STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235461	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clarkston	4800 Clintonville Rd Clarkston, MI 48346

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview, and record review, the facility failed to provide consistent, meaningful and person-centered activities for one (R32) of one resident reviewed for activities, and five of seven residents who attended the confidential Resident Council interview, resulting in potential for loss of interaction, joy, self-esteem, sense of well-being, creativity, and independence. Findings include: R32 A review of R32's clinical record revealed R32 was a long-term resident of the facility and was admitted to the facility on [DATE]. R32's admitting diagnoses included anxiety disorder, bipolar-disorder, insomnia, osteoarthritis, social phobia and depression. Based on a Minimum Data Set (MDS) assessment dated [DATE], R32 had Brief Interview for Mental Status (BIMS) score of 15/15, indicative of intact cognition. On 9/9/24 at approximately 12:15 PM, R32 was observed in their bed. R32 was queried about their daily routine, if they attended any activities and their quality of life at the facility. R32 reported they used to go for activities but the facility did not have enough activity staff after a change in management several months ago. They added they used to have more staff and more programs and right now they had only an activities director. They added the facility had bingo two times per week and no other activities that interested them. R32 reported that one of the Bingo prizes was Bingo Bucks and they could use them to buy things from the store. The store was open for an hour and if they could not make it in the hour they had to wait until the next time. When queried if they received 1:1 activity visits from the staff, R32 reported no. They added that they did not get along with the activities director before and the department did not have any other staff. They added you can check with the other residents. Review of R32's Electronic Medical Record (EMR) revealed a Recreation assessment dated [DATE] (completed approximately over 2.5 years ago). The assessment revealed that R32 liked to play cards, arts and crafts, music and spiritual activities. Review of an activities task list for the last 30 days did not reveal any entries. Review of R32's progress notes did not reveal any activity progress notes. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Activities Calendar for September 2024 from 9/1/24 through 9/7/24 included Card Club, Bingo, and Morning games two times per week between 9/3/24 and 9/6/24. On 9/1/24 (Sunday) and every Sunday in September the scheduled activity was River of Life Church for the whole day and every Saturday in September the scheduled activity was Resident Lead Activities. On 9/2/24 (Monday, which was Holiday), the scheduled activity was Resident Lead Activities. A confidential Resident Council interview was held on 9/10/24 at 10:30 AM. Seven Residents attended the meeting. During the meeting, five residents reported that the facility eliminated all the activities staff when there was a change in management. They reported they had more programs prior to that. They reported it happened several months ago. They added the facility currently had one staff member, the activities director, who tried to handle everything. Four residents confirmed the facility did not have activities staff on weekends. They added they had Church on one day. One resident added they set up some stuff and residents who were able to do things on their own could use the items. It was further reported the Activities Director tried to improvise with the staff they had. A staff member (Certified Nursing Assistant - CNA) assisted residents with smoking and assisted with some activities when they worked on weekends. Another resident stated, It is too much for one person to do. An interview was conducted with Director of Activities (DA) D on 9/9/24 at approximately 3:00 PM. DA D was queried about their activities programming, staffing and how they met the interests/needs of their residents. They reported they were the only staff member in the department at this time and had been since April 2024. They added they used to have three staff members in the department and they had a variety of programs every day of the week. They reported they were recently approved a part-time staff who assisted between nursing and activities. They had some volunteers from church helping on weekends and they were trying to do their best to meet the needs of their residents. They added they tried to spend around three hours for a resident group activity and tried to manage the 1:1 visits and their other responsibilities. An interview was conducted with the Administrator on 9/10/24 at approximately 12:45 PM. When queried about the activities program and the lack of activities and staff, the Administrator acknowledged the concerns and added they just received an approval for a part-time staff member from the management. They added they were trying to change that to a full-time staff member and were trying to have other managers assist with programming. Review of facility provided document titled Activities with a revision date of 1/1/24, read in part, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community. Definitions: Activities refer to any endeavor, other than routine ADLs (activities of daily living), in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical cognitive, and emotional health. These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Each resident's interest and needs will be assessed on a routine basis. The assessment shall include, but is not limited to: a. RAI (resident assessment instrument) Process: MDS/CAA(care area assessment)/Care Plan. b. Activity assessment to include resident's interest, preferences and needed adaptations. c. Social History. d. Discharge Information, when applicable. 