, apple sauce, yogurt (two varieties), chocolate pudding, ice creams and sherbets. There were no sandwiches, no cottage cheese, no string cheese. CNA K was asked how often they see string cheese in the kitchenettes for the residents and CNA K offered, I'm not sure I've ever seen string cheese.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility 1) Failed to ensure that ongoing surveillance for signs and symptoms of infectious illnesses in residents was collected, documented, analyzed and reported and 2) Failed to ensure that Transmission-Based Precautions were identified and Personal Protective Equipment/PPE was worn when indicated, hand hygiene was performed, when necessary, needles were not recapped, personal items were labeled with residents' names in shared bathrooms, and hair nets were readily accessible without risk of cross-contamination in the kitchen, resulting in a lack of compliance with infection prevention and control standards of practice which could result in exposure to infectious organisms and an outbreak of illnesses. Findings Include: FACILITY Infection Control On 10/29/24 10:10 AM, during an interview with Infection Prevention and Control/IPC Nurse A she said she began the IPC role in June 2024. Reviewed with the IPC Nurse on 10/27/2024 at 1:09 PM, a Contact Precaution sign was on the door of room [ROOM NUMBER]/Resident #80. Nurse N was observed walking into the room without performing hand hygiene or Donning/applying Personal Protective Equipment/PPE equipment. The IPC said there were two residents in Contact Precautions, and neither was in room [ROOM NUMBER]. The IPC said Resident #80 in room [ROOM NUMBER] was supposed to be in Enhanced Barrier Precautions and PPE would not be required to enter the resident's room. The IPC did not know Resident #80 had a Contact Precaution sign on the door. She stated, She had knee replacement, with some rejection and infected hardware; she's been on IV antibiotics. Reviewed with the IPC the resident's diagnosis list said MSSA (Methicillin Sensitive Staph. Aureus) and a nurse made a progress note that said MRSA (Methicillin Resistant Staph. Aureus). The IPC Nurse A reviewed the resident's medical record and said Nurse S had incorrect documentation in Resident #80's chart. She said Nurse S had documented MRSA which would require Contact Precautions and the use of PPE to enter the resident's room. The IPC showed a hospital document in the resident's medical record that listed MSSA; the IPC said that Contact Precautions were not needed for MSSA. She said she would make sure correct precautions were identified for Resident #80. During the interview with IPC Nurse A on 10/29/2024 at 10:20 AM, Infection Surveillance was reviewed. The IPC Nurse said if a resident was on antibiotics, then they were added to the Surveillance Report in the computer program. When asked for an Infection Line List, the IPC provided a monthly Infection Surveillance Report that was not a Line list. The document was separated by infection type and only contained Resident infections that were treated with an antibiotic. The Director of Nursing/DON entered the room and said she thought there was an Infection Line list in the computer program. The IPC showed a computer screen that had the residents with antibiotics listed. The screen had several residents to a screen, and it was multiple screens long. The DON said the form could not be printed out. There was no way to see all of the data at once. The data was then pulled out into reports. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the interview with the IPC Nurse and DON, on 10/29/2024 at 10:30 AM, they were asked if they were tracking resident's with signs and symptoms of infection to aid in preventing the spread of infection to other resident's, staff and visitors. They said they were monitoring the residents who were prescribed an antibiotic. The IPC was asked how she became aware of a resident with a potential infection and she said she looked at the antibiotic reports and residents started on antibiotics were reviewed in the morning meeting. The facility was not monitoring residents with signs and symptoms of infection on the Line Listings until they were prescribed an antibiotic, which could potentially lead to an outbreak. The report received from the facility titled, Infection Surveillance Monthly Report provided a monthly running total of infections, by category and listed the residents, infection and antibiotics. There was no identification of infectious organisms to track potential spread. In April 2024, there were 4 Urinary Tract Infections/UTI's identified in the report:1 resident was admitted with the UTI and infectious organisms were identified, although there was no room number for the resident. For the other 3 UTI's there was no identified organism. July 2024 identified 5 UTI's with one present on admission. There were no identified infectious organisms for the 5 UTI's. The facility was identifying there was an infection but was not analyzing the cause or potential results. On 10/29/2024 at 11:45 AM, the IPC provided an untitled printed document dated 7/24/2024-9/25/2024, that did not include resident last names and