STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235458	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Grand Rapids	1950 32nd St S E Grand Rapids, MI 49508

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41982 This citation pertains to Intake MI00148620 Based on observation, interview and record review, the facility failed to provide an environment that promoted a dignified dining experience for 1 (Resident #115) of 3 residents reviewed for dignity and respect, resulting in the potential for feelings of frustration, depression, loss of self-worth, and an overall deterioration of psychological well-being. Findings include: Resident #115 Review of an Admission Record revealed Resident #115 was a female, with pertinent diagnoses which included: Alzheimer's disease (a form of dementia) with late onset, and major depressive disorder. Review of a Minimum Data Set (MDS) assessment for Resident #115, with a reference date of 11/15/24 revealed the Staff Assessment for Mental Status Cognitive Skills for Daily Decision Making indicated Resident #115 was Severely impaired. Further review of said MDS revealed Resident #115 required substantial/maximal assistance for eating. Review of Resident #115's current Care Plan revealed the focus of, (Resident #115) has an ADL (activities of daily living) Self Care Deficit r/t (related to) cognitive deficits secondary to Dementia and care planned interventions which included Extensive to dependent for eating with a date initiated of 8/16/24. (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 - Few	During an observation on 1/2/25 at 11:49 AM, it was noted that residents in The Harbor (memory care unit) were in the dining room being served their lunch meals. There were 3 residents at the same table who needed to be assisted with their meals. Of the 3 residents, 1 was being assisted to eat by Certified Nurse Aide (CNA) EE, 1 was being assisted to eat by a family member, and 1 (Resident #115) was seated at the table with no assistance and her tray was on the table but out of her reach. At 12:12 PM, Resident #115 (who was not yet being assisted), attempted to reach over the table to get her tray but was unsuccessful. Resident #115 then began to knock on the table, presumably to get someone's attention, but was not acknowledged in any way. At 12:17 PM, CNA K began clearing other tables of independent residents who had finished eating. At 12:18 PM, CNA EE asked CNA K if she would assist Resident #115 to eat, to which CNA K replied hold on. CNA K then walked down the hall and started speaking to another staff member about a separate resident's food intake. At 12:20 PM, Resident #115 knocked on the table again. At 12:21 PM, CNA K sat down next to Resident #115 and began assisting the resident to eat her lunch meal. At 12:23 PM, CNA K, while assisting Resident #115, began speaking with the family member who had been assisting their loved one at the same table, and was not engaged with Resident #115. Resident #115 began to knock on the table again. In an interview on 1/2/25 at 12:29 PM, Licensed Practical Nurse (LPN) MM reported staffing was a struggle in The Harbor because so many of the residents on the unit needed assistance. Regarding assisting the dependent residents, LPN MM reported a lot of the residents needed to be assisted to eat, but they had to assist them one at a time, indicating that meant that some residents had to wait. In an interview on 1/7/25 at 8:54 AM Certified Nurse Aide (CNA) R reported staffing on The Harbor (the memory care unit) was challenging because of the needs of the residents. CNA R reported there were many residents who were dependent on staff to feed them and generally there were only 3 aides assist those dependent residents. CNA R reported the nurse on duty would sometimes assist the dependent residents with eating as well, but it depended on the nurse, and many did not help. In an interview on 1/6/25 at 10:36 AM, Administrator A reported if 2 residents were dependent on staff to assist with eating at the same table, the staff member assisting should alternate between the two residents and assist them both at the same time. Administrator A reported a resident should not be seated at a table without food when their table mates were eating. Administrator A reported staff should be engaging with the resident they are assisting and not having separate conversations during that time. In an interview on 1/6/25 at 10:47 AM, Interim Director of Nursing (IDON) B reported the expectation was that every resident who needed to be assisted should be assisted at the same time. IDON B reported staff/family should not have been talking amongst themselves and the staff should have been engaging with the resident. IDON B reported the resident should have the staff's attention.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 36221 This citation pertains to Intake # MI00147580, MI00147822, MI00147838, & MI00149046. This citation has two deficient practice statements, A & B. Deficient Practice Statement A Based on interview, and record review, the facility failed to protect the residents' right to be free from neglect in 7 of 15 residents (Resident #103, #104, #113, #120, #124, #125, #126) reviewed for neglect, resulting in an Immediate Jeopardy when on 10/12/24, 10/18/24, 10/19/24, and 10/26/24 licensed nursing staff did not accept responsibility for the care and supervision of residents on portions of the 300 and 400 Halls, which led to missed medications, significant medication errors (Resident #103 missed seizure medication on 10/18/24, Resident #113 missed insulin on 10/12/24, Resident #124 missed a blood thinner on 10/18/24, and Resident #125 missed insulin on 10/18/24 and 10/19/24), and a lack of overall supervision. On 10/12/24 a total of 30 out of 32 residents on the 400 Hall missed medications. On 10/18/24 a total of 30 out of 30 residents on the 300 Hall missed medications. On 10/19/24 a total of 6 out of 30 residents on the 300 Hall missed medications. On 10/26/24 a total of 24 out of 29 residents on the 300 Hall missed medications. This deficient practice placed all residents on the 300 and 400 Hall at risk and resulted in the likelihood for serious harm, injury, and/or death. Findings include: The Immediate Jeopardy began on 10/12/24 when licensed nursing staff did not accept responsibility for the care and supervision of residents on portions of the 300 and 400 Halls, resulting in missed medications, significant medication errors, and a lack of overall supervision. Administrator A was notified of the Immediate Jeopardy on 1/9/25 at 4:02 PM. The surveyor confirmed by observation, interview, and record review, that the Immediate Jeopardy was removed on 10/28/24, but noncompliance remains at a scope of pattern and severity of no actual harm with the potential for minimal harm that is not Immediate Jeopardy due to sustained compliance that has not been verified by the State Agency. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 1/6/25 at 3:48 PM, Licensed Practical Nurse (LPN) QQ reported staffing was a major issue in September/October 2024 after the change in facility ownership. LPN QQ reported at times they were the only nurse on the 300/400 Hall, or there was no oncoming nurse at the end of their shift. LPN QQ stated .I was exhausted . LPN QQ reported on 10/18/24 the Agency nurse scheduled to relieve them at 6:30 PM on the 300 Hall did not show up for the shift. LPN QQ reported that evening there was only one nurse on the 400 Hall, and no nurse on the 300 Hall. LPN QQ reported the evening of 10/18/24 on the 300 Hall, no residents received scheduled medications. LPN QQ reported on 10/18/24 between 7:00 PM-11:00 PM one resident from the 300 Hall attempted to elope from the facility and was found in the parking lot after setting off a door alarm. LPN QQ reported with Agency staff, the nurses working have no notification when a scheduled Agency staff member calls in or cancels a shift, and stated .we have no idea if they will show up or not . LPN QQ reported after the change in ownership, only two nurses were scheduled on the 300/400 Halls, when previously they had three, and stated .that is how we ended up with this mess . LPN QQ reported when short-staffed, they are unable to pass medications timely or provide quality care. In an interview on 1/8/25 at 9:15 AM, Registered Nurse (RN) LLL reported they were assigned the 400 Hall on 10/18/24 from 6:30 PM-7:00 AM. RN LLL reported they could not recall who was responsible for the 300 Hall that night (10/18/24 between 6:30 PM-11:00 PM). RN LLL recalled a resident on the 300 Hall attempted to elope from the facility between 7:00 PM-11:00 PM. RN LLL stated in regard to staffing .We were always short. (Staffing) was definitely an issue that night . RN LLL reported they had issues getting medications administered timely when short-staffed. RN LLL reported they stopped working at the facility shortly after that night, and stated .That was one of the reasons I left .safety . RN LLL reported management was .fully aware . of the staffing concerns but would not come into the facility to assist when short-staffed. In an interview on 1/8/25 at 9:32 AM, Certified Nursing Assistant (CNA) J reported there was no nurse assigned to the 300 Hall on 10/18/24 between 6:30 PM-11:00 PM) and one nurse on the 400 Hall (Registered Nurse (RN) LLL). In an interview on 1/8/25 at 9:52 AM, Former Assistant Director of Nursing (ADON) MMM reported they were contacted by staff on 10/18/24 between 7:00 PM-11:00 PM in regard to an attempted elopement (Resident #103). Former ADON MMM reported a CNA responded to a door alarm and found Resident #103 outside in the parking lot. ADON MMM reported no issues with staffing that evening and stated .we were at State minimums . ADON MMM reported they were aware that multiple residents missed medications the evening of 10/18/24 and stated .we did look into that . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 1/8/25 at 10:07 AM, Agency Licensed Practical Nurse (LPN) JJJ reported they worked on the 100 Hall the evening of 10/18/24 at the time of Resident #103's attempted elopement from the facility. Agency LPN JJJ reported they heard the alarm going off and began to search/check doors to identify a cause. Agency LPN JJJ reported an Agency CNA found Resident #103 outside in the parking lot. Agency LPN JJJ reported they notified the nurse on-call of the attempted elopement, along with the Administrator at the time. Agency LPN JJJ reported that evening there was no nurse assigned to the section of the building (the 300 Hall) where Resident #103 resided. Agency LPN JJJ reported there was only a nurse on the 400 Hall. Agency LPN JJJ reported they took over some of the rooms on the 300 Hall after 11:00 PM, but from 6:30 PM-11:00 PM on 10/18/24 there was no nurse assigned to the residents on the 300 Hall. Agency LPN JJJ reported the evening of 10/18/24 was not the first time where no nurse was assigned to a section of residents, and stated .I canceled all my shifts after that. (I) did not feel safe working there . Agency LPN JJJ reported they spoke with the on-call manager that evening (Former ADON MMM) about the staffing concerns, and reported there were only three nurses in the building when there should have been four. In an interview on 1/8/25 at 10:44 AM, LPN OOO reported concerns with staffing at the facility. LPN OOO reported at times there would be one nurse assigned to over 50 residents. LPN OOO stated .They were telling me I had to work like that. I told them there are people who are a fall risk, people with mental health issues .I told them it's not safe .I am not going to put these people's lives in jeopardy . LPN OOO reported they worked one shift with a 56 resident assignment and stated .it was too dangerous .It was the most nerve-wracking night of my life . LPN OOO reported they spoke with Former Assistant Director of Nursing (ADON) MMM at the time about the staffing concerns and no assistance/guidance or direction was provided. LPN OOO reported Former ADON MMM often did not answer the phone and stated .if you had an issue at night that was your issue .(Former ADON MMM) wouldn't come in and get on a cart or help at all . LPN OOO reported the evening when she worked with a 56 resident assignment, she was not aware until a CNA came and asked her to get a pain medication for a resident. LPN OOO reported the offgoing nurses that night had locked the keys in the medication cart and left at the end of their shift. LPN OOO stated .I never got report or nothing about that hall or any of those patients . In an interview on 1/8/25 at 11:49 AM, RN PPP reported they worked at the facility on 10/19/24 and stated . they were short on nurses that morning . RN PPP recalled going over to the 300 Hall to assist with passing morning medications. RN PPP reported there was no nurse responsible for the 300 Hall at that time. RN PPP stated .It was horrible because a lot of people did not get their medications . on 10/18/24 and 10/19/24. RN PPP reported in each instance, the offgoing nurse locked the keys in the medication cart and left the facility without giving verbal report. RN PPP reported the nurse on the 400 Hall that day (10/19/24) had been calling management for help, and no plan was in place to assist staff when there was a shortage of nurses. RN PPP reported the on-call nurse manager at the time stopped responding to phone calls. In an interview on 1/8/25 at 12:40 PM, Agency CNA QQQ reported they responded to a door alarm the evening of 10/18/24 and found Resident #103 outside the facility in the parking lot. Agency CNA QQQ reported they redirected Resident #103 back into the facility and brought him back to his room on the 300 Hall. Agency CNA QQQ could not recall which nurse was assigned to Resident #103 at the time of his attempted elopement, and stated .they were short-staffed that whole day .It was so busy. They had days with no nurse on the hall . Agency CNA QQQ reported when there was no nurse assigned to a hall, there would be an additional CNA added to help monitor until a nurse could come in and take the assignment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 1/8/25 at 1:22 PM, with Director of Nursing (DON) B and Assistant Director of Nursing (ADON) C, DON B reported the facility recognized an issue related to the 300 Hall and missed medications on 10/18/24. DON B reported a nurse came in late on 10/19/24 to assist with medication administration on the 300 Hall and help get everything caught up. In an interview on 1/8/25 at 3:40 PM, LPN QQ reported at shift change the evening of 10/18/24, no nurse showed up for the 300 Hall. LPN QQ reported they counted the controlled substances with the other day shift nurse and locked the keys in the medication cart before leaving the facility. LPN QQ reported they wrote a shift-to-shift report on a piece of paper and left it at the desk. LPN QQ stated .(With Agency staff) you don't know who will show up . LPN QQ reported RN LLL was on the 400 Hall that night and refused to take responsibility for the 300 hall because .it was too many people . LPN QQ reported the same thing happened on 10/26/24 on day shift, where no nurse took responsibility for the 300 Hall resulting in residents not receiving their ordered medications. LPN QQ reported at times when working day shift, some residents would ask the nurses to give them their scheduled evening medications before going home because they were anxious and worried that their medications would be missed. LPN QQ stated calling management or the on-call nurse was .a waste of your time . LPN QQ reported there were multiple days with missed medications and management .didn't do anything . LPN QQ reported residents on the 400 Hall missed medications and had no nurse the evening of 10/12/24. LPN QQ reported that night (10/12/24) the Agency nurse on the schedule arrived and refused the assignment, saying she wasn't going to put her license at risk. In an interview on 1/14/25 at 12:36 PM, CNA RRR reported they were assigned to Resident #103 the evening of his attempted elopement on 10/18/24. CNA RRR reported that evening, the facility was short-staffed and there was no nurse caring for the residents on the 300 Hall. CNA RRR reported at the time of Resident #103's attempted elopement, they were in a room caring for a different resident. CNA RRR reported there was a nurse on the 400 Hall, but when they asked the 400 Hall nurse for assistance they would say they were busy. CNA RRR stated .I was like, then who should I ask? CNA RRR reported they were unsure if any residents received their evening medications on 10/18/24. Review of the policy/procedure Medication Administration, dated 8/7/23, revealed .Administer medication in accordance with frequency prescribed by physician and standards of practice . Resident #103 Review of an Admission Record revealed Resident #103 was a male, with pertinent diagnoses which included stroke, anxiety, muscle weakness, depression, high blood pressure, and a history of falls. Review of the October 2024 Medication Administration Record (MAR) for Resident #103 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Latanoprost Ophthalmic Solution 0.005 % (Latanoprost) Instill 1 drop in both eyes one time a day for Glaucoma -Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 1 tablet by mouth one time a day for HTN (hypertension - high blood pressure) -Rosuvastatin Calcium Oral Tablet 5 MG (Rosuvastatin Calcium) Give 1 tablet by mouth one time a day for Hyperlipidemia (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Thiamine HCl Oral Tablet 100 MG (Thiamine HCl) Give 1 tablet by mouth one time a day -traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 75 mg by mouth at bedtime for depression -levETIRAcetam Oral Tablet 500 MG (Levetiracetam) Give 1 tablet by mouth two times a day for Seizures -traMADol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 8 hours for Pain -Acetaminophen Tablet 325 MG Give 2 tablet by mouth four times a day for discomfort Resident #104 Review of an Admission Record revealed Resident #104 was a female, with pertinent diagnoses which included dementia, Alzheimer's disease, depression, anxiety, insomnia (difficulty sleeping), chronic pain, and high blood pressure. Review of the October 2024 Medication Administration Record (MAR) for Resident #104 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Melatonin Oral Tablet 3 MG (Melatonin) Give 2 tablet by mouth one time a day for Sleep Review of the October 2024 Medication Administration Record (MAR) for Resident #104 revealed no documentation (missed medications) on 10/26/24 in the morning for the following physician orders: -Aspirin Oral Tablet Chewable 81 MG (Aspirin) Give 1 tablet by mouth one time a day for blood thinner -Cyanocobalamin Oral Tablet 100 MCG (Cyanocobalamin) Give 1 tablet by mouth one time a day for supplement -Lisinopril Oral Tablet 5 MG (Lisinopril) Give 1 tablet by mouth one time a day for HTN (hypertension - high blood pressure) -Polyethylene Glycol 3350 Powder (Polyethylene Glycol 3350) Give 17 gram by mouth one time a day for Constipation -clonazePAM Oral Tablet 0.5 MG (Clonazepam) Give 1 tablet by mouth two times a day related to anxiety Resident #113 Review of an Admission Record revealed Resident #113 was a female, with pertinent diagnoses which included diabetes, epilepsy (seizure disorder), hypothyroidism, bipolar disorder, depression, and a history of falls. Review of the October 2024 Medication Administration Record (MAR) for Resident #113 revealed no documentation (missed medications) on 10/12/24 in the evening for the following physician orders: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Gabapentin Oral Capsule 300 MG (Gabapentin) Give 1 capsule by mouth one time a day related to neuropathy (nerve pain) -Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 61 unit subcutaneously one time a day for diabetes -Levothyroxine Sodium Oral Tablet 75 MCG (Levothyroxine Sodium) Give 1 tablet by mouth one time a day related to hypothyroidism -Colace Oral Capsule 100 MG (Docusate Sodium) Give 1 capsule by mouth two times a day for constipation -QUEtiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth two times a day related to bipolar disorder -Refresh Plus Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium) Instill 2 drop in both eyes two times a day for Dry eyes -Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth three times a day for Pain Resident #120 Review of an Admission Record revealed Resident #120 was a male, with pertinent diagnoses which included dementia, atrial fibrillation (an irregular heart rate that results in poor blood flow), depression, anxiety, schizoaffective disorder (a mental health condition), Wernicke's encephalopathy (neurological disorder), hyperlipidemia, insomnia, diabetes, and hypotension (low blood pressure). Review of the October 2024 Medication Administration Record (MAR) for Resident #120 revealed no documentation (missed medications) on 10/12/24 in the evening for the following physician orders: -Atorvastatin Calcium Oral Tablet 10 MG (Atorvastatin Calcium) Give 1 tablet by mouth one time a day