2. Activities will be designed with the intent to: a. Enhance the resident's sense of well-being, belonging, and usefulness. b. Create opportunities for each resident to have a meaningful life. c. Promote or enhance physical activity. d. Promote or enhance cognition. e. Promote or enhance emotional health. f. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence. g. Reflect resident's interests and age. h. Reflect cultural and religious interests of the residents. i. Reflect choices of the residents. 3. ADL-related activities, such as manicures/pedicures, hair styling, and makeovers, may be considered part of the activities program. 4. Activities may be conducted in different ways: a. One-to-One Programs. b. Person Appropriate - activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for. c. Program of Activities - to include a combination of large and small groups, one-to-one, and self-directed as the resident desires to attend .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #'s MI00146644 and MI00146449. Based on observation, interview and record review, the facility failed to ensure liquids were provided according to their prescribed therapeutic diet texture for one resident (R57) of four residents reviewed for nutrition. Findings include: On 9/9/24 at approximately 9:03 a.m., R57 was observed in their room, up in their wheelchair attempting to eat their breakfast. R57 was observed to be coughing while eating cereal and drinking their juice. Both the milk and juice appeared to be thin. A review of R57's meal ticket revealed they were supposed to have been provided nectar thick liquids for their meals. On 9/9/24 at approximately 9:07 a.m., Nurse C was informed that R57 was coughing while drinking their juice and eating their cereal. Nurse C was observed going into R57's room and assessing them and indicated that their liquids including the milk and the juice were not thickened and they indicated that R57 should have thickened liquids and was then observed pouring in thickener into the liquids. On 9/9/24 the medical record for R57 was reviewed and revealed the following: R57 was initially admitted to the facility on [DATE] and had diagnoses including Dysphagia, Mild-Protein-Calorie Nutrition and Parkinson's disease. A Physician's order dated 12/29/23 revealed the following: General diet 6-Soft and bite sized texture, Mildly thick/Nectar consistency, Plate guard for all meals A review of R57's care plan revealed the following: I have the potential for a nutritional/hydration problem r/t (related to) PMH (past medical history) of UTI (urinary tract infection), Parkinson's, hernia, restless leg syndrome, prostatic hyperplasia. For my advanced age and or cognition. For my mechanically altered diet & hx (history) of diff chewing/swallowing. Wt (weight) & appetite fluctuations may be anticipated r/t medical dx (diagnosis) and/or age maturation. I receive supplements for added nutritional support Interventions-My diet order is: Reg (regular), Soft/Bite size, Mild/Nectar Thick liquids (Bread products okay) . A nutritional assessment dated [DATE] revealed the following: Diet and Notifications-2. Type of Diet: Reg, Soft/Bite Sized, Mild/Nectar Thick .At Nutritional Risk due to: PMH: UTI, Parkinson's, hernia, restless leg syndrome, prostatic hyperplasia. Res (resident) receives a mechanically altered diet & thickened liquids .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview and record review the facility failed to provide the total amount of physician ordered enteral (tube) feeding, document consistently and accurately the amount of enteral feeding infused, and ensure timely follow up with the physician for one (R63) of one resident reviewed for enteral feeding. Findings include: R63 was a long-term resident of the facility. R63 was originally admitted to the facility on [DATE]. R63 was recently hospitalized and readmitted back to the facility on [DATE]. R63's diagnoses included stroke with hemiplegia (paralysis of one side), malnutrition, and dysphagia (difficulty swallowing). R63 received part of their nutrition via Percutaneous Endoscopic Gastrostomy (PEG Tube - A tube surgically placed directly on the stomach to receive nutrition and hydration). Based on the Minimum Data Set (MDS) assessment dated [DATE], R63 had a Brief Interview for Mental Status (BIMS) score of 00, indicative of severe cognitive impairment. R63 had a family member appointed as their legal representative. An initial observation was completed