included those residents' receiving antibiotics. Some of the residents had identified infectious organisms listed and some did not. Some had room numbers listed and some did not. The untitled document identified 4 infections with Enterobacter cloacae: 2 wounds, 1 osteomyelitis and 1 UTI. It was not identified if the Enterobacter cloacae was a Multi-Drug-Resistant Organism/MDRO. The residents were not matched to the infection, and it was not reviewed on the Infection Surveillance Monthly Report. The untitled document also identified 6 infections with Escherichia coli/E. coli: 2 wounds and 4 UTI's. There were also 2 Klebsiella pneumoniae infections: 1 wound and 1 UTI. It was not identified if the organisms were MDRO's or to which resident they belonged and was not reviewed on the Infection Surveillance Monthly Report. A review of a U.S. Department of Health and Human Services: Centers for Disease Control and Prevention/CDC, Resource titled CRE: Carbapenem-resistant Enterobacterales/CRE, provided . Enterobacterales is an order of gram-negative bacteria that includes some organisms commonly identified in clinical microbiology laboratories, like Escherichia coli and Klebsiella pneumoniae . Common Enterobacterales Species: Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Citrobacter freundii, Serratia marcescens . Carbapenems are last-line antibiotics used to treat serious multidrug-resistant infections. In the United States, about 2-3% of Enterobacterales associated with healthcare-associated infections are resistant to carbapenems. CRE infections don't respond to common antibiotics and invasive infections are associated with high mortality rates . Who is at Risk: Hospital patients and long-term care facility residents . A review of the Centers for Disease Control and Prevention's CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in all Settings, dated April 12, 2024 provided the following: Adherence to infection prevention and control practices is essential to providing safe and high quality patient care across all settings where healthcare is delivered . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235456	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtney Manor	1167 E Hopson Street Bad Axe, MI 48413

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	APIC (Association for Professional in Infection Control and Epidemiology) Text: Surveillance, revised publication January 17, 2024 provided, . Surveillance can be defined as a comprehensive method of measuring outcomes and related processes of care, analyzing the data, and providing information to members of the healthcare team to assist in improving those outcomes. Surveillance is an essential component of an effective IPC program. Infection surveillance is a process that includes review of both laboratory data and clinical data to allow for identification of specific infection types . A review of the facility policy titled, Infection Prevention Surveillance, origination date 8/1/2010 and last revised 9/29/2023 provided, The Infection Preventionist does surveillance of infections among residents and employees . Review of culture reports and other pertinent lab data, chart review, review of the 24-hour report, or morning stand-up meeting and walking rounds throughout the facility . Surveillance Symptoms Considerations: All symptoms must be new or acutely worse . a new symptom or change from baseline may be an indication that an infection is developing . 39059 On 10/27/24, at 11:25 AM, an observation of room [ROOM NUMBER] was conducted, there were numerous unlabeled personal items in the bathroom including toothpastes, soaps, lotions and mouthwashes. On 10/27/24, at 11:40 AM, An observation of room [ROOM NUMBER] was conducted, there were multiple unlabeled personal items in the bathroom including, toothpastes, brushes, and a denture cup. Resident in A bed offered, yes, we both use the bathroom. On 10/27/24, at 11:49 AM, Resident #26 was sitting in their room. There were multiple unlabeled personal items in the bathroom including a plastic cup with a toothbrush. Resident #26 offered, yes, we both use the bathroom. Resident #26 was asked if they brush their teeth in the bathroom and Resident #26 offered it was his toothbrush and quickly added, I hope he doesn't use my toothbrush. On 10/28/24, at 9:26 AM, Resident #53 was in their shared room. There were multiple unlabeled personal items in the bathroom including shaving creams, combs, lotions, mouth washes and toothbrushes. On 10/28/24, at 1:31 PM, an observation of a contact isolation room [ROOM NUMBER]. Nurse F was observed inside room [ROOM NUMBER] with no personal protection equipment (PPE) on. Nurse F provided the resident in bed A medications, left out of the room back to their medication cart without performing hand hygiene. Nurse F was asked which resident was in contact isolation and Nurse F stated, (the resident) and pointed to the resident in A bed. Nurse F was asked if they needed to wear PPE and Nurse F stated, No only if we're doing care. Nurse F was asked to clarify the isolation sign on the door was in fact a contact isolation sign and Nurse F reviewed the sign, did not respond and continued at