related to hyperlipidemia -Melatonin Oral Tablet 3 MG (Melatonin) Give 1 tablet by mouth one time a day for Sleep -OLANZapine Oral Tablet 20 MG (Olanzapine) Give 1 tablet by mouth one time a day related to schizoaffective disorder -traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth one time a day related to depression -Sotalol HCl Oral Tablet 160 MG (Sotalol HCl) Give 1 tablet by mouth two times a day related to atrial fibrillation -Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 4 capsule by mouth three times a day related to dementia (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Lactulose Oral Solution 10 GM/15 ML (Lactulose) Give 30 ml by mouth three times a day related to Wernicke's encephalopathy -Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 1 tablet by mouth three times a day related to hypotension -Haloperidol Oral Tablet 5 MG (Haloperidol) Give 1 tablet by mouth four times a day related to schizoaffective disorder Resident #124 Review of an Admission Record revealed Resident #124 was a male, with pertinent diagnoses which included heart disease, hyperlipidemia (high levels of fat in the blood), seizure disorder, high blood pressure, atrial fibrillation (an irregular heart rate that results in poor blood flow), and BPH (an enlarged prostate that can cause difficulty urinating). Review of the October 2024 Medication Administration Record (MAR) for Resident #124 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Atorvastatin Calcium Oral Tablet 40 MG (Atorvastatin Calcium) Give 1 tablet by mouth one time a day for hyperlipidemia -Tamsulosin HCl Oral Capsule 0.4 MG (Tamsulosin HCl) Give 1 capsule by mouth one time day for BPH -Eliquis Oral Tablet 5 MG Apixaban) Give 1 tablet by mouth two times a day related to heart disease/atrial fibrillation -Gabapentin Oral Capsule 100 MG Give 2 capsule by mouth two times a day for Pain -Lacosamide Oral Tablet 100 MG (Lacosamide) Give 1 tablet by mouth two times a day for seizure -Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours for pain Review of the October 2024 Medication Administration Record (MAR) for Resident #124 revealed no documentation (missed medications) on 10/26/24 in the morning for the following physician orders: -Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day for heart failure/atrial fibrillation -Senna Oral Tablet 8.6 MG (Sennosides) Give 2 tablet by mouth one time a day for bowels -Eliquis Oral Tablet 5 MG Apixaban) Give 1 tablet by mouth two times a day related to heart disease/atrial fibrillation -Gabapentin Oral Capsule 100 MG Give 2 capsule by mouth two times a day for Pain -Lacosamide Oral Tablet 100 MG (Lacosamide) Give 1 tablet by mouth two times a day for seizure (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours for pain Resident #125 Review of an Admission Record revealed Resident #125 was a male, with pertinent diagnoses which included diabetes. Review of the October 2024 Medication Administration Record (MAR) for Resident #125 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously one time a day for diabetes -traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth one time a day for Depression Review of the October 2024 Medication Administration Record (MAR) for Resident #125 revealed no documentation (missed medications) on 10/19/24 in the morning for the following physician orders: -NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject 10 unit subcutaneously three times a day for diabetes -NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale three times a day for diabetes Resident #126 Review of an Admission Record revealed Resident #126 was a female, with pertinent diagnoses which included depression, anxiety, and diabetes. Review of a Minimum Data Set (MDS) assessment for Resident #126, with a reference date of 11/15/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated she was cognitively intact. In an interview on 1/9/25 at 12:21 PM, Resident #126 recalled several nights in October 2024 where no nurse was assigned to her hall. Resident #126 stated .I guess (the nurse) just didn't show up. I think that is what the excuse was . Resident #126 reported she missed some medications and others were administered late. Resident #126 stated .I was kind of worried because I didn't know. I have sugar (diabetes). I didn't know then if I would have a reaction . Resident #126 reported she was worried about how long she could go without medication. Resident #126 reported issues with anxiety and stated .The anxiety got to be so bad . nobody (was) handing out meds (medications) .there was no one . In an email on 1/9/25 at 3:47 PM, DON B reported 30 of 32 residents on the 400 Hall missed medication on 10/12/24, 30 of 30 residents on the 300 Hall missed medication on 10/18/24, 6 of 30 residents on the 300 Hall missed medication on 10/19/24, and 24 of 29 residents on the 300 Hall missed medication on 10/26/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Immediate Jeopardy that began on 10/12/24 was removed on 10/28/24 when the facility took the following actions to remove the immediacy: 1) Staff involved in the incidents were disciplined including termination. 2) All missed medications were addressed with physician orders reviewed and implemented. Families and responsible parties were notified of the incidents and corrective actions taken. Beginning 10/21/24, morning meetings now include reviews of missed medications for immediate investigation and follow-up. Medication errors are documented, with physicians, residents, and responsible parties notified. 3) Facility policies on Medication Administration and Controlled Medication Guidelines were reviewed and all licensed nurses were re-educated. All licensed nursing staff received additional and/or re-education on Medication Administration and Error Prevention and Reporting Shortages and Advocating for Residents on 11/1/24. Additional in-service education provided to all nursing and CNA staff on 11/5/24 and 11/7/24. 4) Beginning 10/28/24, nursing leadership on-call with an identified cell phone for staff to call if needed for any reason. Nursing remains on-call 24/7. An additional process was added for calling at the start of each shift to ensure all scheduled staff have arrived. 5) In situations where coverage is needed, the on-call staff will prioritize ensuring clinical supervision and assistance with medication pass. Management staff to review the current staffing matrix and identify available resources including but not limited to agency use through two contracted vendors, PRN (as needed) staff and current staff working overtime. Identify on-call staff to come in as well as beginning to cross-train existing personnel to cover immediate needs. 6) DON/Designee and Administrator will meet daily to discuss any calls from the previous day/night to ensure continuity of care throughout all departments and ensuring all needs have been met. 41982 DPS Statement B: Based on interview and record review, the facility failed to protect the residents' right to be free from physical/verbal abuse by staff and physical abuse by a resident in 3 of 15 residents reviewed for abuse, resulting in staff-to-resident physical and verbal abuse by CNA UU toward Resident #114 on 11/20/24 and resident-to-resident physical abuse by Resident #106 toward Resident #108 on 9/29/24 and Resident #109 on 10/3/24. Findings include: Staff-to-Resident Abuse: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a Facility Reported Incident (FRI) Intake Information Report revealed, .Facility incident report received via online submission on: 11/20/24, 1:30 PM .Incident Summary Staff members (Certified Nurse Aide (CNA) M) & (CNA N) reported to (Assistant Director of Nursing (ADON) C) that (CNA UU) while washing resident (Resident #114) up, resident hit (CNA UU) in the arm. The assigned CNA (CNA UU) hit resident back .Investigation Summary Title of Incident: Resident Abuse Date/Time of Incident: 11/20/24 11:30 am .Statement of Incident: Three CNAs were providing care to (Resident #114) around 11:30 am. The assigned CNA (CNA UU) was standing to the left side of the resident. The resident reached up and grabbed at the CNAs (CNA UU) shoulders. The CNA (CNA UU) began smacking her with an open palm to (Resident #114)'s back. It was reported by the two other CNAs (CNA M & N) that (CNA UU) and (Resident #114) continued hitting each other back and forth. Per CNA (CNA UU) she grabbed the residents arm to stop her from hitting her. Per CNAs (CNA M & N), CNA (CNA UU) had pushed it down and they felt she had twisted it and continued to hit each other with an open hand. There is a discrepancy in the number of times that the resident was hit, however statements of both CNAs (CNA M & N) state that it was approximately 10-20 times 911 was called. (CNA UU) was kept in an office with oversight until the police arrived. When they arrived, they talked with (CNA UU), and she admitted to them what she had just done to Resident #114. They immediately arrested her and escorted her out of the facility .A skin assessment was completed, and redness was identified immediately to the left shoulder and arm .Pain assessment was completed and pain meds (medications) given post incident . Resident #114 Review of an Admission Record revealed Resident #114 was a female, with pertinent diagnoses which included: cognitive communication deficit, major depressive disorder, muscle weakness (generalized). Review of a Minimum Data Set (MDS) assessment for Resident #114, with a reference date of 10/10/24 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #114 was severely cognitively impaired. Review of Resident #114's current Care Plan revealed the focus, Resident has a past potentially traumatic event related to being physical assault (being slapped multiple times) with a date initiated of 11/21/24 and care planned interventions which included, Encourage resident to talk about traumatic event at their own pace .Monitor for changes in cognition and behavior and report observation to services/nursing .Offer reassurance of safety and security with date initiated of 11/21/24. (It should be noted that this care plan was developed following the staff to resident abuse incident.) Review of a witness statement from CNA M (not dated) revealed, We were wrapping up the bed bath. Assigned CNA (CNA UU) washed up arm pits. Resident had hit assigned CNA (CNA UU) in the arm. The assigned CNA (CNA UU) hit resident with substantial force. They hit each other back and forth over 10 times. During the situation the CNA (CNA UU) said, I fight back multiple times. Resident called assigned CNA (CNA UU) an A**hole the assigned CNA (CNA UU) responded by saying, your mom is an a**hole. The area of injury is upper arm, shoulder, twisting the wrist. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 1/2/25 at 2:23 PM, CNA M reported that he and 2 other staff (CNA N and CNA UU) went in to provide Resident #114 care. CNA M reported CNA N was a unit aide at the time and was there to watch and learn. CNA M reported Resident #114 got combative during her care and began to swat and swing at CNA UU. CNA M reported CNA UU began swatting and swinging back at Resident #114 and when Resident #114 told CNA UU that her mom was an a**hole, CNA UU then told Resident #114 that her mom was an a**hole. CNA M reported CNA UU also told Resident #114 that she fought back. CNA M reported he wasn't sure when, but at one point CNA UU grabbed Resident #114's hand and twisted her arm. CNA M reported Resident #114 and CNA UU continued to hit each other back and forth. CNA M reported that doing anything back to a resident was excessive and that Resident #114's arm from the elbow up was red where CNA UU had hit her. CNA M reported it wasn't just a slap, but rather, CNA UU had moved her hand back over her head and then hit the resident with open hand multiple times. Review of a witness statement from CNA N (not dated) revealed, Around 1130-1140am, I (CNA N), (CNA M), (CNA UU) went to give a resident to give her a bed bath. I was standing at the foot of the bed and (CNA UU) was on the left side of the resident. The resident grabbed (CNA UU)'s shoulder and (CNA UU) started smacking the resident saying, I hit back and smacked the resident's hand again. The resident began crying and they started hitting each other back and forth. (CNA UU) then twisted the resident's arm. Me and (CNA M) walked out. As we were walking down the hall, I could still hear (CNA UU) and resident yelling at each other and another loud slap. I texted (ADON C) to talk and told her everything. Resident got hit at least over 20 times on her left upper side of her body and back of the head and upper back. In an interview on 1/2/25 at 3:46 PM, CNA N reported on the day of the incident, she had been training at the time and had gone in Resident #114's room with CNA M and CNA U to observe them provide Resident #114 with a bed bath. CNA N reported when CNA UU started washing Resident #114 up, Resident #114 grabbed CNA UU's clothing. CNA N reported then CNA UU decided to turn around and started slapping Resident #114. CNA N reported Resident #114 started yelling and crying at that point to which CNA UU yelled back at Resident #114 and reportedly said f*ck you, f*uck your mom, you hit me and I will hit you back. CNA N reported at that time CNA UU started hitting Resident #114 repeatedly. CNA N reported the slapping happened for approximately 3-5 minutes, but that it seemed like forever. CNA N reported CNA UU then told CNA M to give her the brief for Resident #114 so they could put it on her. CNA N reported after CNA M gave CNA UU the brief (incontinence underwear) and put it on Resident #114, they (CNA N and CNA M) walked out of the room. CNA N reported that is when she realized that CNA UU was still in the room with Resident #114 and heard a loud slap, like a clapping sound. CNA N reported hearing the slap down the hallway. CNA N reported she then text messaged ADON C to report the incident. In an interview on 1/3/25 at 9:30 AM, ADON C reported CNA N had texted her and said she needed to speak with her because she had just seen something real bad. ADON C reported when she approached CNA N, CNA N started crying and reported to ADON C that she had just seen CNA UU beat a resident. ADON C reported she went and found CNA UU (who was out of Resident #114's room at this point) and CNA UU openly admitted that she had hit Resident #114. ADON C reported CNA UU, CNA M, and CNA N were placed in separate rooms to give statements and the police [TRUNCATED]

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 This citation pertains to Intake # MI00149269, MI00149295, & MI00149428. Based on interview, and record review, the facility failed to prevent the misappropriation of resident medications in 3 of 15 residents (Resident #116, #118, & #119) reviewed for misappropriation of property, resulting in the unauthorized use of a resident's personal property, and the potential for missed medications and uncontrolled anxiety. Findings include: Review of the policy/procedure Controlled Medication Guidelines, dated 3/20/24, revealed .When the licensed nurse removes the controlled medication from the package, they will document the quantity removed and the quantity left on the Controlled Drug Receipt/Record/Disposition Form .After administration of the controlled medication the licensed nurse will document the administration on the medication administration record . Resident #116 Review of an Admission Record revealed Resident #116 was a male, with pertinent diagnoses which included lung cancer, heart failure, and obstructive lung disease. Review of an Order Summary Report for Resident #116 revealed the physician order .LORazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for Anxiety . with a start date of 12/13/24. In an interview on 1/6/25 at 3:48 PM, Licensed Practical Nurse (LPN) QQ reported they were present upon Resident #116's admission to the facility on [DATE]. LPN QQ recalled Resident #116 brought a bottle of lorazepam tablets (a controlled substance) from home to the facility. LPN QQ reported they counted the number of lorazepam tablets with another nurse, LPN FF, and wrote the total number of tablets at the top of a Controlled Substances Proof of Use form. LPN QQ reported they then placed the medication in the secondary locked controlled substance drawer of the medication cart. In an interview on 1/6/25 at 4:10 PM, Assistant Director of Nursing (ADON) C reported they were notified the morning of 12/19/24 of a discrepancy in the total number of lorazepam tablets for Resident #116 during the shift change controlled substances count process at 10:49 AM. ADON C reported the offgoing nurse who had responsibility for the controlled substances, Agency Registered Nurse (RN) GGG was immediately suspended pending investigation, and the police were notified. ADON C reported Resident #116 admitted on [DATE] with a total of 17 lorazepam tablets, one was administered on 12/13/24, and the total remaining should have been 16 tablets. ADON C reported during the shift change controlled substances count process the morning of 12/19/24 at 10:49 AM, only 12 tablets remained. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/7/25 at 12:45 PM, Agency LPN HHH reported they were assigned to Resident #116 on night shift after his admission to the facility on [DATE]. Agency LPN HHH reported they counted the total number of lorazepam tablets for Resident #116 during shift-to-shift handoff with LPN QQ, and recalled Resident #116 admitted from home with a total of 17 lorazepam tablets. Agency LPN HHH reported that night Resident #116 was anxious and restless, so they administered one of the PRN (as needed) lorazepam to Resident #116. Review of a Controlled Substances Proof of Use form for Resident #116 revealed one Lorazepam 0.5 MG Tablet was pulled from Resident #116's medication supply for administration on 12/13/24 at 7:55 PM. In an interview on 1/7/25 at 1:22 PM, Registered Nurse (RN) KK reported they came into work late morning on 12/19/24 and when completing the shift-to-shift controlled substances count, noted a discrepancy with the total number of lorazepam tablets for Resident #116. RN KK stated .When I did the count, it was not right . and identified that several doses were missing. RN KK reported when a controlled substance is removed from the secondary locked box within the medication cart it should be signed out (accounted for) on the Controlled Substances Proof of Use form. RN KK reported when the medication is administered to the resident, it should be documented in the Medication Administration Record (MAR). Resident #118 Review of an Admission Record revealed Resident #118 was a male, with pertinent diagnoses which included heart failure, atrial fibrillation (an irregular heart rate that results in poor blood flow), respiratory failure, kidney disease, stroke, and high blood pressure. Review of a Minimum Data Set (MDS) assessment for Resident #118, with a reference date of 12/17/24, revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated severe cognitive impairment. Review of a Nursing - Transfer to Hospital Summary for Resident #118, dated 12/30/24 at 6:37 PM, revealed .Resident was in bed alert with prompting .Resident brother at bedside during the morning. Medications reviewed with brother .Brother was concerned resident was not staying awake during visit .VS (Vital Signs) obtained (oxygen via nasal cannula) increased to 5 (Liters) .to maintain (oxygen) above 90%. NP (Nurse Practitioner) called .brother wanted to send patient to ED (Emergency Department) . In an interview on 1/6/25 at 12:15 PM, Unit Manager LL reported they assessed Resident #118 prior to his hospitalization on [DATE]. Unit Manager LL reported they were working on a different unit when Resident #118's nurse came to get them for a second opinion. Unit Manager LL reported Resident #118's family member had been in earlier asking about Resident #118's ordered medications. Unit Manager LL reported Resident #118's oxygen saturation had been low and the assigned nurse had increased his oxygen to keep his saturation above 90%. Unit Manager LL reported Resident #118 appeared calm and did make eye contact and respond to his name. Unit Manager LL reported Resident #118's family member was concerned, and wanted Resident #118 to be sent to the hospital since he seemed more sleepy/tired than usual. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/6/25 at 12:23 PM, Agency Licensed Practical Nurse (LPN) DDD reported they were the nurse assigned to Resident #118 at the time of his hospitalization on [DATE]. Agency LPN DDD reported Resident #118 was awake but appeared to have labored breathing. Agency LPN DDD reported since they were not sure of Resident #118's baseline, they requested Unit Manager LL to assess Resident #118. Agency LPN DDD reported they checked on him several times and he would respond and make eye contact. Agency LPN DDD stated .the breathing was my concern . and reported both Resident #118's pulse and respiration rate were high. Agency LPN DDD reported Resident #118's family member was concerned that Resident #118 was not his usual self, and wanted him sent to the hospital for further evaluation. Agency LPN DDD reported Resident #118 had a PRN (as needed) medication ordered for anxiety, but no doses were administered on their shift. Review of a Hospital Physician Note for Resident #118, dated 1/1/25, revealed .Patient was brought in from his long-term care facility to emergency department with acute encephalopathy leading to worsening acute hypoxic respiratory failure. He was difficult to arouse in the emergency department so he was admitted to intensive care unit for close monitoring .suspected to be medication related: Drug screen was positive for trazodone (not on facility med (medication) list, so unclear how he received this medication), but also had been on Xanax but this did not show on drug screen . Review of a Hospital Physician Note for Resident #118, dated 1/2/25, revealed .Drug Screen .Trazodone . Facility was contacted, and there was no record of trazodone administration .there is report that the patient did receive Vistaril and Xanax on the days leading up to admission. There was no benzodiazapines identified on screens .It is felt that the altered mental status may have been related to trazodone (found) on a drug screen, there is no documentation of this ever being given at the facility .there is concern for drug diversion . In an interview on 1/7/25 at 9:30 AM, Agency Registered Nurse (RN) BBB reported Resident #118 had a PRN medication for anxiety and recalled administering the medication to Resident #118. Agency RN BBB stated .(Resident #118) had a lot of anxiety. (He) wouldn't keep his oxygen (nasal cannula) on (and) would have episodes of rapid breathing . Agency RN BBB reported Resident #118 took all his medication via a PEG (Percutaneous Endoscopic Gastrostomy) tube (a feeding tube placed through the abdominal wall). Review of an Order Summary Report for Resident #118 revealed the physician order .Xanax Oral Tablet 0.5 MG (Alprazolam) Give 0.5 mg via G-Tube (feeding tube) every 8 hours as needed for Anxiety . with a start date of 12/19/24. Note this order was discontinued on 12/26/24. Review of an Order Summary Report for Resident #118 revealed the physician order .Xanax Oral Tablet 0.5 MG (Alprazolam) Give 1 tablet via PEG-Tube (feeding tube) every 8 hours as needed for Anxiety . with a start date of 12/29/24. Review of a Controlled Drug Receipt/Record/Disposition Form for Resident #118 revealed one Alprazolam 0.5 MG Tablet was pulled from Resident #118's medication supply for administration on 12/19/24 at 7:00 AM, one on 12/19/24 at 7:00 PM, one on 12/28/24 at 9:00 PM, and one on 12/29/24 at 12:22 PM. Note there was no active physician order for Alprazolam 0.5 MG Tablet for Resident #118 on 12/28/24. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the December 2024 Medication Administration Record (MAR) for Resident #118 revealed the medication Alprazolam 0.5 MG Tablet was documented as administered only one time, on 12/29/24 at 12:22 PM. No administration documentation noted in the December 2024 MAR related to the Alprazolam 0.5 MG Tablets pulled from Resident #118's medication supply on 12/19/24 (two doses) and 12/28/24 (one dose). Review of an Order Summary Report for Resident #118 revealed no physician order for Trazodone. In an interview on 1/9/25 at 1:42 PM, Assistant Director of Nursing (ADON) C reported Resident #118 was sent to the hospital on 12/30/24 and a drug screen revealed trazodone (an antidepressant) in his system, which he was not prescribed. ADON C reported the drug screen also indicated no alprazolam in his system, which he did have a prescription for and per the facility medication administration records had been given two doses prior to his hospitalization . ADON C reported the facility is currently investigating the situation due to the potential for medication diversion. Resident #119 Review of an Admission Record revealed Resident #119 was a female, with pertinent diagnoses which included hypothyroidism. Review of an Order Summary Report for Resident #119 revealed the physician order .Levothyroxine Sodium Oral Tablet 100 MCG (Levothyroxine Sodium) Give 1 tablet by mouth one time a day for Hypothyroidism . with a start date of 12/17/24. In an interview on 1/7/25 at 9:30 AM, Agency Registered Nurse (RN) BBB reported they took Resident #119's .Levothyroxine Sodium 100 MCG . tablets from the medication cart and administered the medication to a different resident.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41982 This citation pertains to intake #MI00149046 Based on interview and record review, the facility failed to implement their abuse policy and respond immediately to protect a resident from staff to resident abuse in 1 (Resident #114) of 15 residents reviewed for abuse, resulting in continued physical/verbal abuse when facility staff did not immediately identify abuse and remove the resident from contact with the alleged abuser. Findings include: Review of a Facility Reported Incident (FRI) Intake Information Report revealed, .Facility incident report received via online submission on: 11/20/24, 1:30 PM .Incident Summary Staff members (Certified Nurse Aide (CNA) M) & (CNA N) reported to (Assistant Director of Nursing (ADON) C) that (CNA UU) while washing resident (Resident #114) up, resident hit (CNA UU) in the arm. The assigned CNA (CNA UU) hit resident back .Investigation Summary Title of Incident: Resident Abuse Date/Time of Incident: 11/20/24 11:30 am .Statement of Incident: Three CNAs were providing care to (Resident #114) around 11:30 am. The assigned CNA (CNA UU) was standing to the left side of the resident. The resident reached up and grabbed at the CNAs (CNA UU) shoulders. The CNA (CNA UU) began smacking her with an open palm to (Resident #114)'s back. It was reported by the two other CNAs (CNA M & N) that (CNA UU) and (Resident #114) continued hitting each other back and forth. Per CNA (CNA UU) she grabbed the residents arm to stop her from hitting her. Per CNAs (CNA M & N), CNA (CNA UU) had pushed it down and they felt she had twisted it and continued to hit each other with an open hand. There is a discrepancy in the number of times that the resident was hit, however statements of both CNAs (CNA M & N) state that it was approximately 10-20 times Resident #114 Review of an Admission Record revealed Resident #114 was a female, with pertinent diagnoses which included: cognitive communication deficit, major depressive disorder, muscle weakness (generalized). Review of a Minimum Data Set (MDS) assessment for Resident #114, with a reference date of 10/10/24 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #114 was severely cognitively impaired. Review of Resident #114's current Care Plan revealed the focus, Resident has a past potentially traumatic event related to being physical assault (being slapped multiple times) with a date initiated of 11/21/24 and care planned interventions which included, Encourage resident to talk about traumatic event at their own pace .Monitor for changes in cognition and behavior and report observation to services/nursing .Offer reassurance of safety and security with date initiated of 11/21/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a witness statement from CNA M (not dated) revealed, We were wrapping up the bed bath. Assigned CNA (CNA UU) washed up arm pits. Resident had hit assigned CNA (CNA UU) in the arm. The assigned CNA (CNA UU) hit resident with substantial force. They hit each other back and forth over 10 times. During the situation the CNA (CNA UU) said, I fight back multiple times. Resident called assigned CNA (CNA UU) an A**hole the assigned CNA (CNA UU) responded by saying, your mom is an a**hole. The area of injury is upper arm, shoulder, twisting the wrist. In an interview on 1/2/25 at 2:23 PM, CNA M discussed the details of his witness statement with this surveyor and recounted the staff-to-resident abuse event that he had witnessed on 11/20/24 at 1:30 PM. CNA M reported he had been in the room at the time of the abuse because he was there to assist with Resident #114's bed bath. This surveyor asked CNA M what, if anything, had he and the other CNA (CNA N) who were present during the abuse done to intervene and protect Resident #114. CNA M reported they had done nothing. CNA M reported he had thought if he had gotten in the middle, CNA UU might have posed a threat to him as well and stated, I honestly couldn't even think straight. I have never seen anybody actually hit a resident with substantial force before at work with an elderly patient. CNA M reported it was hard to make the right decision and by the time he had gotten himself together the incident was over. Review of a witness statement from CNA N (not dated) revealed, Around 1130-1140am, I (CNA N), (CNA M), (CNA UU) went to give a resident to give her a bed bath. I was standing at the foot of the bed and (CNA UU) was on the left side of the resident. The resident grabbed (CNA UU)'s shoulder and (CNA UU) started smacking the resident saying, I hit back and smacked the resident's hand again. The resident began crying and they started hitting each other back and forth. (CNA UU) then twisted the resident's arm. Me and (CNA M) walked out. As we were walking down the hall, I could still hear (CNA UU) and resident yelling at each other and another loud slap. I texted (ADON C) to talk and told her everything. Resident got hit at least over 20 times on her left upper side of her body and back of the head and upper back. In an interview on 1/2/25 at 3:46 PM, CNA N discussed the details of her witness statement with this surveyor and recounted the staff-to-resident abuse event that she had witnessed on 11/20/24 at 1:30 PM. CNA N reported she had been training with CNA UU that day and was told to observe CNA UU and CNA M provide Resident #114 with a bed bath. CNA N reported when CNA UU started washing Resident #114 up, Resident #114 grabbed CNA UU's clothing at which point CNA UU turned around and started slapping Resident #114. CNA N reported then CNA UU and Resident #114 started hitting each other back and forth. This surveyor asked CNA N what, if anything, had she and the other CNA (CNA M) who were present during the abuse done to intervene and protect Resident #114. CNA N reported that she and CNA M were just in shock. CNA N reported she hadn't tried to intervene because she just got stuck and was scared and didn't know what to do. CNA N reported she hadn't known if intervening would escalate things worse. In an interview on 1/3/25 at 9:30 AM, ADON C reported she had worked on the investigation of the staff-to-resident abuse between CNA UU and Resident #114. ADON C reported the expectation was that CNA M and CNA N would have stopped the abuse and protected the resident. ADON C reported CNA M and CNA N should not have left CNA UU alone in the room with Resident #114 after they had witnessed the abuse. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Abuse Policy & Procedure last revised 4/13/23 revealed, POLICY OVERVIEW: Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property .PROTECTION: Abuse against residents can be perpetrated by various people within the facility. The facility supports and protects residents, family members, and staff from harm during an investigation of alleged abuse including retribution and retaliation. Protective actions depend upon the people involved. Any allegation of abuse must be immediately reported to the supervisor and the Abuse Prevention Coordinator .The facility will make efforts to ensure all residents area protected from retaliation, physical and psychosocial harm during and after the investigation. Examples include but are not limited to: * Immediately removing the resident from contact with the alleged abuser . During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included re-education to all staff on the facility policy & procedure on Abuse, on-going staff training on caregiver fatigue, re-education to staff on dealing with combative residents, and provided information and resources on staff burnout and fatigue. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 This citation pertains to Intake # MI00147580, MI00147814, MI00147822, & MI00147838. Based on interview, and record review, the facility failed to report allegations of abuse and neglect to the State Agency in a timely manner in 11 of 15 residents (Resident #103, #104, #113, #120, #124, #125, #126, #105, #106, #108, & #109) reviewed for abuse and neglect, resulting in the potential for additional allegations of abuse and neglect to go unreported and delayed investigation. Findings include: In an interview on 1/6/25 at 3:48 PM, Licensed Practical Nurse (LPN) QQ reported staffing was a major issue in September/October 2024 after the change in facility ownership. LPN QQ reported at times they were the only nurse on the 300/400 Hall, or there was no oncoming nurse at the end of their shift. LPN QQ reported on 10/18/24 the Agency nurse scheduled to relieve them at 6:30 PM on the 300 Hall did not show up for the shift. LPN QQ reported that evening there was only one nurse on the 400 Hall, and no nurse on the 300 Hall. LPN QQ reported the evening of 10/18/24 on the 300 Hall, no residents received scheduled medications. In an interview on 1/8/25 at 9:15 AM, Registered Nurse (RN) LLL reported they were assigned the 400 Hall on 10/18/24 from 6:30 PM-7:00 AM. RN LLL reported they could not recall who was responsible for the 300 Hall that night (10/18/24 between 6:30 PM-11:00 PM). In an interview on 1/8/25 at 9:32 AM, Certified Nursing Assistant (CNA) J reported there was no nurse assigned to the 300 Hall on 10/18/24 between 6:30 PM-11:00 PM) and one nurse on the 400 Hall (Registered Nurse (RN) LLL). In an interview on 1/8/25 at 9:52 AM, Former Assistant Director of Nursing (ADON) MMM reported they were aware that multiple residents missed medications the evening of 10/18/24 and stated .we did look into that . In an interview on 1/8/25 at 10:07 AM, Agency Licensed Practical Nurse (LPN) JJJ reported they worked on the 100 Hall the evening of 10/18/24 at the time of Resident #103's attempted elopement from the facility. Agency LPN JJJ reported that evening there was no nurse assigned to the section of the building (the 300 Hall) where Resident #103 resided. Agency LPN JJJ reported there was only a nurse on the 400 Hall. Agency LPN JJJ reported they took over some of the rooms on the 300 Hall after 11:00 PM, but from 6:30 PM-11:00 PM on 10/18/24 there was no nurse assigned to the residents on the 300 Hall. Agency LPN JJJ reported the evening of 10/18/24 was not the first time where no nurse was assigned to a section of residents, and stated .I canceled all my shifts after that. (I) did not feel safe working there . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/8/25 at 10:44 AM, LPN OOO reported concerns with staffing at the facility. LPN OOO reported at times there would be one nurse assigned to over 50 residents. LPN OOO stated .They were telling me I had to work like that. I told them there are people who are a fall risk, people with mental health issues .I told them it's not safe .I am not going to put these people's lives in jeopardy . LPN OOO reported they worked one shift with a 56 resident assignment and stated .it was too dangerous .It was the most nerve-wracking night of my life . LPN OOO reported they spoke with former Assistant Director of Nursing (ADON) MMM at the time about the staffing concerns and no assistance/guidance or direction was provided. LPN OOO reported the evening when she worked with a 56 resident assignment, she was not aware until a CNA came and asked her to get a pain medication for a resident. LPN OOO reported the offgoing nurses that night had locked the keys in the medication cart and left at the end of their shift. LPN OOO stated .I never got report or nothing about that hall or any of those patients . In an interview on 1/8/25 at 11:49 AM, RN PPP reported they worked at the facility on 10/19/24 and stated . they were short on nurses that morning . RN PPP recalled going over to the 300 Hall to assist with passing morning medications. RN PPP stated .It was horrible because a lot of people did not get their medications . on 10/18/24 and 10/19/24. RN PPP reported in each instance, the offgoing nurse locked the keys in the medication cart and left the facility without giving verbal report. In an interview on 1/8/25 at 12:40 PM, Agency CNA QQQ reported they responded to a door alarm the evening of 10/18/24 and found Resident #103 outside the facility in the parking lot. Agency CNA QQQ reported they redirected Resident #103 back into the facility and brought him back to his room on the 300 Hall. Agency CNA QQQ could not recall which nurse was assigned to Resident #103 at the time of his attempted elopement, and stated .they were short-staffed that whole day .It was so busy. They had days with no nurse on the hall . In an interview on 1/8/25 at 1:22 PM, with Director of Nursing (DON) B and Assistant Director of Nursing (ADON) C, DON B reported the facility recognized an issue related to the 300 Hall and missed medications on 10/18/24. DON B reported a nurse came in late on 10/19/24 to assist with medication administration on the 300 Hall and help get everything caught up. In an interview on 1/8/25 at 3:40 PM, LPN QQ reported at shift change the evening of 10/18/24, no nurse showed up for the 300 Hall. LPN QQ reported they counted the controlled substances with the other day shift nurse and locked the keys in the medication cart before leaving the facility. LPN QQ reported they wrote a shift-to-shift report on a piece of paper and left it at the desk. LPN QQ reported RN LLL was on the 400 Hall that night and refused to take responsibility for the 300 hall because .it was too many people . LPN QQ reported the same thing happened on 10/26/24 on day shift, where no nurse took responsibility for the 300 Hall resulting in residents not receiving their ordered medications. LPN QQ reported there were multiple days with missed medications and management .didn't do anything . LPN QQ reported residents on the 400 Hall missed medications and had no nurse the evening of 10/12/24. LPN QQ reported that night (10/12/24) the Agency nurse on the schedule arrived and refused the assignment, saying she wasn't going to put her license at risk. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/14/25 at 12:36 PM, CNA RRR reported they were assigned to Resident #103 the evening of his attempted elopement on 10/18/24. CNA RRR reported that evening, the facility was short-staffed and there was no nurse caring for the residents on the 300 Hall. CNA RRR reported at the time of Resident #103's attempted elopement, they were in a room caring for a different resident. CNA RRR reported there was a nurse on the 400 Hall, but when they asked the 400 Hall nurse for assistance they would say they were busy. CNA RRR stated .I was like, then who should I ask? CNA RRR reported they were unsure if any residents received their evening medications on 10/18/24. Resident #103 Review of an Admission Record revealed Resident #103 was a male, with pertinent diagnoses which included stroke, anxiety, muscle weakness, depression, high blood pressure, and a history of falls. Review of the October 2024 Medication Administration Record (MAR) for Resident #103 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Latanoprost Ophthalmic Solution 0.005 % (Latanoprost) Instill 1 drop in both eyes one time a day for Glaucoma -Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 1 tablet by mouth one time a day for HTN (hypertension - high blood pressure) -Rosuvastatin Calcium Oral Tablet 5 MG (Rosuvastatin Calcium) Give 1 tablet by mouth one time a day for Hyperlipidemia -Thiamine HCl Oral Tablet 100 MG (Thiamine HCl) Give 1 tablet by mouth one time a day -traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 75 mg by mouth at bedtime for depression -levETIRAcetam Oral Tablet 500 MG (Levetiracetam) Give 1 tablet by mouth two times a day for Seizures -traMADol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 8 hours for Pain -Acetaminophen Tablet 325 MG Give 2 tablet by mouth four times a day for discomfort Resident #104 Review of an Admission Record revealed Resident #104 was a female, with pertinent diagnoses which included dementia, Alzheimer's disease, depression, anxiety, insomnia (difficulty sleeping), chronic pain, and high blood pressure. Review of the October 2024 Medication Administration Record (MAR) for Resident #104 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Melatonin Oral Tablet 3 MG (Melatonin) Give 2 tablet by mouth one time a day for Sleep (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October 2024 Medication Administration Record (MAR) for Resident #104 revealed no documentation (missed medications) on 10/26/24 in the morning for the following physician orders: -Aspirin Oral Tablet Chewable 81 MG (Aspirin) Give 1 tablet by mouth one time a day for blood thinner -Cyanocobalamin Oral Tablet 100 MCG (Cyanocobalamin) Give 1 tablet by mouth one time a day for supplement -Lisinopril Oral Tablet 5 MG (Lisinopril) Give 1 tablet by mouth one time a day for HTN (hypertension - high blood pressure) -Polyethylene Glycol 3350 Powder (Polyethylene Glycol 3350) Give 17 gram by mouth one time a day for Constipation -clonazePAM Oral Tablet 0.5 MG (Clonazepam) Give 1 tablet by mouth two times a day related to anxiety Resident #113 Review of an Admission Record revealed Resident #113 was a female, with pertinent diagnoses which included diabetes, epilepsy (seizure disorder), hypothyroidism, bipolar disorder, depression, and a history of falls. Review of the October 2024 Medication Administration Record (MAR) for Resident #113 revealed no documentation (missed medications) on 10/12/24 in the evening for the following physician orders: -Gabapentin Oral Capsule 300 MG (Gabapentin) Give 1 capsule by mouth one time a day related to neuropathy (nerve pain) -Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 61 unit subcutaneously one time a day for diabetes -Levothyroxine Sodium Oral Tablet 75 MCG (Levothyroxine Sodium) Give 1 tablet by mouth one time a day related to hypothyroidism -Colace Oral Capsule 100 MG (Docusate Sodium) Give 1 capsule by mouth two times a day for constipation -QUEtiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth two times a day related to bipolar disorder -Refresh Plus Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium) Instill 2 drop in both eyes two times a day for Dry eyes -Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth three times a day for Pain (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #120 Review of an Admission Record revealed Resident #120 was a male, with pertinent diagnoses which included dementia, atrial fibrillation (an irregular heart rate that results in poor blood flow), depression, anxiety, schizoaffective disorder (a mental health condition), Wernicke's encephalopathy (neurological disorder), hyperlipidemia, insomnia, diabetes, and hypotension (low blood pressure). Review of the October 2024 Medication Administration Record (MAR) for Resident #120 revealed no documentation (missed medications) on 10/12/24 in the evening for the following physician orders: -Atorvastatin Calcium Oral Tablet 10 MG (Atorvastatin Calcium) Give 1 tablet by mouth one time a day related to hyperlipidemia -Melatonin Oral Tablet 3 MG (Melatonin) Give 1 tablet by mouth one time a day for Sleep -OLANZapine Oral Tablet 20 MG (Olanzapine) Give 1 tablet by mouth one time a day related to schizoaffective disorder -traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth one time a day related to depression -Sotalol HCl Oral Tablet 160 MG (Sotalol HCl) Give 1 tablet by mouth two times a day related to atrial fibrillation -Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 4 capsule by mouth three times a day related to dementia -Lactulose Oral Solution 10 GM/15 ML (Lactulose) Give 30 ml by mouth three times a day related to Wernicke's encephalopathy -Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 1 tablet by mouth three times a day related to hypotension -Haloperidol Oral Tablet 5 MG (Haloperidol) Give 1 tablet by mouth four times a day related to schizoaffective disorder Resident #124 Review of an Admission Record revealed Resident #124 was a male, with pertinent diagnoses which included heart disease, hyperlipidemia (high levels of fat in the blood), seizure disorder, high blood pressure, atrial fibrillation (an irregular heart rate that results in poor blood flow), and BPH (an enlarged prostate that can cause difficulty urinating). Review of the October 2024 Medication Administration Record (MAR) for Resident #124 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Atorvastatin Calcium Oral Tablet 40 MG (Atorvastatin Calcium) Give 1 tablet by mouth one time a day for hyperlipidemia (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Tamsulosin HCl Oral Capsule 0.4 MG (Tamsulosin HCl) Give 1 capsule by mouth one time day for BPH -Eliquis Oral Tablet 5 MG Apixaban) Give 1 tablet by mouth two times a day related to heart disease/atrial fibrillation -Gabapentin Oral Capsule 100 MG Give 2 capsule by mouth two times a day for Pain -Lacosamide Oral Tablet 100 MG (Lacosamide) Give 1 tablet by mouth two times a day for seizure -Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours for pain Review of the October 2024 Medication Administration Record (MAR) for Resident #124 revealed no documentation (missed medications) on 10/26/24 in the morning for the following physician orders: -Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day for heart failure/atrial fibrillation -Senna Oral Tablet 8.6 MG (Sennosides) Give 2 tablet by mouth one time a day for bowels -Eliquis Oral Tablet 5 MG Apixaban) Give 1 tablet by mouth two times a day related to heart disease/atrial fibrillation -Gabapentin Oral Capsule 100 MG Give 2 capsule by mouth two times a day for Pain -Lacosamide Oral Tablet 100 MG (Lacosamide) Give 1 tablet by mouth two times a day for seizure -Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours for pain Resident #125 Review of an Admission Record revealed Resident #125 was a male, with pertinent diagnoses which included diabetes. Review of the October 2024 Medication Administration Record (MAR) for Resident #125 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously one time a day for diabetes -traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth one time a day for Depression Review of the October 2024 Medication Administration Record (MAR) for Resident #125 revealed no documentation (missed medications) on 10/19/24 in the morning for the following physician orders: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject 10 unit subcutaneously three times a day for diabetes -NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale three times a day for diabetes Resident #126 Review of an Admission Record revealed Resident #126 was a female, with pertinent diagnoses which included depression, anxiety, and diabetes. Review of a Minimum Data Set (MDS) assessment for Resident #126, with a reference date of 11/15/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated she was cognitively intact. In an interview on 1/9/25 at 12:21 PM, Resident #126 recalled several nights in October 2024 where no nurse was assigned to her hall. Resident #126 stated .I guess (the nurse) just didn't show up. I think that is what the excuse was . Resident #126 reported she missed some medications and others were administered late. Resident #126 stated .I was kind of worried because I didn't know. I have sugar (diabetes). I didn't know then if I would have a reaction . Resident #126 reported she was worried about how long she could go without medication. Resident #126 reported issues with anxiety and stated .The anxiety got to be so bad . nobody (was) handing out meds (medications) .there was no one . In an interview on 1/9/25 at 9:47 AM, with Director of Nursing (DON) B and Assistant Director of Nursing (ADON) C, DON B reported the incidents involving missed medications and a lack of nursing supervision in October 2024 were not reported to the State Agency. 41982 Review of a Facility Reported Incident (FRI) Intake Information Report revealed, .Date of Alleg (allegation) 09/17/2024 Time: 03:35 .Facility incident report received via online submission on: 09/18/2024, 4:13 PM . Incident Summary On [DATE]th at approximately 3:35pm it was reported by Nurse; (Resident #106) (perpatrator [sic]) became agitated related to noise in common area. Resident balled his fist and struck another resident closest to him (Resident #105); Abuse Coordinator notified and investigation initiated . Review of a Facility Reported Incident (FRI) Intake Information Report revealed, .Date of Alleg (allegation) 09/29/2024 Time: 04:40 . Facility incident report received via online submission on: 9/30/2024, 4:42 PM . Incident Summary On [DATE] at approximately 16:40pm (4:40 PM) RN (Agency Registered Nurse (ARN) ZZ) reported she noticed pt (patient) to be agitated on the memory care unit, pt grimaced and began swearing, pt also yelled the n-word at someone named (name omitted). This RN gave pt prn (as needed) dose of ativan at about 15mins (minutes) later pt came really close to another pt, this RN encouraged pt to give other pt personal space. the pt (Resident #106) stepped away and then slapped another resident's leg (Resident #108) when walking away. Residents were separated and assessed for injury. No injury and parties notified . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Facility Reported Incident (FRI) Intake Information Report revealed, .Date of Alleg (allegation) 10/03/2024 Time 10:00 .Facility incident report received via online submission on: 10/3/24, 5:18 PM .Incident Summary On 10/03/2024 around 10 am in the dining room, (Resident #106) was observed by (Licensed Practical Nurse (LPN) MM), holding (Resident #109)'s right wrist. (Certified Nurse Aide (CNA) R) & (LPN MM) were able to get his hands undone. (Resident #106) was redirected to a different section of the dining room, fingernails trimmed. Skin tear noted on (Resident #109)'s right wrist, treated. Physician and family members were notified . In an interview on 1/8/25 at 1:27 PM, Interim Director of Nursing (IDON) B was queried as to why the Facility Reported Incidents for the events that occurred on 9/17/24 at 3:35, 9/29/24 at 4:40, at 10/3/24 at 10:00 had not been reported to the State Agency within the 2-hour required timeframe. IDON B reported that the Administrator of record at the time (former Administrator) believed she had 24 hours to report to the State Agency and that she had not had a clear understanding of the reporting guidelines. Resident #120 Review of a Nursing Progress Note dated 9/14/24 at 2:10 AM for Resident #120 revealed, Note Text: (Certified Nurse Aide (CNA) WWW) reports to nurse a possible abuse concerning (Resident #120) . (Resident #120) was observed by (CNA WWW) with his hand under residents' .sheet; nurse notifies on-call supervisor .new orders are to start 15minute rounds/checks; nurse left voice massage (sic) for ADON (assistant director of nursing) .nurse will continuously try to notify administration; (CNA WWW) will write a statement. Review of a Behavior Note dated 9/15/24 at 5:02 AM for Resident #120 revealed, Note Text: Resident remains on 15minute checks; resident in room resting quietly throughout the night; no behaviors noted. Review of a Nursing Progress Note dated 9/15/24 at 10:03 AM for Resident #120 revealed, Late Entry: Note Text: This nurse spoke to nurse and staff related to event documented. This nurse discovered Resident was attempting to help Resident in chair with her blanket. Resident easily redirected and did not attempt to assist Resident with blanket after redirection. Resident's 15 minutes (sic) checks were discontinued. No negative behaviors noted. SW (social worker) aware and followed up with Resident and no concerns noted. In an interview on 1/9/25 at 10:05 AM, IDON B and Assistant Director of Nursing (ADON) C were queried whether the possible abuse concern by Resident #120 as written in his 9/14/24 at 2:10 AM Nursing Progress Note had been reported to the State Agency. IDON B reported the incident had not been reported because the conclusion was that the other resident had been fussing with her blanket and Resident #120 went over and sat down and was trying to pull her blanket up for her and that it was determined to have been misinterpreted by CNA WWW after the facility got witness statements as part of their investigation. IDON B reported the conclusion that it was not abuse had been determined the next day and not within the required 2-hour timeframe. IDON B reported the incident should have been reported to the State Agency within 2 hours pending investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on interview, and record review, the facility failed to develop and/or implement a person centered, comprehensive care plans for 2 residents (Resident #120 and #200) of 4 residents reviewed for care planning, resulting in Resident #120 not receiving adequate supervision to prevent resident to resident abuse, and the potential for residents to not meet their highest practicable level of physical and psychosocial wellbeing. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident 's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident 's written plan of care . Resident #120 Review of an Admission Record revealed Resident #120 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alcohol induced dementia (type of alcohol-related brain damage), schizoaffective disorder (condition in which symptoms of schizophrenia and a mood disorder are present, symptoms may include hallucinations, manic periods which are cyclical), wernicke's encephalopathy (brain damage caused by lack of thiamine). Review of a Minimum Data Set (MDS) assessment for Resident #120 with a reference date of 3/20/25, revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #120 was moderately cognitively impaired. Review of a Care Plan for Resident #120 with a reference date of 8/14/24, revealed a focus/goal/interventions of: Focus: (Resident #120) has potential to demonstrate verbal abusive behaviors and physical behaviors r/t (related to) Dementia. (Resident #120) at times will single out particular individuals and may be verbally or physically aggressive toward them. Goal: (Resident #120) will have fewer episodes of aggressiveness .Interventions .closely monitor Resident #120's) whereabouts upon his rising in the AM when he leaves his room. Nursing staff to be in close proximity to (sic) him and keep him in clear view at all times when he is out of his room . Review of a Behavior Log for Resident #120 revealed the resident had displayed yelling, hitting, pushing, grabbing, biting, pinching, abusive language, sexually inappropriate behavior and threatening behavior between 2/24-3/25/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/25/25 Certified Nursing Assistant (CNA) O reported she saw Resident #120 hit Resident #206 in the dining room on 3/3/25. CNA O reported she was unaware that Resident #120 needed any special supervision prior to that incident. CNA O reported she had not been told Resident #120 was supposed to be within the staff's line of sight when outside of his room. In an interview on 3/25/25, at 3:03pm, Activity Assistant (AA) CC reported Resident #120 was left unattended in the activities room with several other residents, on 3/4/25, shortly after 3:00pm. AA CC reported she left the activity room to go to resident rooms and invite them to the next activity. AA CC reported she was gone for a few minutes and as she was returning to the activity room, she saw Resident #120 standing above Resident #124 in an aggressive manner. AA CC reported as she approached the doorway of the activities room, she saw Resident #120 strike the back of Resident #124's wheelchair. AA CC reported she looked around for other staff so she could call for help, but no other staff were within sight. AA CC reported she was aware Resident #120 had episodes of physical aggression but was usually fine in the activities room. In an interview on 3/27/25, at 1:27pm, Director of Nursing (DON) B reported after Resident #120 hit Resident #206 on 3/3/25, the facility responded by placing Resident #120 on 15-minute checks, which meant staff would monitor the resident's whereabouts every 15 minutes. When further queried, DON B confirmed per Resident #120's care plan, the resident was supposed to be always watched by staff when he was out of his room and thus, the implementation of 15 minutes checks actually reduced the amount of supervision the resident was supposed to receive. DON B reported she thought all staff were aware that Resident #120 should not be left alone with other residents and that the actions of AA CC conflicted with the interventions in the resident's plan of care. Review of a Care Plan-Comprehensive and Revision policy with a reference date of 8/25/23 revealed Policy Overview: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. General Guidelines: The Interdisciplinary Team (IDT) develops and implements a comprehensive, person-centered care plan for each resident. The IDT includes but is not limited to .other staff as appropriate or necessary to meet the needs of the resident . 41027 Resident #200 Review of an Admission Record revealed Resident #200 was originally admitted to the facility on [DATE], with pertinent diagnoses which included dementia. Review of a Minimum Data Set (MDS) assessment for Resident #200, with a reference date of 3/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #200 was cognitively impaired. Review of the Functional Abilities revealed that Resident #200 required total dependent assistance with personal hygiene and transfers from bed to chair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #200's current Care Plan revealed, .has ADL self care deficit .Interventions: .Does not ambulate .has upper and lower dentures. Assist with oral/denture care q (every) am .Encourage resident to be dressed and out of bed for all meals ., .at risk for skin impairment/pressure ulcer development r/t (related to) impaired mobility, weakness, incontinence . Interventions: .Check and change about every 2 hours as needed .Frequent turning and repositioning . The care plan did not include that Resident #200 wore glasses. During an observation on 3/24/25 at 11:29 AM in the dining room, Resident #200 was in her wheelchair sitting at a table. Resident #200 was wearing a clothing protector that was covered with food crumbs. This observation was prior to lunch being served. At 11:58 AM Resident #200's lunch tray was delivered and staff assisted the resident with her meal. Resident #200 was observed with only top dentures in. During an observation on 3/25/25 at 10:25 AM Resident #200 was lying in her bed, and there were breakfast food crumbs in the bed and on the floor. Resident #200 was wearing a pajama shirt and her incontinence brief half off. At 10:27 AM Certified Nursing Assistant (CNA) U reported that Resident #200 had eaten her breakfast in bed that day and would be getting up into her chair soon. During an observation on 3/25/25 at 10:34 AM CNA U prepared to get Resident #200 out of bed and into her chair. CNA U performed incontinence care, got the resident dressed, but did not offer oral care, hair brushing, lotion, deodorant, etc. After Resident #200 was sitting in her wheelchair, CNA U offered her a washcloth to wash her face, put her glasses on, and then wheeled her out to the dining room to wait for lunch. Resident #200's hair was sticking up and snarled in the back, and she was only wearing top dentures that had not been cleaned. During an observation on 3/26/25 at 8:42 AM Resident #200 was in her wheelchair near the nurse's station. The resident was dressed, her hair was snarled in the back, and she did not have her glasses on. Resident #200 was complaining that her head hurt. In a subsequent observation of Resident #200's room, her glasses were on the nightstand. In an interview on 3/26/25 at 9:00 AM, Director of Social Work (DSW) F reported that she had never seen Resident #200 wearing glasses and to her knowledge the resident did not have glasses. Another staff member fetched Resident #200's glasses and assisted the resident with them. Resident #200 stated, Oh thank you, where did you find them? In an interview on 3/26/25 at 12:01 PM, Family Member (FM) NN reported that Resident #200 always had food on her clothes, her hair was a mess, she didn't have both dentures in, and was always sitting at the nurse's desk when they visited. FMNN reported that often times he had to find Resident #200's glasses, clean them and put them on her. In an interview on 3/27/25 at approximately 9:00 AM, Director of Nursing (DON) B reported that they had updated Resident #200's care plan to include her glasses and educated staff about personal hygiene. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Fundamentals of Nursing ([NAME] and [NAME]) 9th edition, The care plan (see Chapter 18) is a map for nursing care and demonstrates your accountability for patient care. By making accurate nursing diagnoses, your subsequent care plan communicates a patient's health care problems to other professionals and ensures that you select relevant and appropriate nursing interventions .A well-planned, comprehensive nursing care plan reduces the risk for incomplete, incorrect, or inaccurate care. As a patient's problems and status change, so does the plan. A nursing care plan is a guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used later in evaluation (see Chapter 20). The plan of care communicates nursing care priorities to nurses and other health care providers.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 This citation pertains to Intake # MI00147061, MI00149269, MI00149295, & MI00149428. Based on interview, and record review, the facility failed to follow professional standards of practice for medication administration in 3 of 14 residents (Resident #101, #116, & #118) reviewed for medication administration, resulting in missed thyroid medication, inaccurate documentation of medication administration, and medications administered without a valid physician order. Findings include: The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe that the orders are in error, violate agency policy, or are harmful to the patient. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 20717-20719). Elsevier Health Sciences. Kindle Edition. Resident #101 Review of an Admission Record revealed Resident #101 was a female, with pertinent diagnoses which included hypothyroidism. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 12/13/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. Review of an Order Summary Report for Resident #101 revealed the active physician order .Levothyroxine Sodium Oral Tablet (Levothyroxine Sodium) Give 100 mcg by mouth one time a day for hypothyroid . with a start date of 9/7/24. In an interview on 1/2/25 at 3:06 PM, Resident #101 reported an instance about a month ago where she went without her thyroid medication for approximately seven days. Resident #101 reported staff did not notify her that they were out of the medication. Review of the November 2024 Medication Administration Record (MAR) for Resident #101 revealed the ordered medication .Levothyroxine Sodium Oral Tablet (Levothyroxine Sodium) Give 100 mcg by mouth one time a day . was not administered on 11/26/24, 11/27/24, and 11/29/24. Review of an eMAR (electronic MAR) - Administration Note for Resident #101, dated 11/26/24, revealed . Levothyroxine Sodium Oral Tablet Give 100 mcg by mouth one time a day for hypothyroid .med on order . Review of an eMAR - Administration Note for Resident #101, dated 11/27/24, revealed .Levothyroxine Sodium Oral Tablet Give 100 mcg by mouth one time a day for hypothyroid .med on order . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an eMAR - Administration Note for Resident #101, dated 11/29/24, revealed .Levothyroxine Sodium Oral Tablet Give 100 mcg by mouth one time a day for hypothyroid .med on order . Review of the December 2024 Medication Administration Record (MAR) for Resident #101 revealed the ordered medication .Levothyroxine Sodium Oral Tablet (Levothyroxine Sodium) Give 100 mcg by mouth one time a day . was not administered on 12/2/24, 12/4/24, and 12/5/24. Review of an eMAR - Administration Note for Resident #101, dated 12/2/24, revealed .Levothyroxine Sodium Oral Tablet Give 100 mcg by mouth one time a day for hypothyroid .medication on order . Review of an eMAR - Administration Note for Resident #101, dated 12/4/24, revealed .Levothyroxine Sodium Oral Tablet Give 100 mcg by mouth one time a day for hypothyroid .medication on order . Review of an eMAR - Administration Note for Resident #101, dated 12/5/24, revealed .Levothyroxine Sodium Oral Tablet Give 100 mcg by mouth one time a day for hypothyroid .med on order . In an interview on 1/3/25 at 2:33 PM, Agency Registered Nurse (RN) XX reported they did not recall the specific reason for Resident #101's missed doses of thyroid medication. Agency RN XX reported typically, when a medication is ordered from the pharmacy, it arrives within a day. Agency RN XX reported Agency nurses do not have access to the facility backup medication supply, and there are often multiple Agency nurses scheduled on the same day. Agency RN XX stated in regard to retrieving medications from the facility backup supply .someone who does have access may be working but could be on another unit . In an interview on 1/7/25 at 9:30 AM, Agency RN BBB reported they recalled Resident #101 not having thyroid medication available in the medication cart on multiple instances. Agency RN BBB reported they did reorder the medication, however Resident #101 did go several days with missed doses. Agency RN BBB reported Agency nurses do not have access to the facility backup medication supply. Agency RN BBB reported most of the time there are only Agency nurses working, so there is no one available to access the backup medication supply. In an interview on 1/7/25 at 3:09 PM, Pharmacist XXX reported a refill request for Resident #101's thyroid medication was sent to the pharmacy on 11/23/24. Pharmacist XXX reported a note was then sent to the facility that it was too early to refill the medication. Pharmacist XXX reported .Levothyroxine Sodium 100 mcg Oral Tablet . was available in the backup medication supply at the facility. Review of the policy/procedure Medication Administration, dated 8/7/23, revealed .Administer medication in accordance with frequency prescribed by physician and standards of practice .If a pharmacy supplied medication is not available, refer to the pharmacy policy and procedures related to emergency pharmacy delivery and emergency supply kit usage . Resident #116 Review of an Admission Record revealed Resident #116 was a male, with pertinent diagnoses which included lung cancer, heart failure, and obstructive lung disease. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Order Summary Report for Resident #116 revealed the physician order .LORazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for Anxiety . with a start date of 12/13/24. Review of a Controlled Substances Proof of Use form for Resident #116 revealed one Lorazepam 0.5 MG Tablet was pulled from Resident #116's medication supply for administration on 12/13/24 at 7:55 PM. Review of the December 2024 Medication Administration Record (MAR) for Resident #116 revealed no documentation that the medication .LORazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for Anxiety . was given. In an interview on 1/7/25 at 12:45 PM, Agency Licensed Practical Nurse (LPN) HHH reported they were assigned to Resident #116 on night shift after his admission to the facility on [DATE]. Agency LPN HHH reported that night Resident #116 was anxious and restless, so they administered one of the PRN (as needed) lorazepam to Resident #116. In an interview on 1/7/25 at 1:22 PM, Registered Nurse (RN) KK reported when a controlled substance is removed from the secondary locked box within the medication cart it should be signed out (accounted for) on the Controlled Substances Proof of Use form. RN KK reported when the medication is administered to the resident, it should be documented in the Medication Administration Record (MAR). Resident #118 Review of an Admission Record revealed Resident #118 was a male, with pertinent diagnoses which included heart failure, atrial fibrillation (an irregular heart rate that results in poor blood flow), respiratory failure, kidney disease, stroke, and high blood pressure. Review of an Order Summary Report for Resident #118 revealed the physician order .Xanax Oral Tablet 0.5 MG (Alprazolam) Give 0.5 mg via G-Tube (feeding tube) every 8 hours as needed for Anxiety . with a start date of 12/19/24. Note this order was discontinued on 12/26/24. Review of an Order Summary Report for Resident #118 revealed the physician order .Xanax Oral Tablet 0.5 MG (Alprazolam) Give 1 tablet via PEG-Tube (feeding tube) every 8 hours as needed for Anxiety . with a start date of 12/29/24. Review of a Controlled Drug Receipt/Record/Disposition Form for Resident #118 revealed one Alprazolam 0.5 MG Tablet was pulled from Resident #118's medication supply for administration on 12/19/24 at 7:00 AM, one on 12/19/24 at 7:00 PM, one on 12/28/24 at 9:00 PM, and one on 12/29/24 at 12:22 PM. Note there was no active physician order for Alprazolam 0.5 MG Tablet for Resident #118 on 12/28/24. Review of the December 2024 Medication Administration Record (MAR) for Resident #118 revealed the medication Alprazolam 0.5 MG Tablet was documented as administered only one time, on 12/29/24 at 12:22 PM. No administration documentation noted in the December 2024 MAR related to the Alprazolam 0.5 MG Tablets pulled from Resident #118's medication supply on 12/19/24 (two doses) and 12/28/24 (one dose). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy/procedure Controlled Medication Guidelines, dated 3/20/24, revealed .When the licensed nurse removes the controlled medication from the package, they will document the quantity removed and the quantity left on the Controlled Drug Receipt/Record/Disposition Form .After administration of the controlled medication the licensed nurse will document the administration on the medication administration record .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 This citation pertains to Intake # MI00147061, MI00147744, & MI00148986. Based on observation, interview, and record review, the facility failed to ensure baths/showers and hygiene care were provided per resident preference and plan of care in 3 of 5 residents (Resident #101, #104, & #113) reviewed for Activities of Daily Living (ADL) care, resulting in the potential for dissatisfaction with care, hygiene concerns, skin irritation, and low self-esteem. Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition.Personal hygiene affects patients' comfort, safety, and well-being. Hygiene care includes cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities such as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation, foster a positive self-image, promote healthy skin, and help prevent infection and disease . Resident #101 Review of an Admission Record revealed Resident #101 was a female, with pertinent diagnoses which included bladder dysfunction, depression, anxiety, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 12/13/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. Review of a current Care Plan for Resident #101 revealed the focus .ADL (Activities of Daily Living) Self care deficit as evidenced by weakness . initiated 9/6/24, with interventions which included .Assist to bathe/shower as preferred per shower schedule and as needed . initiated 12/11/24. In an observation and interview on 1/2/25 at 2:37 PM, Resident #101 was noted in bed in her room. Resident #101 reported missed bed baths, and stated she went almost two weeks between bed baths recently. Resident #101 reported staff do not offer to wash her hair and stated .only once or twice has someone taken my compression socks off to wash my feet and lower legs . Noted Resident #101's hair appeared greasy and unkempt. Review of the Shower/Bath documentation for Resident #101, from 12/3/24 to 1/2/25, revealed only five showers/baths documented as given within that time frame, on 12/5/24, 12/12/24, 12/19/24, 12/23/24, and 12/27/24. Noted Shower/Bath was documented as Resident Refused on 12/16/24, 12/26/24, and 12/30/24, with no supporting documentation in the electronic medical record regarding the refusals, or any education provided to the resident or follow-up completed on those dates. Noted Shower/Bath was documented as Not Applicable on 12/9/24. Resident #104 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #104 was a female, with pertinent diagnoses which included dementia, Alzheimer's disease, depression, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 11/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 1, out of a total possible score of 15, which indicated she had severe cognitive impairment. In an interview on 1/2/25 at 11:04 AM, Family Member VV reported Resident #104 does not receive adequate showers or hygiene care, and stated .She just [NAME] of urine . Review of a current Care Plan for Resident #104 revealed the focus .ADL (Activities of Daily Living) Self Care Deficit r/t (related to) cognitive deficit . with interventions which included .BATHING/SHOWERING: 1 person assist . both initiated 8/13/24. Review of the Shower/Bath documentation for Resident #104, from 12/7/24 to 1/6/25, revealed only three showers/baths documented as given within that time frame, on 12/24/24, 12/31/24, and 1/3/25. Noted Shower/Bath was documented as Resident Refused on 12/13/24, 12/20/24, and 12/27/24 with no supporting documentation in the electronic medical record regarding the refusals, or follow-up completed on those dates. Resident #113 Review of an Admission Record revealed Resident #113 was a female, with pertinent diagnoses which included diabetes, obesity, muscle weakness, intellectual disabilities, and depression. Review of a Minimum Data Set (MDS) assessment for Resident #113, with a reference date of 11/1/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated she was cognitively intact. In an interview on 1/2/25 at 10:45 AM, Legal Guardian WW reported concerns involving missed showers for Resident #113. Legal Guardian WW reported Resident #113 prefers her showers twice a week after dinner, on Mondays and Thursdays. Legal Guardian WW reported they met with facility staff on 12/17/24 to discuss the shower concerns, and stated prior to the meeting Resident #113 .went three weeks without a shower . Legal Guardian WW reported Resident #113 had declined several showers because .they were offering her showers at times when she would not want them . Legal Guardian WW reported Resident #113 is developmentally delayed and did not understand that if she declined a shower offered earlier in the day, it would not be offered again later that evening. Review of a current Care Plan for Resident #113 revealed the focus .Resident has an ADL (Activities of Daily Living) self-care performance deficit . with interventions which included .BATHING: The resident requires 1 staff participation with bathing . Review of the Shower/Bath documentation for Resident #113, from 12/4/24 to 1/3/25, revealed only two showers/baths documented as given within that time frame, on 12/18/24 and 12/27/24. Noted Shower/Bath was documented as Resident Refused on 12/14/24, 12/20/24, and 12/24/24, with no supporting documentation in the electronic medical record regarding the refusals on 12/20/24 and 12/24/24, or any education provided to the resident or follow-up completed. Noted Shower/Bath was documented as Not Applicable on 12/31/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note for Resident #113, dated 12/14/24 at 1:54 PM, revealed .Resident said that she has not had a bath .ask(ed) resident (if I could) give her a bath after lunch and she (agreed), then at (1:30 PM) .approach(ed) resident for a shower, she refused .(asked) her twice but continue(d) to (refuse) . Note this shower was not offered per resident preference. Review of a Progress Note for Resident #113, dated 12/22/24 at 12:00 PM, revealed .Resident c/o (complained of) not getting shower, offered her to get it .this shift and refused. She stated I do not like to get shower in the morning, I like after diner so I can lay down. Will ask the 2nd shift to complete it . Review of a Progress Note for Resident #113, dated 12/22/24 at 7:12 PM, revealed .Offered resident to get shower after (dinner) and (she) took it . In an interview on 1/14/25 at 2:55 PM, with Administrator A, Director of Nursing (DON) B, and Assistant Director of Nursing (ADON) C, DON B and ADON C reported showers are offered to residents twice per week and documented in the electronic medical record.

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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. 36221 This citation pertains to Intake # MI00147580. Based on interview, and record review, the facility failed to assess the resident and implement immediate interventions to ensure safety after an attempted elopement in 1 of 6 residents (Resident #103) reviewed for safety/supervision, resulting in the potential for additional elopement attempts and serious injury. Findings include: Review of the policy/procedure Elopement, dated 8/2022, revealed .This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk .The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary .Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering .a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team .b. The interdisciplinary team will evaluate the unique factors contributing to risk to develop a person-centered care plan .c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff .d. Adequate supervision will be provided to help prevent accidents or elopements .e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly .f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff . Resident #103 Review of an Admission Record revealed Resident #103 was a male, with pertinent diagnoses which included stroke, anxiety, depression, muscle weakness, seizures, high blood pressure, and a history of falls. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 10/16/24, revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated moderate cognitive impairment. Review of a Progress Note for Resident #103, dated 10/18/24 at 9:14 PM, revealed .(Certified Nursing Assistant (CNA)) informed writer that resident was observed in the parking lot. (300 Hall) nurse not available. (400 Hall) nurse made aware .On call RN (Registered Nurse) notified along with NHA (Nursing Home Administrator) at this time of hour. Resident is safe and in his room at this time . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/8/25 at 9:32 AM, Certified Nursing Assistant (CNA) J stated in regard to Resident #103's attempted elopement on 10/18/24 he .got out the door . CNA J reported an Agency CNA responded to a door alarm and found Resident #103 outside in the parking lot. CNA J reported there was no nurse assigned to Resident #103 on the 300 Hall that night (10/18/24 between 6:30 PM-11:00 PM). In an interview on 1/8/25 at 10:07 AM, Agency Licensed Practical Nurse (LPN) JJJ reported they worked on the 100 Hall the evening of 10/18/24 at the time of Resident #103's attempted elopement from the facility. Agency LPN JJJ reported they heard the alarm going off and began to search/check doors to identify a cause. Agency LPN JJJ reported an Agency CNA found Resident #103 outside in the parking lot. Agency LPN JJJ reported they notified the nurse on-call of the attempted elopement, along with the Administrator at the time. Agency LPN JJJ reported that evening there was no nurse assigned to the section of the building (the 300 Hall) where Resident #103 resided. In an interview on 1/8/25 at 11:49 AM, RN PPP reported they worked at the facility on 10/19/24 and stated . they were short on nurses that morning . RN PPP recalled going over to the 300 Hall to assist with passing morning medications. RN PPP reported they administered morning medication to Resident #103 on 10/19/24, however, they were not assigned to Resident #103. RN PPP reported they were unaware of any new interventions put in place after Resident #103's attempted elopement on 10/18/24. RN PPP stated . (Resident #103) didn't have a nurse that morning (10/19/24) . In an interview on 1/8/25 at 12:40 PM, Agency CNA QQQ reported they responded to a door alarm the evening of 10/18/24 and found Resident #103 outside the facility in the parking lot. Agency CNA QQQ reported they redirected Resident #103 back into the facility and brought him back to his room on the 300 Hall. Agency CNA QQQ clarified they did not observe Resident #103 exit the facility, but instead found him in the parking lot after responding to the door alarm. Agency CNA QQQ could not recall which nurse was assigned to Resident #103 at the time of his attempted elopement, and stated .they were short-staffed that whole day .It was so busy. They had days with no nurse on the hall . Agency CNA QQQ stated in regard to new interventions after Resident #103's attempted elopement on 10/18/24 .(RN LLL) said we should put a wander guard (a monitoring device to prevent elopement) on him (Resident #103) .We are aides, we don't know where to get a wander guard .We couldn't put a wander guard on him, so we were just checking on him. You have to have a key to get stuff like that . In an interview on 1/9/25 at 11:38 AM, Agency LPN JJJ reported after Resident #103's attempted elopement on 10/18/24 he was returned to his room, and stated .That night he stayed on his unit (300 Hall) . Agency LPN JJJ reported they took over responsibility for a portion of the 300 Hall at 11:00 PM on 10/18/24, and at that time Resident #103 was in bed, in his room. Review of a Progress Note for Resident #103, dated 10/18/24 at 9:30 PM, revealed .Investigation initiated by RN and NHA. Alarm alerted CNA responded immediately and redirected back to room. CNA had visual contact the entire time (Note this statement directly contradicts the interview completed with Agency CNA QQQ). Increase monitoring of resident initiated immediately for safety. Clinical to review potential change in condition. Assessments to follow . Note no documentation or indication as how the facility would increase monitoring of Resident #103. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Care Plan for Resident #103 revealed the focus .Exit seeking / elopement risk . with interventions which included .Allow to vent feelings and/or frustration prn (as needed) .Calmly redirect to an appropriate area .Distract with food, activities, conversation, television, books, etc .Educate family/visitors to advise staff when leaving patient following visit .Encourage socialization with others and provide recreational programming . all initiated 10/19/24 (the day after Resident #103's attempted elopement). Review of the electronic medical record for Resident #103 revealed no skin assessment or nursing evaluation was completed on 10/18/24 after Resident #103's attempted elopement.