on 9/9/24 at approximately 10:50 AM. R63 was observed in their bed. R63 did not answer any questions. R63's tube feeding was not connected. The tube feeding stand had a full bottle of enteral feeding (that was not opened) hanging. The bottle had a date 9/6/24 (3 days prior to the observation) with R63's name and order details. During that observation, Registered Nurse (RN) E, who was the charge nurse for the shift reported that R63 refused tube feeding for the last few days. They added that R63 was able to eat, was on a soft diet, and that it was not very appetizing. RN E added that R63 required tube feeding because their food intake was not meeting their nutritional needs and it needed to be addressed. RN 'E' reported that behavior (refusing tube feeding) was new and R63 was waiting to be seen by the physician. They also added that R63 recently returned from the hospital and they were diagnosed with a pelvic mass. The surveyor asked R63 if they had pain in abdomen and R63 nodded their head. A follow up observation was completed on 9/9/24 at approximately 2:40 PM. R63 was observed in their bed. A lunch tray was on their bedside table. They ate part of their lunch (macaroni and cheese). When asked if they had enough to eat, R63 nodded their head and did not answer further questions. Review of R63's Electronic Medical Record (EMR) revealed that R63 was recently admitted to hospital on 8/24/24 due to difficulty swallowing and to rule out stroke or respiratory infection and readmitted back on 8/31/24. Review of R63's physicians orders included: Enteral feeding order - one time a day for nutrition. Jevity 1.5 @ 55ml (milliliter)/hr. (hour) x 18 hrs. =990 ml =1485 kcal (kilocalories); up at 5 PM until dose complete - order dated 9/3/24 (3 days after admission), an order for mechanical soft (bite sized) texture and thin liquids ordered on 9/2/24, and an order for NPO (nothing by mouth) upon readmission into the facility on [DATE]. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R63's Enteral feeding administration record revealed that R63 received their enteral feeding as ordered on 9/6/24, 9/7/24 and refused on 9/8/24, as indicated by RN 'D's electronic signature on all the above dates. Review of R63's progress revealed the NPO diet was discontinued on 9/2/24. Further review revealed a nursing summary dated 9/3/24 at 5:40 AM, that R63 had emesis (vomiting) on 9/3/24 and enteral feeding was stopped. However, a Registered Dietician (RD) note dated 9/3/24 at 11:21 (approximately 5 hours after the vomiting episode) read in part, Resident seen bedside and appears doing well. No signs/symptoms of distress. Noted adjustments from NPO to mech soft textures and thin liquids .monitor weight trend, appetite, tube feed and diet tolerance. RD to follow. The note did not address why enteral feeding was ordered 3 days after R63's admission or the concerns with vomiting on 9/3/24. Further review of progress notes revealed no documentation that indicated R63 did not receive their enteral feeding on 9/6/24, 9/7/24 and 9/8/24. R63's clinical record revealed no evidence that a medical provider was notified of R63's tube feeding refusals, that they did not receive their tube feeding on multiple days, or that they had an episode of vomiting. After the concern was brought to the facility's attention a late entry progress for 9/8/24 was completed on 9/9/24 at 11:05 AM that read, Resident refusing enteral feedings. She is refusing, yelling, crying, shaking her 'no', patting her belly indicating discomfort .on list to see physician at next clinic day. Report passed on to next shift. An interview was completed with R63's legal representative on 9/9/24 at approximately 10:55 AM. They were queried if they were notified of R63 refusing their enteral feeding for the last few days. The legal representative stated, Nobody called me and I come there every day. They added that R63 had been different since they returned from hospital and not sure what was happening. An interview was completed with Unit Manager (UM) F on 9/10/24 at approximately 9:50 AM. They were queried about their expectation/process on R63's refusal of tube feeding for the last few days as reported by RN 'E' and the enteral feeding bottle dated 9/6/24 that was found hanging on 9/9/24. UM F reported that staff should have taken down the tube feeding from 9/6/24. If R63 refused their tube feeding the nurse should have called and notified the physician and RD. When queried why R63's representative who visited the facility every day was not notified they reported that they should have been notified. When questioned further why the enteral administration for 9/6/24 and 9/7/24 were completed as administered when R63 refused their tube feeding, they reported that they were unaware of the erroneous documentation and they would follow up with their staff. UM F reported that they understood the concern. An interview was completed with RD G on 9/10/24 at approximately 1:00 PM and they were queried about the facility process and team communication expectation if a resident refused their tube feedings. RD G reported that they expect the staff to notify them if a resident refused enteral feeding so they could follow up and address the issue in a timely manner. They added that they were notified on Monday morning (after the concern was brought to the facility's attention on 9/9/24). An interview was completed with the Director of Nursing (DON) on 9/10/24 at approximately 2:10 PM. The DON was notified on the observations of enteral feeding that was dated 9/6/24 hanging on the tube feeding pole, R63's refusals, inaccurate documentation, failure to notify the legal representative, physician, and RD. The DON reported that they were notified of the concern by the unit manager on 9/9/24 and that should not have happened. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility provided document titled Care and Treatment of Feeding Tubes with the most recent revision date of 6/2023 read in part, Policy: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Policy Explanation and Compliance Guidelines: 1. Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush. 2. Only tubes designed or intended for enteral feeding will be utilized, except under extenuating circumstances and for the shortest time possible. 3. The facility will utilize the Registered Dietitian in estimating and calculating a resident's daily nutritional and hydration needs . 8. The residents plan of care will direct staff regarding proper positioning of the resident consistent with the resident's individual needs and preferences. 9. The facility will notify and involve the physician or designated practitioner of any complications, and in evaluating and managing care to address the complications and risk factors .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on interview and record review facility failed to consistently assess a resident after dialysis; and maintain accessible communication/collaboration between the dialysis center and the facility for one (R4) of one resident reviewed for dialysis. Findings include: Review of R4's clinical record revealed R4 was a long-term resident of the facility. R4 was admitted to the facility on [DATE]. R4's admitting diagnoses included end stage renal failure and aphasia (inability to speak/comprehend). Based on the Minimum Data Set (MDS) assessment dated [DATE], R4 had a Brief interview for Mental Assessment (BIMS) assessment score of 00/15, indicative of severe cognitive impairment. Review of R4's Electronic Medical Record (EMR) revealed a physician order dated 5/22/24 that read In-house dialysis 4 times/week. Further review of records revealed that R4 had been going out for dialysis on Monday, Tuesday, Thursday, and Friday. Further review of physician orders reveals an order dated 6/13/24 that read, monitor dialysis port site to left upper chest, document in PN (progress notes) and notify MD (Medical Doctor) of any abnormal findings: bleeding, redness, edema, pain, numbness/tingling every shift. Review of R4's nursing progress notes from 8/1/24 to 9/10/24 did not reveal consistent assessment/monitoring of the dialysis port site and post dialysis nursing assessment documentation. Further review of R4's records revealed dialysis communication forms from 2/23/24 to 3/1/24. R4's clinical record did not have any recent dialysis communication. Review of the dialysis binder located in the conference room revealed communication records for multiple residents filed in one book. There was no dialysis communication form for R4 for 9/2/24, 9/3/24, 9/5/24, 9/6/24 or 9/10/24. There were forms from August-2024 that were filed with other resident records. Floor nurses did not have access to this binder. An interview with Unit Manger (UM) F was completed on 9/10/24 at approximately 8:50 AM. During the interview they were queried about the dialysis communication and the facility's follow up after dialysis. They reported that the staff sent the communication forms with the residents and they reviewed the forms and filed them in a binder that was kept in the conference room. When queried further they added forms were kept in the cabinet behind the nursing station that day and they filed it in the book the next morning. When queried who was responsible to follow up with physician/practitioner, and how did the nurses have access to those records, they reported that dialysis staff were following up with practitioners/physician and they were new to the facility and still learning the facility process. Later the UM F reported they were unaware of the process and they should not have filed the forms in the binder and instead uploaded the forms in the EMR. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Dialysis Manager (DM) H on 9/10/24 at approximately 9 AM, they were queried about the dialysis communication process. They reported that staff members who transported the residents from the facility brought the forms. The forms were completed after dialysis and sent back to the facility after treatment. Two copies were made, one for their records and the other copy was filed in a binder in the conference room for the facility's nursing leadership access. The facility staff were expected to review the communication form and complete the follow up as needed. If there were any complications or unusual incidents they called the facility's nurse manager and notified them. When queried if they followed up with the facility's physician/practitioner, they reported that they followed up with the nephrologist, during their monthly clinic day. Routine communication was sent via communication form and facility staff were expected to follow up. An interview with the Director of Nursing (DON) was completed on 9/10/24 at approximately 2:15 PM. The DON was queried about the facility process for dialysis communication and their expectations for their staff. The DON reported that forms were sent with the residents and when they returned back the nurses were expected to complete assessment and follow up as needed. The forms were uploaded to the resident's EMR. When queried about R4 and their dialysis communication and evidence of follow-up they confirmed after they reviewed the EMR , the forms were not in the records. Review of a facility provided document titled Dialysis Special Needs Car plan with a revision date of 6/23 read in part, This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving dialysis. Policy Explanation and Compliance Guidelines: 1. Comprehensive care plans will be developed based on resident assessments, goals, and preferences in accordance with assessment and care plan procedures. 2. The care plan will reflect the coordination between the facility and the dialysis provider and will identify nursing home and dialysis responsibilities. 3. Nursing staff will provide a report to the dialysis provider regarding the resident's condition and treatment provisions each dialysis treatment day, and as needed. 4. If no written report is received upon return from dialysis, nursing staff will call the dialysis provider to receive a report. 5. Changes in condition following a dialysis treatment will be reported to the physician. 6. The care plan will be reviewed routinely and as needed for effectiveness and revised as needed.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47283 Based on interview and record review facility failed to provide sufficient staff to provide adequate care and services for residents on the weekends for three of seven residents who attended the Resident Council interview who wished to remain anonymous, resulting in extended call light response and resident dissatisfaction. This deficient practice had the ability to affect multiple residents that resided in the facility. Findings include: A confidential Resident Council interview was completed on 9/10/24 at 10:30 AM. During the interview one resident who wished to remain anonymous reported that they had to wait longer to get assistance after activating their call light on weekends. Two residents who wished to remain anonymous agreed when the concern was brought up and reported longer wait times during the afternoon and midnight shifts. One resident reported that their toilet broke over a weekend and they did not have anyone to fix it. They had a hard time getting assistance to assist them with their toileting as they did not have enough help. Two residents reported they have one person doing multiple jobs. Review of facility submitted staffing report from 4/1/24 to 6/30/24 revealed that facility had low weekend staffing. During an interview with Unit Manager (UM) F on 9/10/24, they reported that the facility had staffing challenges with call offs on afternoon/midnight shift and weekends. An interview with CNA I was completed on 9/11/24 at approximately 9:15 AM. They were queried about the facility staffing and how they were able to meet the needs of their residents. They reported they usually worked day shift and staffing on day shift was not a challenge. The challenges were more on midnight shifts and afternoon shifts. They reported that it was due to staff calling off. They were mandated to stay for four hours if there was a call off and they have done it a few times. During an interview with the facility Administrator on 9/10/24 at approximately 12:45 PM they were queried about the facility staffing. They reported they recently started at the facility and felt they had enough staff. They added the staffing challenges were due to staff call ins and they were trying to hold staff accountable based on their attendance policy. They added they were monitoring all the call ins and recently hired additional staff. They were notified of the concerns from group meeting and low weekend staffing that was reported by the facility. An interview was completed with Director of Nursing (DON) on 9/11/24 at approximately 11:30 AM. They were queried about the facility staffing and they reported that it was getting better. They added that had many new staff and challenges with staffing were due to staff call offs/attendance and they going to hold staff accountable and reported that was a work in progress. They were notified of the concerns and they reported that they understood the concerns.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clarkston	4800 Clintonville Rd Clarkston, MI 48346