their medication cart. On 10/29/24, at 10:52 AM, an observation of CNA E in room [ROOM NUMBER] was conducted. CNA E assisted the resident in B bed. CNA E was sitting on the bed without a gown on. 37771 On 10/29/24 at 8:42 AM, the Medication Administration task of the survey was started. The following were observed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 9:42 AM, Nurse T was observed to prepare Resident #82's medications by removing the pills from the blister packets. Nurse S was observed to prepare the insulin. Nurse S uncapped the needle of the syringe, inserted the needle into the insulin vial, extracted the insulin and when completed with getting the amount needed from the vial, the Nurse recapped the insulin syringe with the cap that was between her 5th digit and palm of her hand. The Insulin syringe had a guard that could be extracted to cover the needle without having to recap the needle. -At 11:05 AM, an observation was made of Nurse B giving insulin from a vial to a Resident. The Nurse was observed to draw up the correct amount of insulin and then pull the plastic sleeve over the needle. When asked if the needle should be recapped, the Nurse reported no, you should never recap a needle and explained how the sleeve went over the needle and if twisted then would lock into place which was to be done once the insulin was given to the Resident. On 2/29/24 at 2:20 PM, an interview was conducted with the Director of Nursing (DON) regarding concerns observed during the medication administration task of the survey. A review of the recapping of the insulin syringe was reviewed with the DON who indicated they should not be recapping the needle. 22348 Kitchen Observation During observation tour conducted on 10/27/24 11:29 AM ,the afternoon cook toured the surveyor and observed that the hairnets were not readily available at the entrance of the kitchen. There were 2 entrances that staff can enter the kitchen. Door 1 is where the dietary/kitchen employees enter and door 2 is where the kitchen staff go fin and out of the kitchen to the dining room area. Both doors did not have a box of hairnets or a hairnet dispenser. When the afternoon cook was queried, she stated that they keep all hairnet supplies in their chemical room. When the afternoon cook was ask to show the surveyor, the afternoon cook brought the surveyor into the soiled utility chemical storage room where the keep chemical supplies and dirty used janitorial supplies including dirty dustpans and brooms. The afternoon cook walked the surveyor through how one obtain a hairnet. from the employee door entrance Door 1, the kitchen staff would have to pass through the clean kitchen prep area with their street clothes and hair passing by the clean kitchen area. Then they enter the chemical room where all the dirty janitorial supply are kept and put the hairnet on. Then the surveyor asked where they go to wash hands after touching their hair and put on the hairnet. The afternoon cook walked the surveyor through where the employees wash their hands was to cross the clean food prep table again to get to the sink on the opposite side of the room from the chemical room where the store all the hairnets. When asked since when have they been without the dispenser of have the hairnet by the door before entering the kitchen? The afternoon cook said it has been over 6 years or so. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When queried about sanitation and infection control and prevention, the afternoon cook stated, that's why I bring home my own hairnet and wear them before coming to work. The afternoon cook was asked if all staff wear their hairnets when working as part of the protocol, she said yes. Then she continued to describe that kitchen staff go through the employee Door 1, cross the clean food prep table area with no hairnet, take the hairnet out from the box in the chemical room, put them on their street contaminated hair, then cross the clean food prep table again to get to the sink to wash their hands and sanitize. The surveyor continued to ask, Do they have to cross the clean food prep area twice before their hair is covered and hands sanitized? The afternoon cook replied by saying yes. The dietary manager (on 10/27/24 at around 12:30 PM, confirmed that the hairnet was kept in the dirty chemical room. When discussed about crossing the clean area twice to get obtain the hairnet and wash/sanitize the hands, the CDM agreed of the cross contamination and that is where the employee wash their hands. The surveyor requested a copy of the hairnet and hand washing policy at 12:45 PM No policy was submitted upon request related to hairnet use and appropriate storage for hairnets. However, the Hand Hygiene Policy (Effective date 10/11/2023) was reviewed. Policy: To decrease the risk of transmission of infection by appropriate hand hygiene. Hand washing/hand hygiene is generally considered the most important single procedure for preventing healthcare-associated infections. Antiseptics control or kill microorganisms contaminating skin and other superficial tissues and are sometimes composed of the same chemicals that are used for disinfection of inanimate objects .