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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. 36221 This citation pertains to Intake # MI00147061 & MI00147821. Based on observation, interview, and record review, the facility failed to provide appropriate incontinence and catheter care in 2 of 4 residents (Resident #101 & #107) reviewed for incontinence/catheter care, resulting in cross-contamination, missed episodes of nephrostomy (a tube that drains urine from the kidney) care, and the potential for catheter related complications including the development of urinary tract infections. Findings include: Review of the policy/procedure Incontinence Care, dated 4/22/24, revealed .POLICY OVERVIEW: To provide guidelines for cleansing the perineum and buttocks after an incontinence episode or with daily care . GUIDELINES .Perform hand hygiene and don gloves (and other PPE (Personal Protective Equipment) as needed) .Position the resident on their back with their knees flexed and feet flat on the bed .If the resident is unable to maintain this position, assist to a side lying position .If feces are present, remove with toilet paper or disposable wipe by wiping from the front of the perineum toward the rectum .Discard soiled materials and gloves .Perform hand hygiene and (don) gloves .Cleanse peri-area and buttocks with disposable bathing wipe or washcloth and incontinent cleansing spray or soap and water, wiping from the front of the perineum toward the rectum. Use a separate area of the cloth or new disposable wipe for each stroke. Turn the resident side to side to cleanse the entire affected areas, as needed. Rinse with water, if needed, or per incontinent product instructions . Review of the policy/procedure Catheter Care, dated 8/24/23, revealed .POLICY OVERVIEW: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use .Catheter care will be performed every shift and as needed by nursing personnel .FEMALE RESIDENT CATHETER CARE .Assist the resident to a lying position on their back if medically able .Gently separate the labia to expose the urinary meatus .Use a washcloth with warm water and soap (or clean bathing wipe) to cleanse the labia. Use one area of the washcloth (or wipe) for each downward, cleansing stroke (front to back) .Change the position of the washcloth (or wipe) and cleanse around the urethral meatus. Do not allow the washcloth/wipe to drag on the resident's skin or bed linen .If using a washcloth, rinse using the above technique .With a clean washcloth/wipe clean and rinse the catheter from the insertion site to approximately four inches outward, making sure to hold the catheter in place so as to not pull on the catheter .Dry area with towel . Resident #101 Review of an Admission Record revealed Resident #101 was a female, with pertinent diagnoses which included bladder dysfunction, depression, anxiety, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 12/13/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a current Care Plan for Resident #101 revealed the focus .Use of indwelling urinary catheter . with interventions which included .Catheter Care . both initiated 9/6/24, along with the focus .Bowel Incontinence related to Impaired Mobility . initiated 12/24/24. Review of an Order Summary Report for Resident #101 revealed the active physician order .Change urinary catheter securement device q (every) week . with a start date of 9/7/24. In an observation and interview on 1/2/25 at 1:47 PM, Resident #101 was noted in bed in her room. Resident #101 reported she had an indwelling catheter and has had issues with frequent Urinary Tract Infections (UTIs) while at the facility. Observed Certified Nursing Assistant (CNA) AA and CNA BB assist Resident #101 with incontinence care due to a bowel movement. Noted CNA AA and CNA BB donned gowns and gloves prior to entering Resident #101's room. CNA AA and CNA BB lowered the head of Resident #101's bed and opened Resident #101's soiled brief to begin incontinence care. Noted no catheter tubing securement device in place to prevent pulling/tugging and damage to Resident #101's urethra. Resident #101 reported the nurses sometimes ask if she wants a securement device, and stated .I say yes but I don't think they remember to come back (and apply the securement device) . Resident #101 reported without the securement device, the tubing pulls and is uncomfortable when moving in bed. Resident #101 could not recall the last time a catheter securement device had been applied. CNA AA and CNA BB rolled Resident #101 onto her left side and used washcloths/soap to perform incontinence care. Observed CNA AA clean bowel movement from Resident #101's buttocks, and then immediately handle Resident #101's pillows and place a new pad below Resident #101 with no glove change or hand hygiene performed. Resident #101 was then assisted onto her right side. Observed CNA BB clean bowel movement from Resident #101's buttocks and thighs, wiping from back to front with the washcloth. After drying Resident #101's buttocks, CNA BB applied protective cream to Resident #101's buttocks using the same soiled gloves, and then wiped the excess cream from the soiled gloves with a towel and continued with care. CNA AA and CNA BB assisted Resident #101 to a laying position to complete incontinence care, and wash Resident #101's vaginal/perineal area. Noted both CNA AA and CNA BB continued to wear the same soiled gloves originally donned upon entering Resident #101's room. CNA AA dampened the corner of a large towel (since no washcloths were left in the room) and washed Resident #101's vaginal/perineal area. Noted neither CNA washed or rinsed the catheter tubing near the urethra. Both CNA AA and CNA BB reported washing the catheter tubing is not part of incontinence care. In an interview on 1/2/25 at 2:37 PM, Resident #101 reported CNAs generally do not clean the catheter tubing during incontinence care. In an interview on 1/2/25 at 3:02 PM, CNA AA reported the nurses were responsible to clean the catheter tubing. In an interview on 1/3/25 at 9:33 AM, Agency Registered Nurse (RN) XX reported they would expect the CNAs to perform catheter care/clean the catheter tubing as part of incontinence/hygiene care. In an interview on 1/3/25 at 2:43 PM, Agency RN AAA reported catheter securement devices are available at the facility and should be used for residents with indwelling catheters. Agency RN AAA reported both nurses and CNAs can complete catheter care and wash catheter tubing. Resident #107 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #107 was a female, with pertinent diagnoses which included diabetes, anxiety, and depression. Review of a Minimum Data Set (MDS) assessment for Resident #107, with a reference date of 12/5/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. Review of a current Care Plan for Resident #107 revealed the focus .Use of indwelling (nephrostomy) tubes Bilateral (both sides) . with interventions which included .Catheter Care .Change catheter per physician order .Maintain drainage bag below bladder level .Report any changes in amount and color, or odor of urine . Secure catheter with securement device . all initiated 10/29/24. In an interview on 1/3/25 at 12:05 PM, Resident #107 reported instances of missed nephrostomy care in the past month. Review of the December 2024 Treatment Administration Record (TAR) for Resident #107 revealed no documentation (missed treatments) for the physician order .Nephrostomy Care QD (daily) and as needed . on 12/4/24, 12/5/24, 12/16/24, 12/26/24, and 12/29/24.

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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** 36221 This citation pertains to Intake # MI00146268, MI00147061, MI00147580, MI00147744, MI00147821, MI00148620, & MI00148986. Based on interview, and record review, the facility failed to provide sufficient staff to meet resident needs in 9 of 11 residents (Resident #101, #107, #104, #103, #113, #120, #124, #125, & #126) reviewed for sufficient staffing, resulting in missed showers/baths, a lack of supervision of residents at risk for falls and elopement, long call light wait times, rushed staff, and missed medications. For additional information see citations F600, F677, F689, and F760. Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 1589-1592). Elsevier Health Sciences. Kindle Edition.Time management, therapeutic communication, patient education, and compassionate implementation of bedside skills are just a few of the essential skills you need. It is important for your patients to leave the health care setting with a positive image of nursing and a feeling that they received quality care. Your patients should never feel rushed. They need to feel that they are important and are involved in decisions and that their needs are met . Review of the policy/procedure Staffing, dated 11/3/23, revealed .The facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for the residents in accordance with the residents plan of care .Licensed nurses and nursing assistants are available 24 hours a day, 7 days a week to provide direct resident care services .Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on their plan of care . Review of the policy/procedure Staffing (Department: Nursing), dated 4/13/22, revealed .All employees of the facility are responsible for Residents and required to report to work when scheduled and to remain at work until replaced by someone else . In an interview on 1/2/25 at 11:33 AM, Licensed Practical Nurse (LPN) Q reported there were currently three nurses and six Certified Nursing Assistants (CNAs) on the 300 and 400 Halls. LPN Q reported five CNAs is more typical for day shift staffing. LPN Q reported the facility uses a significant number of Agency staff, for both nurses and CNAs. LPN Q reported there are a lot of issues with call-ins and no-shows, and reported if an Agency nurse/CNA cancels a scheduled shift, the floor staff working that day have no idea until .no one shows up for the shift . In an interview on 1/6/25 at 12:23 PM, Agency LPN DDD reported issues with staffing at the facility. Agency LPN DDD reported sometimes the schedule will say three nurses (on the 300 and 400 Hall) but only two will show up. Agency LPN DDD reported three nurses on the 300/400 Hall is ideal, and reported more care/treatments can be completed. Agency LPN DDD stated when only two nurses are on the 300/400 Hall it .gets very time sensitive . regarding care. Agency LPN DDD reported staffing constraints result in medications/treatments being administered outside of designated time frames. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/6/25 at 3:48 PM, LPN QQ reported staffing was a major issue in September/October 2024 after the change in facility ownership. LPN QQ reported at times they were the only nurse on the 300/400 Hall, or there was no oncoming nurse at the end of their shift. LPN QQ stated .I was exhausted . LPN QQ reported on 10/18/24 the Agency nurse scheduled to relieve them at 6:30 PM on the 300 Hall did not show up for the shift. LPN QQ reported that evening there was only one nurse on the 400 Hall, and no nurse on the 300 Hall. LPN QQ reported the evening of 10/18/24 on the 300 Hall, no residents received scheduled medications. LPN QQ reported on 10/18/24 between 7:00 PM-11:00 PM one resident from the 300 Hall attempted to elope from the facility and was found in the parking lot after setting off a door alarm. LPN QQ reported with Agency staff, the nurses working have no notification when a scheduled Agency staff member calls in or cancels a shift, and stated .we have no idea if they will show up or not . LPN QQ reported after the change in ownership, only two nurses were scheduled on the 300/400 Halls, when previously they had three, and stated .that is how we ended up with this mess . LPN QQ reported when short-staffed, they are unable to pass medications timely or provide quality care. In an interview on 1/7/25 at 10:18 AM, LPN FF reported staffing at the facility .varies . and reported the number of CNAs on the 300/400 hall for day shift fluctuates between four and seven. LPN FF stated .it depends on who shows up for work . LPN FF reported management posts the open shifts for other staff to pick up, and stated .(If) they don't pick (the open shift) up, we work with what we get . LPN FF reported when short-staffed, it can be difficult to ensure medications are administered timely. LPN FF stated .we try our best but there (are) a number of residents that require more care than others . LPN FF reported when short-staffed, they try to prioritize who needs a shower .the most . and complete bed baths on other residents .to save time . In an interview on 1/7/25 at 1:22 PM, Registered Nurse RN KK reported after the change in facility ownership, the staffing levels were adjusted and stated it was a .very heavy, heavy workload .it was very hard . RN KK reported medications were .barely . administered on time. RN KK stated when the facility is short-staffed they .have to work with what we have . In an interview on 1/8/25 at 9:15 AM, RN LLL reported they were assigned the 400 Hall on 10/18/24 from 6:30 PM-7:00 AM. RN LLL reported they could not recall who was responsible for the 300 Hall that night (10/18/24 between 6:30 PM-11:00 PM). RN LLL recalled a resident on the 300 Hall attempted to elope from the facility between 7:00 PM-11:00 PM. RN LLL stated in regard to staffing .We were always short. (Staffing) was definitely an issue that night . RN LLL reported they had issues getting medications administered timely when short-staffed. RN LLL reported they stopped working at the facility shortly after that night, and stated . That was one of the reasons I left .safety . In an interview on 1/8/25 at 10:07 AM, Agency Licensed Practical Nurse (LPN) JJJ reported they worked on the 100 Hall the evening of 10/18/24. Agency LPN JJJ reported that evening there was no nurse assigned to the 300 Hall between 6:30 PM-11:00 PM. Agency LPN JJJ reported there was only a nurse on the 400 Hall. Agency LPN JJJ reported they took over some of the rooms on the 300 Hall after 11:00 PM, but from 6:30 PM-11:00 PM on 10/18/24 there was no nurse assigned to the residents on the 300 Hall. Agency LPN JJJ reported the evening of 10/18/24 was not the first time where no nurse was assigned to a section of residents, and stated .I canceled all my shifts after that. (I) did not feel safe working there . Agency LPN JJJ reported they spoke with the on-call manager that evening about the staffing concerns, and reported there were only three nurses in the building when there should have been four. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/8/25 at 10:44 AM, LPN OOO reported concerns with staffing at the facility. LPN OOO reported at times there would be one nurse assigned to over 50 residents. LPN OOO stated .They were telling me I had to work like that. I told them there are people who are a fall risk, people with mental health issues .I told them it's not safe .I am not going to put these people's lives in jeopardy . LPN OOO reported they worked one shift with a 56 resident assignment and stated .it was too dangerous .It was the most nerve-wracking night of my life . LPN OOO reported they spoke with former Assistant Director of Nursing (ADON) MMM at the time about the staffing concerns and no assistance/guidance or direction was provided. LPN OOO reported former ADON MMM often did not answer the phone and stated .if you had an issue at night that was your issue .(Former ADON MMM) wouldn't come in and get on a cart or help at all . LPN OOO reported the evening when she worked with a 56 resident assignment, she was not aware until a CNA came and asked her to get a pain medication for a resident. LPN OOO reported the offgoing nurses that night had locked the keys in the medication cart and left at the end of their shift. LPN OOO stated .I never got report or nothing about that hall or any of those patients . In an interview on 1/8/25 at 12:40 PM, Agency CNA QQQ reported they responded to a door alarm the evening of 10/18/24 and found Resident #103 outside the facility in the parking lot. Agency CNA QQQ reported they redirected Resident #103 back into the facility and brought him back to his room on the 300 Hall. Agency CNA QQQ could not recall which nurse was assigned to Resident #103 at the time of his attempted elopement, and stated .they were short-staffed that whole day .It was so busy. They had days with no nurse on the hall . Agency CNA QQQ reported when there was no nurse assigned to a hall, there would be an additional CNA added to help monitor until a nurse could come in and take the assignment. In an interview on 1/14/25 at 12:36 PM, CNA RRR reported they were assigned to Resident #103 the evening of his attempted elopement on 10/18/24. CNA RRR reported that evening, the facility was short-staffed and there was no nurse caring for the residents on the 300 Hall. CNA RRR reported at the time of Resident #103's attempted elopement, they were in a room caring for a different resident. CNA RRR reported there was a nurse on the 400 Hall, but when they asked the 400 Hall nurse for assistance they would say they were busy. CNA RRR stated .I was like, then who should I ask? CNA RRR reported they were unsure if any residents received their evening medications on 10/18/24. Resident #101 Review of an Admission Record revealed Resident #101 was a female, with pertinent diagnoses which included bladder dysfunction, depression, anxiety, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 12/13/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. Review of a current Care Plan for Resident #101 revealed the focus .ADL (Activities of Daily Living) Self care deficit as evidenced by weakness . initiated 9/6/24, with interventions which included .Assist to bathe/shower as preferred per shower schedule and as needed . initiated 12/11/24. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Shower/Bath documentation for Resident #104, from 12/7/24 to 1/6/25, revealed only three showers/baths documented as given within that time frame, on 12/24/24, 12/31/24, and 1/3/25. Noted Shower/Bath was documented as Resident Refused on 12/13/24, 12/20/24, and 12/27/24 with no supporting documentation in the electronic medical record regarding the refusals, or follow-up completed on those dates. Review of the October 2024 Medication Administration Record (MAR) for Resident #104 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Melatonin Oral Tablet 3 MG (Melatonin) Give 2 tablet by mouth one time a day for Sleep Review of the October 2024 Medication Administration Record (MAR) for Resident #104 revealed no documentation (missed medications) on 10/26/24 in the morning for the following physician orders: -Aspirin Oral Tablet Chewable 81 MG (Aspirin) Give 1 tablet by mouth one time a day for blood thinner -Cyanocobalamin Oral Tablet 100 MCG (Cyanocobalamin) Give 1 tablet by mouth one time a day for supplement -Lisinopril Oral Tablet 5 MG (Lisinopril) Give 1 tablet by mouth one time a day for HTN (hypertension - high blood pressure) -Polyethylene Glycol 3350 Powder (Polyethylene Glycol 3350) Give 17 gram by mouth one time a day for Constipation -clonazePAM Oral Tablet 0.5 MG (Clonazepam) Give 1 tablet by mouth two times a day related to anxiety Resident #103 Review of an Admission Record revealed Resident #103 was a male, with pertinent diagnoses which included stroke, anxiety, muscle weakness, depression, high blood pressure, and a history of falls. Review of the October 2024 Medication Administration Record (MAR) for Resident #103 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Latanoprost Ophthalmic Solution 0.005 % (Latanoprost) Instill 1 drop in both eyes one time a day for Glaucoma -Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 1 tablet by mouth one time a day for HTN (hypertension - high blood pressure) -Rosuvastatin Calcium Oral Tablet 5 MG (Rosuvastatin Calcium) Give 1 tablet by mouth one time a day for Hyperlipidemia -Thiamine HCl Oral Tablet 100 MG (Thiamine HCl) Give 1 tablet by mouth one time a day (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 75 mg by mouth at bedtime for depression -levETIRAcetam Oral Tablet 500 MG (Levetiracetam) Give 1 tablet by mouth two times a day for Seizures -traMADol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 8 hours for Pain -Acetaminophen Tablet 325 MG Give 2 tablet by mouth four times a day for discomfort Resident #113 Review of an Admission Record revealed Resident #113 was a female, with pertinent diagnoses which included diabetes, epilepsy (seizure disorder), hypothyroidism, bipolar disorder, depression, and a history of falls. Review of the October 2024 Medication Administration Record (MAR) for Resident #113 revealed no documentation (missed medications) on 10/12/24 in the evening for the following physician orders: -Gabapentin Oral Capsule 300 MG (Gabapentin) Give 1 capsule by mouth one time a day related to neuropathy (nerve pain) -Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 61 unit subcutaneously one time a day for diabetes -Levothyroxine Sodium Oral Tablet 75 MCG (Levothyroxine Sodium) Give 1 tablet by mouth one time a day related to hypothyroidism -Colace Oral Capsule 100 MG (Docusate Sodium) Give 1 capsule by mouth two times a day for constipation -QUEtiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth two times a day related to bipolar disorder -Refresh Plus Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium) Instill 2 drop in both eyes two times a day for Dry eyes -Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth three times a day for Pain Resident #120 Review of an Admission Record revealed Resident #120 was a male, with pertinent diagnoses which included dementia, atrial fibrillation (an irregular heart rate that results in poor blood flow), depression, anxiety, schizoaffective disorder (a mental health condition), Wernicke's encephalopathy (neurological disorder), hyperlipidemia, insomnia, diabetes, and hypotension (low blood pressure). Review of the October 2024 Medication Administration Record (MAR) for Resident #120 revealed no documentation (missed medications) on 10/12/24 in the evening for the following physician orders: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Atorvastatin Calcium Oral Tablet 10 MG (Atorvastatin Calcium) Give 1 tablet by mouth one time a day related to hyperlipidemia -Melatonin Oral Tablet 3 MG (Melatonin) Give 1 tablet by mouth one time a day for Sleep -OLANZapine Oral Tablet 20 MG (Olanzapine) Give 1 tablet by mouth one time a day related to schizoaffective disorder -traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth one time a day related to depression -Sotalol HCl Oral Tablet 160 MG (Sotalol HCl) Give 1 tablet by mouth two times a day related to atrial fibrillation -Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 4 capsule by mouth three times a day related to dementia -Lactulose Oral Solution 10 GM/15 ML (Lactulose) Give 30 ml by mouth three times a day related to Wernicke's encephalopathy -Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 1 tablet by mouth three times a day related to hypotension -Haloperidol Oral Tablet 5 MG (Haloperidol) Give 1 tablet by mouth four times a day related to schizoaffective disorder Resident #124 Review of an Admission Record revealed Resident #124 was a male, with pertinent diagnoses which included heart disease, hyperlipidemia (high levels of fat in the blood), seizure disorder, high blood pressure, atrial fibrillation (an irregular heart rate that results in poor blood flow), and BPH (an enlarged prostate that can cause difficulty urinating). Review of the October 2024 Medication Administration Record (MAR) for Resident #124 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Atorvastatin Calcium Oral Tablet 40 MG (Atorvastatin Calcium) Give 1 tablet by mouth one time a day for hyperlipidemia -Tamsulosin HCl Oral Capsule 0.4 MG (Tamsulosin HCl) Give 1 capsule by mouth one time day for BPH -Eliquis Oral Tablet 5 MG Apixaban) Give 1 tablet by mouth two times a day related to heart disease/atrial fibrillation -Gabapentin Oral Capsule 100 MG Give 2 capsule by mouth two times a day for Pain -Lacosamide Oral Tablet 100 MG (Lacosamide) Give 1 tablet by mouth two times a day for seizure (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours for pain Review of the October 2024 Medication Administration Record (MAR) for Resident #124 revealed no documentation (missed medications) on 10/26/24 in the morning for the following physician orders: -Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day for heart failure/atrial fibrillation -Senna Oral Tablet 8.6 MG (Sennosides) Give 2 tablet by mouth one time a day for bowels -Eliquis Oral Tablet 5 MG Apixaban) Give 1 tablet by mouth two times a day related to heart disease/atrial fibrillation -Gabapentin Oral Capsule 100 MG Give 2 capsule by mouth two times a day for Pain -Lacosamide Oral Tablet 100 MG (Lacosamide) Give 1 tablet by mouth two times a day for seizure -Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours for pain Resident #125 Review of an Admission Record revealed Resident #125 was a male, with pertinent diagnoses which included diabetes. Review of the October 2024 Medication Administration Record (MAR) for Resident #125 revealed no documentation (missed medications) on 10/18/24 in the evening for the following physician orders: -Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously one time a day for diabetes -traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth one time a day for Depression Review of the October 2024 Medication Administration Record (MAR) for Resident #125 revealed no documentation (missed medications) on 10/19/24 in the morning for the following physician orders: -NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject 10 unit subcutaneously three times a day for diabetes -NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale three times a day for diabetes Resident #126 Review of an Admission Record revealed Resident #126 was a female, with pertinent diagnoses which included depression, anxiety, and diabetes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Minimum Data Set (MDS) assessment for Resident #126, with a reference date of 11/15/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated she was cognitively intact. In an interview on 1/9/25 at 12:21 PM, Resident #126 recalled several nights in October 2024 where no nurse was assigned to her hall. Resident #126 stated .I guess (the nurse) just didn't show up. I think that is what the excuse was . Resident #126 reported she missed some medications and others were administered late. Resident #126 stated .I was kind of worried because I didn't know. I have sugar (diabetes). I didn't know then if I would have a reaction . Resident #126 reported she was worried about how long she could go without medication. Resident #126 reported issues with anxiety and stated .The anxiety got to be so bad . nobody (was) handing out meds (medications) .there was no one . 41982 In an interview on 1/7/25 at 8:54 AM Certified Nurse Aide (CNA) R reported staffing on The Harbor (the memory care unit) was challenging because of the needs of the residents. CNA R reported there were many residents who were dependent on staff to feed them and generally there were only 3 aides to feed. CNA R reported the nurse on duty would sometimes assist with feeding as well, but it depended on the nurse, and many did not help. CNA R reported sometimes there was only 2 aides and a nurse on the unit which was not enough because they couldn't keep an eye on every resident adequately. In an interview on 1/7/25 at 2:38 PM, CNA X reported she usually worked on the 400 Hall but sometimes on the 300 Hall as well. CNA X reported the staffing here is horrible. CNA X gave the example that the facility hadn't had enough staff to feed dependent residents for lunch and dinner the day before. CNA X reported at times, there had not been enough staff to feed residents for breakfast either. CNA X reported when a CNA called off, the facility couldn't always get somebody to come in to fill the open spot, and the CNAs working just do what they can. In an interview on 1/8/25 at 2:53 PM, Licensed Practical Nurse (LPN) Q reported staffing was frustrating. LPN Q reported staff often showed up late. LPN Q reported call lights didn't always get answered in a timely fashion, it was difficult to keep an eye on some of the residents who have behaviors or who are fall risks, and sometimes meal trays were delivered late or got missed altogether.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 This citation pertains to Intake # MI00147580, MI00149295, & MI00149428. Based on interview, and record review, the facility failed to ensure residents are free from significant medication errors in 5 of 14 residents (Resident #118, #103, #113, #124, & #125) reviewed for medication administration, resulting in a significant change in condition and hospitalization for Resident #118, and the potential for adverse effects due to missed medications. Findings include: The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe that the orders are in error, violate agency policy, or are harmful to the patient. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 20717-20719). Elsevier Health Sciences. Kindle Edition. Resident #118 Review of an Admission Record revealed Resident #118 was a male, with pertinent diagnoses which included heart failure, atrial fibrillation (an irregular heart rate that results in poor blood flow), respiratory failure, kidney disease, stroke, and high blood pressure. Review of a Minimum Data Set (MDS) assessment for Resident #118, with a reference date of 12/17/24, revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated severe cognitive impairment. Review of a Nursing - Transfer to Hospital Summary for Resident #118, dated 12/30/24 at 6:37 PM, revealed .Resident was in bed alert with prompting .Resident brother at bedside during the morning. Medications reviewed with brother .Brother was concerned resident was not staying awake during visit .VS (Vital Signs) obtained (oxygen via nasal cannula) increased to 5 (Liters) .to maintain (oxygen) above 90%. NP (Nurse Practitioner) called .brother wanted to send patient to ED (Emergency Department) . In an interview on 1/6/25 at 12:15 PM, Unit Manager LL reported they assessed Resident #118 prior to his hospitalization on [DATE]. Unit Manager LL reported they were working on a different unit when Resident #118's nurse came to get them for a second opinion. Unit Manager LL reported Resident #118's family member had been in earlier asking about Resident #118's ordered medications. Unit Manager LL reported Resident #118's oxygen saturation had been low and the assigned nurse had increased his oxygen to keep his saturation above 90%. Unit Manager LL reported Resident #118 appeared calm and did make eye contact and respond to his name. Unit Manager LL reported Resident #118's family member was concerned, and wanted Resident #118 to be sent to the hospital since he seemed more sleepy/tired than usual. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview on 1/6/25 at 12:23 PM, Agency Licensed Practical Nurse (LPN) DDD reported they were the nurse assigned to Resident #118 at the time of his hospitalization on [DATE]. Agency LPN DDD reported Resident #118 was awake but appeared to have labored breathing. Agency LPN DDD reported since they were not sure of Resident #118's baseline, they requested Unit Manager LL to assess Resident #118. Agency LPN DDD reported they checked on him several times and he would respond and make eye contact. Agency LPN DDD stated .the breathing was my concern . and reported both Resident #118's pulse and respiration rate were high. Agency LPN DDD reported Resident #118's family member was concerned that Resident #118 was not his usual self, and wanted him sent to the hospital for further evaluation. Agency LPN DDD reported Resident #118 had a PRN (as needed) medication ordered for anxiety, but no doses were administered on their shift. Review of an Emergency Department (ED) Physician Note for Resident #118, dated 12/30/24, revealed . presented from nursing facility with acute Encephalopathy, un arousable, only arousing to sternal rub .Drug screen pending .Upper and lower extremities are cold to touch .Concerned if he is in cardiogenic shock .QTC is very prolonged >600s, holding amiodarone .Avoid QT prolonging (medications) .transferred to the intensive care unit (ICU) . Review of a Hospital Physician Note for Resident #118, dated 12/31/24, revealed .Presented this admission from LTC (Long-Term Care) for change in mentation and abnormal breathing .Amiodarone started last admission .EKG upon admission demonstrated prolonged QTc. Agree with holding at this time .Per ICU notes - may be related to Trazodone use .Monitor QTc and rhythm . Review of a Hospital Physician Note for Resident #118, dated 1/1/25, revealed .Patient was brought in from his long-term care facility to emergency department with acute encephalopathy leading to worsening acute hypoxic respiratory failure. He was difficult to arouse in the emergency department so he was admitted to intensive care unit for close monitoring .suspected to be medication related: Drug screen was positive for trazodone (not on facility med (medication) list, so unclear how he received this medication), but also had been on Xanax but this did not show on drug screen . Review of a Hospital Physician Note for Resident #118, dated 1/2/25, revealed .Drug Screen .Trazodone . Facility was contacted, and there was no record of trazodone administration .there is report that the patient did receive Vistaril and Xanax on the days leading up to admission. There was no benzodiazapines identified on screens .It is felt that the altered mental status may have been related to trazodone (found) on a drug screen, there is no documentation of this ever being given at the facility . In an interview on 1/7/25 at 9:30 AM, Agency Registered Nurse (RN) BBB reported Resident #118 had a PRN medication for anxiety and recalled administering the medication to Resident #118. Agency RN BBB stated .(Resident #118) had a lot of anxiety. (He) wouldn't keep his oxygen (nasal cannula) on (and) would have episodes of rapid breathing . Agency RN BBB reported Resident #118 took all his medication via a PEG (Percutaneous Endoscopic Gastrostomy) tube (a feeding tube placed through the abdominal wall). Review of an Order Summary Report for Resident #118 revealed the physician order .Xanax Oral Tablet 0.5 MG (Alprazolam) Give 0.5 mg via G-Tube (feeding tube) every 8 hours as needed for Anxiety . with a start date of 12/19/24. Note this order was discontinued on 12/26/24. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of an Order Summary Report for Resident #118 revealed the physician order .Xanax Oral Tablet 0.5 MG (Alprazolam) Give 1 tablet via PEG-Tube (feeding tube) every 8 hours as needed for Anxiety . with a start date of 12/29/24. Review of a Controlled Drug Receipt/Record/Disposition Form for Resident #118 revealed one Alprazolam 0.5 MG Tablet was pulled from Resident #118's medication supply for administration on 12/19/24 at 7:00 AM, one on 12/19/24 at 7:00 PM, one on 12/28/24 at 9:00 PM, and one on 12/29/24 at 12:22 PM. Note there was no active physician order for Alprazolam 0.5 MG Tablet for Resident #118 on 12/28/24. Review of the December 2024 Medication Administration Record (MAR) for Resident #118 revealed the medication Alprazolam 0.5 MG Tablet was documented as administered only one time, on 12/29/24 at 12:22 PM. No administration documentation noted in the December 2024 MAR related to the Alprazolam 0.5 MG Tablets pulled from Resident #118's medication supply on 12/19/24 (two doses) and 12/28/24 (one dose). Review of an Order Summary Report for Resident #118 revealed the physician order .Amiodarone HCl Oral Tablet 200 MG (Amiodarone HCl) Give 1 tablet .one time a day . with a start date of 12/28/24. Review of an Order Summary Report for Resident #118 revealed no physician order for Trazodone. In an interview on 1/9/25 at 1:42 PM, Assistant Director of Nursing (ADON) C reported Resident #118 was sent to the hospital on 12/30/24 and a drug screen revealed trazodone (an antidepressant) in his system, which he was not prescribed. ADON C reported the drug screen also indicated no alprazolam in his system, which he did have a prescription for and per the facility medication administration records had been given two doses prior to his hospitalization . ADON C reported Resident #118 was prescribed amiodarone which cannot be taken simultaneously with trazodone, due to the potential for drug interactions. Resident #103 Review of an Admission Record revealed Resident #103 was a male, with pertinent diagnoses which included stroke and a seizure disorder. Review of a current Care Plan for Resident #103 revealed the focus .The resident has a seizure disorder r/t (related to) hx (history) intracerebral hemorrhage (stroke) . with interventions which included .Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness . both initiated 8/14/24. Review of the October 2024 Medication Administration Record (MAR) for Resident #103 revealed no documentation (missed medication) on 10/18/24 in the evening for the physician order .levETIRAcetam Oral Tablet 500 MG (Levetiracetam) Give 1 tablet by mouth two times a day for Seizures . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of an article titled Missed Medicines as a Seizure Trigger, dated 2024, revealed .Missing doses of seizure medicine is the most common cause of breakthrough seizures. Missed medicines can trigger seizures in people with both well-controlled and poorly controlled epilepsy. Seizures can happen more often than normal, be more intense or develop into long seizures called status epilepticus. Status epilepticus is a medical emergency and can lead to death if the seizures aren't stopped. Missing doses of medicine can also lead to falls, injuries and other problems from seizures and changes in medicine levels . Retrieved from https://www.epilepsy.com/what-is-epilepsy/seizure-triggers/missed-medicines Resident #113 Review of an Admission Record revealed Resident #113 was a female, with pertinent diagnoses which included diabetes. Review of a current Care Plan for Resident #113 revealed the focus .Risk (for) adverse outcomes from potential hypoglycemic (low blood sugar) or hyperglycemic (high blood sugar) episodes (diagnosis of diabetes) . initiated 8/14/24. Review of the October 2024 Medication Administration Record (MAR) for Resident #113 revealed no documentation (missed medication) on 10/12/24 in the evening for the physician order .Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 61 unit subcutaneously one time a day for diabetes . Resident #124 Review of an Admission Record revealed Resident #124 was a male, with pertinent diagnoses which included heart disease, high blood pressure, and atrial fibrillation (an irregular heart rate that results in poor blood flow). Review of a current Care Plan for Resident #124 revealed the focus .The resident is on anticoagulant therapy r/t (related to) Atrial fibrillation, history of PE (pulmonary embolism) . with interventions which included .Administer medications as ordered by physician. Monitor for side effects . both initiated 8/13/24. Review of the October 2024 Medication Administration Record (MAR) for Resident #124 revealed no documentation (missed medication) on 10/18/24 in the evening for the physician order .Eliquis (an anticoagulant) Oral Tablet 5 MG Apixaban) Give 1 tablet by mouth two times a day related to heart disease/atrial fibrillation . Review of the October 2024 Medication Administration Record (MAR) for Resident #124 revealed no documentation (missed medication) on 10/26/24 in the morning for the physician order .Eliquis Oral Tablet 5 MG Apixaban) Give 1 tablet by mouth two times a day related to heart disease/atrial fibrillation . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of a Cleveland Clinic page titled Anticoagulants, last reviewed/updated 1/10/22, revealed . Anticoagulants are a family of medications that stop your blood from clotting too easily. They can break down existing clots or prevent clots from forming in the first place. These medications can help stop life-threatening conditions like strokes, heart attacks and pulmonary embolisms, all of which can happen because of blood clots . Retrieved from https://my.clevelandclinic.org/health/treatments/22288-anticoagulants Resident #125 Review of an Admission Record revealed Resident #125 was a male, with pertinent diagnoses which included diabetes. Review of a current Care Plan for Resident #125 revealed the focus .The resident has Diabetes Mellitus . with interventions which included .Administer medication as ordered by the physician . both initiated 8/13/24. Review of the October 2024 Medication Administration Record (MAR) for Resident #125 revealed no documentation (missed medication) on 10/18/24 in the evening for the physician order .Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously one time a day for diabetes . Review of the October 2024 Medication Administration Record (MAR) for Resident #125 revealed no documentation (missed medications) on 10/19/24 in the morning for the physician orders .NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject 10 unit subcutaneously three times a day for diabetes . and .NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale three times a day for diabetes . Review of a Cleveland Clinic page titled Insulin, last reviewed/updated 1/17/24, revealed .Insulin is an essential hormone. It helps your body turn food into energy and manages your blood sugar levels. If you have diabetes, your body can't make enough insulin or can't use it properly. Your healthcare provider can prescribe manufactured insulin that you take through an injection (shot), injectable pen or pump .Insulin is a naturally occurring hormone your pancreas makes that's essential for allowing your body to use sugar (glucose) for energy. If your pancreas doesn't make enough insulin or your body doesn't use insulin properly, it leads to high blood sugar levels (hyperglycemia). This results in diabetes .There are also manufactured types of insulin that people with diabetes use to manage the condition .Regular insulin (or short-acting insulin) .They begin working about 30 to 45 minutes after injection and wear off after about five to eight hours. Regular insulin peaks about two to four hours after injection .Long-lasting insulin: It takes about an hour for this type of insulin to reach your bloodstream and start working. It peaks between three and 14 hours after injection. It lasts up to a day. Types include insulin glargine .Follow your provider's instructions carefully . Retrieved from https://my.clevelandclinic.org/health/body/22601-insulin In an interview on 1/6/25 at 3:48 PM, Licensed Practical Nurse (LPN) QQ reported the evening of 10/18/24 on the 300 Hall, no residents received scheduled medications. In an interview on 1/8/25 at 9:52 AM, Former Assistant Director of Nursing (ADON) MMM reported they were aware that multiple residents missed medications the evening of 10/18/24 and stated .we did look into that . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview on 1/8/25 at 10:07 AM, Agency Licensed Practical Nurse (LPN) JJJ reported they worked on the 100 Hall the evening of 10/18/24. Agency LPN JJJ reported that evening there was no nurse assigned to the 300 Hall from 6:30 PM-11:00 PM. In an interview on 1/8/25 at 11:49 AM, RN PPP reported they worked at the facility on 10/19/24 and stated . they were short on nurses that morning . RN PPP recalled going over to the 300 Hall to assist with passing morning medications. RN PPP reported there was no nurse responsible for the 300 Hall at that time. RN PPP stated .It was horrible because a lot of people did not get their medications . on 10/18/24 and 10/19/24. In an interview on 1/8/25 at 1:22 PM, with Director of Nursing (DON) B and Assistant Director of Nursing (ADON) C, DON B reported the facility recognized an issue related to the 300 Hall and missed medications on 10/18/24. DON B reported a nurse came in late on 10/19/24 to assist with medication administration on the 300 Hall and help get everything caught up. In an interview on 1/8/25 at 3:40 PM, LPN QQ reported at shift change the evening of 10/18/24, no nurse showed up for the 300 Hall. LPN QQ reported they counted the controlled substances with the other day shift nurse and locked the keys in the medication cart before leaving the facility. LPN QQ reported they wrote a shift-to-shift report on a piece of paper and left it at the desk. LPN QQ stated .(With Agency staff) you don't know who will show up . LPN QQ reported RN LLL was on the 400 Hall that night and refused to take responsibility for the 300 hall because .it was too many people . LPN QQ reported the same thing happened on 10/26/24 on day shift, where no nurse took responsibility for the 300 Hall resulting in residents not receiving their ordered medications. LPN QQ reported residents on the 400 Hall missed medications and had no nurse the evening of 10/12/24. LPN QQ reported that night (10/12/24) the Agency nurse on the schedule arrived and refused the assignment, saying she wasn't going to put her license at risk.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 This citation pertains to Intake # MI00147580. Based on interview, and record review, the facility failed to ensure it was administered in a manner that maintains the safety and care of residents, so residents may reach their highest practicable physical, mental, and psychosocial well-being, for all 92 residents who reside at the facility, resulting in quality care not being provided to residents, insufficient management of facility staffing, and a lack of follow-up in regard to concerns voiced by staff. For additional information see citations F600 and F725. Findings include: Review of the policy/procedure Staffing, dated 11/3/23, revealed .The facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for the residents in accordance with the residents plan of care .Licensed nurses and nursing assistants are available 24 hours a day, 7 days a week to provide direct resident care services .Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on their plan of care .Inquiries or concerns related to the facility's staffing should be directed to the Administrator or their designee . Review of the policy/procedure Staffing (Department: Nursing), dated 4/13/22, revealed .There will be a designated staff member listed at the front desk who is responsible to ensure appropriate staffing at all times . Designated staff member will ensure that there is staff appropriate to care for all residents in the facility . In an interview on 1/8/25 at 9:15 AM, RN LLL reported they were assigned the 400 Hall on 10/18/24 from 6:30 PM-7:00 AM. RN LLL reported they could not recall who was responsible for the 300 Hall that night (10/18/24 between 6:30 PM-11:00 PM). RN LLL recalled a resident on the 300 Hall attempted to elope from the facility between 7:00 PM-11:00 PM. RN LLL stated in regard to staffing .We were always short. (Staffing) was definitely an issue that night . RN LLL reported management was .fully aware . of the staffing concerns but would not come into the facility to assist when short-staffed. In an interview on 1/8/25 at 9:52 AM, Former Assistant Director of Nursing (ADON) MMM reported no issues with staffing the evening of 10/18/24 between 6:30 PM-11:00 PM and stated .we were at State minimums . Former ADON MMM reported they were aware that multiple residents missed medications the evening of 10/18/24 and stated .we did look into that . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 1/8/25 at 10:07 AM, Agency Licensed Practical Nurse (LPN) JJJ reported they worked on the 100 Hall the evening of 10/18/24. Agency LPN JJJ reported that evening there was no nurse assigned to the 300 Hall between 6:30 PM-11:00 PM. Agency LPN JJJ reported there was only a nurse on the 400 Hall. Agency LPN JJJ reported they took over some of the rooms on the 300 Hall after 11:00 PM, but from 6:30 PM-11:00 PM on 10/18/24 there was no nurse assigned to the residents on the 300 Hall. Agency LPN JJJ reported the evening of 10/18/24 was not the first time where no nurse was assigned to a section of residents, and stated .I canceled all my shifts after that. (I) did not feel safe working there . Agency LPN JJJ reported they spoke with the on-call manager that evening (Former ADON MMM) about the staffing concerns, and reported there were only three nurses in the building when there should have been four. In an interview on 1/8/25 at 10:44 AM, LPN OOO reported concerns with staffing at the facility. LPN OOO reported at times there would be one nurse assigned to over 50 residents. LPN OOO stated .They were telling me I had to work like that. I told them there are people who are a fall risk, people with mental health issues .I told them it's not safe .I am not going to put these people's lives in jeopardy . LPN OOO reported they worked one shift with a 56 resident assignment and stated .it was too dangerous .It was the most nerve-wracking night of my life . LPN OOO reported they spoke with Former Assistant Director of Nursing (ADON) MMM at the time about the staffing concerns and no assistance/guidance or direction was provided. LPN OOO reported former ADON MMM often did not answer the phone and stated .if you had an issue at night that was your issue .(Former ADON MMM) wouldn't come in and get on a cart or help at all . LPN OOO reported the evening when she worked with a 56 resident assignment, she was not aware until a CNA came and asked her to get a pain medication for a resident. LPN OOO reported the offgoing nurses that night had locked the keys in the medication cart and left at the end of their shift. LPN OOO stated .I never got report or nothing about that hall or any of those patients . In an interview on 1/8/25 at 11:49 AM, RN PPP reported they worked at the facility on 10/19/24 and stated . they were short on nurses that morning . RN PPP recalled going over to the 300 Hall to assist with passing morning medications. RN PPP reported there was no nurse assigned to the 300 Hall that day. RN PPP stated .It was horrible because a lot of people did not get their medications . on 10/18/24 and 10/19/24. RN PPP reported in each instance, the offgoing nurse locked the keys in the medication cart and left the facility without giving verbal report. RN PPP reported the nurse on the 400 Hall that day had been calling management for help, and no plan was in place to assist staff when there was a shortage of nurses. RN PPP reported the on-call nurse manager at the time stopped responding to phone calls. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 1/8/25 at 3:40 PM, LPN QQ reported at shift change the evening of 10/18/24, no nurse showed up for the 300 Hall. LPN QQ reported they counted the controlled substances with the other day shift nurse and locked the keys in the medication cart before leaving the facility. LPN QQ reported they wrote a shift-to-shift report on a piece of paper and left it at the desk. LPN QQ stated .(With Agency staff) you don't know who will show up . LPN QQ reported RN LLL was on the 400 Hall that night and refused to take responsibility for the 300 hall because .it was too many people . LPN QQ reported the same thing happened on 10/26/24 on day shift, where no nurse took responsibility for the 300 Hall resulting in residents not receiving their ordered medications. LPN QQ stated calling management or the on-call nurse was .a waste of your time . LPN QQ reported there were multiple days with missed medications and management .didn't do anything . LPN QQ reported residents on the 400 Hall missed medications and had no nurse the evening of 10/12/24. LPN QQ reported that night (10/12/24) the Agency nurse on the schedule arrived and refused the assignment, saying she wasn't going to put her license at risk. In an interview on 1/9/25 at 3:09 PM, LPN QQ reported they attempted to notify the on-call manager on 10/12/24 when the Agency nurse arrived refused the assignment. LPN QQ reported the on-call manager did not answer the phone. LPN QQ reported they also attempted to contact the scheduler and the Regional Manager with no answer. LPN QQ stated .to call them was a waste of time. They wouldn't do anything . LPN QQ stated .This is why it didn't matter if you called the on-call because nothing would be done . The executive's position within an organization is critical in uniting the strategic direction of an organization with the philosophical values and goals of nursing. The nurse executive is a clinical and business leader who is concerned with maximizing quality of care and cost-effectiveness while maintaining relationships and professional satisfaction of the staff. Perhaps the most important responsibility of the nurse executive is to establish a philosophy for nursing that enables managers and staff to provide quality nursing care. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 18631-18634). Elsevier Health Sciences. Kindle Edition.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982 Based on interview and record review, the facility failed to maintain a complete and accurate medical record related to Advance Directives / Code Status for 1 (Resident #111) of 1 sampled resident reviewed for Advance Directives / Code Status, resulting in an incongruent reflection of the resident records and the potential for the resident's care wishes not being honored as desired. Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing.High-quality documentation is necessary to enhance efficient, individualized patient care. Quality documentation has five important characteristics: it is factual, accurate, complete, current, and organized . Accessed from: Kindle Locations ,d+[DATE]). Elsevier Health Sciences. Kindle Edition. Resident #111 Review of an Admission Record revealed Resident #111 was a male. Review of Resident #111's DO-NOT-RESUSCITATE ORDER signed by Resident #111's Responsible Party (Family Member FM TT), 2 physicians (names omitted), and 2 witnesses (names omitted) on [DATE] revealed, .PATIENT ADVOCATE CONSENT I authorize that in the event the declarant's heart and breathing should stop, no person shall attempt to resuscitate the declarant. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law . Review of Resident #111's current Care Plan revealed the focus of .Request to limit treatment form filled out indicating residents wishes . with care planned interventions which included, Follow the limited treatment sheet and advanced directives as written per residents wishes with Date Initiated of [DATE]. Review of Resident #111's Order Summary as of [DATE] revealed an active order of, Adv (advance) Directive: Full Cardiopulmonary Resuscitation (CPR) .Order Status Active Order Date [DATE] Review of Resident #111's Electronic Medical Record Dashboard (home screen) on [DATE] at 10:54 AM revealed, Code Status (Advance Directives) Adv Directive: Full Cardiopulmonary Resuscitation (CPR) In an interview on [DATE] beginning at 10:54 AM, Assistant Director of Nursing (ADON) C reviewed Resident #111's DO-NOT-RESUSCITATE ORDER document as well as Resident #111's Adv (advance) Directive: Full Cardiopulmonary Resuscitation (CPR) .Order Status Active Order Date [DATE] and Resident #111's Electronic Medical Record Dashboard (home screen) with this surveyor and confirmed they did not match. ADON C reported it looked like when Resident #111 returned to the facility from the hospital, he was entered as a Full Code. ADON C reported the order was entered incorrectly, and that it should have been entered as a DNR (do not resuscitate) to match Resident #111's DNR paperwork.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235458	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Grand Rapids	1950 32nd St S E Grand Rapids, MI 49508

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36221 This citation pertains to Intake # MI00147061. Based on observation, interview, and record review, the facility failed to ensure effective hand hygiene and glove use during incontinence care in 1 of 4 residents (Resident #101) reviewed for infection control during incontinence care, resulting in the potential for cross-contamination and the development and spread of infection and disease. Findings include: Resident #101 Review of an Admission Record revealed Resident #101 was a female, with pertinent diagnoses which included bladder dysfunction, depression, anxiety, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 12/13/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. In an observation and interview on 1/2/25 at 1:47 PM, Resident #101 was noted in bed in her room. Resident #101 reported she had an indwelling catheter and has had issues with frequent Urinary Tract Infections (UTIs) while at the facility. Observed Certified Nursing Assistant (CNA) AA and CNA BB assist Resident #101 with incontinence care due to a bowel movement. Noted CNA AA and CNA BB donned gowns and gloves prior to entering Resident #101's room. CNA AA and CNA BB lowered the head of Resident #101's bed and opened Resident #101's soiled brief to begin incontinence care. CNA AA and CNA BB rolled Resident #101 onto her left side and used washcloths/soap to perform incontinence care. Observed CNA AA clean bowel movement from Resident #101's buttocks, and then immediately handle Resident #101's pillows and place a new pad below Resident #101 with no glove change or hand hygiene performed. Resident #101 was then assisted onto her right side. Observed CNA BB clean bowel movement from Resident #101's buttocks and thighs, wiping from back to front with the washcloth. After drying Resident #101's buttocks, CNA BB applied protective cream to Resident #101's buttocks using the same soiled gloves, and then wiped the excess cream from the soiled gloves with a towel and continued with care. CNA AA and CNA BB assisted Resident #101 to a laying position to complete incontinence care, and wash Resident #101's vaginal/perineal area. Noted both CNA AA and CNA BB continued to wear the same soiled gloves originally donned upon entering Resident #101's room. CNA AA dampened the corner of a large towel (since no washcloths were left in the room) and washed Resident #101's vaginal/perineal area. After incontinence care was completed, both CNA AA and CNA BB handled Resident #101's pillows/linens and personal items using the same soiled gloves originally donned upon entering Resident #101's room. In an observation on 1/2/25 at 2:37 PM, CNA AA returned to Resident #101's room wearing a gown and gloves to empty the catheter bag. Once care was complete, observed CNA AA remove their gloves and perform hand washing at the sink in Resident #101's room for approximately five seconds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/2/25 at 2:37 PM, Resident #101 reported staff generally do not change their gloves during incontinence care. In an interview on 1/2/25 at 2:57 PM, CNA BB stated gloves are .not usually . changed with incontinence care. In an interview on 1/2/25 at 3:02 PM, CNA AA reported staff typically don't change gloves during incontinence care. Review of the policy/procedure Hand Hygiene, dated 4/14/23, revealed .To provide guidelines to staff for proper hand hygiene techniques that will aid in the prevention and transmission of infections .SITUATIONS IN WHICH USING SOAP AND WATER OR ALCOHOL BASED HAND RUB CAN BE USED .Before and after handling clean or soiled dressings, linens, etc .Before moving from a contaminated body site to a clean body site during resident care .After handling contaminated objects, equipment, dressings, etc .HAND HYGIENE TECHNIQUE WHEN USING SOAP AND WATER .Wet hands with water .Apply soap .Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers .Rinse hands with water .Dry thoroughly with a paper towel .Use clean paper towel to turn off the faucet . Review of the CDC (U.S. Centers for Disease Control and Prevention) Guidance Clinical Safety: Hand Hygiene for Healthcare Workers, last updated 2/27/24, revealed .Gloves are not a substitute for hand hygiene .When to change gloves and clean hands .If gloves become soiled with blood or body fluids after a task .If moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs .If they look dirty or have blood or body fluids on them after completing a task . Retrieved from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 36221 This citation pertains to Intake # MI00147744 & MI00148620. Based on observation, interview, and record review, the facility failed to ensure a sanitary and comfortable environment in 2 of 5 residents (Resident #103 & #104) reviewed for a clean/homelike environment, resulting in noxious odors and the potential for decreased satisfaction with the living environment. Findings include: Resident #103 Review of an Admission Record revealed Resident #103 was a male, with pertinent diagnoses which included stroke, muscle weakness, anxiety, and depression. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 10/16/24, revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated moderate cognitive impairment. In an observation on 1/6/25 at 3:09 PM, noted a strong urine smell in Resident #103's bathroom. Observed that Resident #103's toilet seat was up, and the toilet bowl was unflushed with yellow urine and toilet paper visible in the bowl. Noted a splattered brown substance on the back surface of the toilet bowl. Observed a toilet riser, detached from Resident #103's toilet and laying on the floor, with a smeared brown substance on the bottom surface of the riser. In an observation on 1/7/25 at 2:24 PM, noted a splattered brown substance on the back surface of the toilet bowl in Resident #103's bathroom. Resident #104 Review of an Admission Record revealed Resident #104 was a female, with pertinent diagnoses which included dementia, Alzheimer's disease, depression, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 11/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 1, out of a total possible score of 15, which indicated she had severe cognitive impairment. In an interview on 1/2/25 at 11:04 AM, Family Member VV reported Resident #104's room is unsanitary and smells of urine. In an observation on 1/2/25 at 11:30 AM, noted Resident #104's bathroom door was ajar with visible toilet paper debris on the bathroom floor. Observed a toilet brush laying on the floor beside the toilet, not in a holder. Noted a strong urine smell in Resident #104's bathroom. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 1/6/25 at 1:23 PM, noted a strong urine smell in Resident #104's bathroom. Observed a soiled brief on the floor in Resident #104's bathroom, to the left of the toilet along the wall, along with multiple small pieces of toilet paper. In an observation on 1/7/25 at 2:11 PM, noted a strong urine smell in Resident #104's bathroom. Observed multiple bits of trash/debris on Resident #104's bathroom floor including two wadded up, soiled briefs. Observed Resident #104's toilet bowl was unflushed with yellow urine and toilet paper visible in the bowl. Noted Resident #104's bathroom floor was tacky when walked on. In an observation on 1/8/25 at 12:23 PM, noted a slight urine smell in Resident #104's bathroom. Observed multiple sugar packs and bits of trash/paper on the floor of Resident #104's bathroom. Observed a brown, splattered substance on the back of the toilet bowl and toilet seat. In an observation on 1/13/25 at 11:44 AM, noted a strong urine smell in Resident #104's room and bathroom. Observed multiple small bits of paper trash on the floor of the bathroom, along the wall behind the toilet. Noted Resident #104's toilet bowl was unflushed with yellow urine, stool, and toilet paper visible in the bowl.