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observations, interviews, and record reviews the facility failed to ensure non-pharmacological interventions were implemented, failed to ensure a Gradual Dose Reduction (GDR) was attempted (R30), failed to provide non-pharmacological interventions (R12) and failed to ensure as needed (PRN) psychotropic medications had a stop date (R4) for three of five residents reviewed for psychotropic medications. Findings include: R30 On 9/9/24 at 10:00 AM, R30 was observed sleeping in bed. Multiple verbal attempts were made to interview the resident, however unsuccessful. On 9/10/24 at 8:40 AM, R30 was observed alert in bed. R30 did not respond to any questions asked. A review of the medical record revealed R30 was admitted to the facility on [DATE], with diagnoses that included: Alzheimer's disease, major depressive disorder, anxiety disorder and psychotic disorder with delusions. A review of the physician orders revealed an order for Ativan 1 mg (milligram), Benadryl 25 mg and Haldol 1 mg Gel to be applied to the skin topically twice a day for agitation, anxiety, and psychosis. A review of the behavioral consultations from December 2023 through August 2024 noted the following in part . Patient has a history of resistance to care with episodes of agitation and anger . No recent behavioral changes reported by staff or noted per chart . generally non-verbal and rarely responds to question or interacts with staff or other residents. He is calm, alert, and resting in bed, though not answering questions or making eye contact. No agitation or aggression noted. No recent worsening depression/anxiety or other mood changes reported . Last GDR Consideration . 07/12/2024 . GDR Contraindicated Risk & Benefit statement: Target symptoms have not been sufficiently relived by non-pharmacological interventions. In my professional opinion, the continued use of the present medication regimen is in accordance with relevant current standards of practice. Any type of dose reduction at this time would likely further exacerbate behavioral symptoms and present a danger to the resident or others . Further review of the medical record revealed no previous GDR attempts of the Ativan, Benadryl and Haldol gel and no documentation of any behavioral incidents noted in the medical record for the last year, as indicated in the behavioral consultant consultations. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at 10:16 AM, Social Worker (SW) A (who served as the facility's liaison with the behavioral consultant team) was interviewed and asked what R30 behaviors were and SW A stated they believed it was agitation. When asked if they can provide the date of the last attempt of the Ativan/Benadryl and Haldol medication, SW A stated were recently hired at the facility a few months ago however would look into it and follow back up. At 2:06 PM, SW A returned and stated they received an email response from the facility's behavior consultant that documented in part . I know I have not recommended it or attempted recently. He has been on the same medication since before I was even coming to the facility and appears to have not done well with other medication options previously. I wouldn't necessarily advocate for a GDR, though would be open to attempting to lower the dose if necessary . SW A was then asked what other medication options were previously attempted with R30 and the date of the actual last GDR attempt on their current medication. SW A stated they went back to 2016 in the resident medical record and could not find any documented previous GDR attempts or other medication attempts for R30. SW A stated they were completing an audit of the residents in the facility receiving psychotropic medications and would review the records to ensure moving forward any required GDR's are completed for those that deem necessary. No further explanation or documentation was provided by the end of the survey. 38271 R12 On 9/11/24 The medical record for R12 was reviewed and revealed the following: R12 was initially admitted to the facility on [DATE] and had diagnoses including Schizoaffective disorder, Bipolar disorder and Anxiety disorder. A Physicians order dated 8/28/24 revealed the following: diazePAM Oral Tablet 2 MG (Diazepam) Give 1 mg by mouth every 8 hours as needed (PRN) for anxiety for 14 Days. A review of the EMAR progress notes (electronic medication administration record) for August and September 2024 revealed the following dates of R12's diazepam administration in which no documented non-pharmacological interventions were attempted prior to administration: 9/11, 9/10 (7:45 PM), 9/10 (10:19 AM), 9/9 (4:59 PM), 9/9 (9:36 AM), 9/8 (8:24 PM), 9/8 (6:12 PM), 9/8 (8:14 AM), 9/7 (12:13 PM), 9/6, 9/3, and 9/2/24. On 9/11/24 at approximately 1:10 p.m., during a follow-up conversation with the DON, the DON was queried regarding the lack of documentation of non-pharmacological interventions being attempted prior to administration of their PRN diazepam. The DON indicated that the Nursing staff should document what interventions they attempted in the progress notes prior to the administration of the diazepam. 47283 R4 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's clinical record revealed R4 was a long-term resident of the facility. R4 was admitted to the facility on [DATE]. R4's admitting diagnoses included major depressive disorder and anxiety disorder. Based on the Minimum Data Set (MDS) assessment dated [DATE], R4 had a Brief interview for Mental Assessment (BIMS) assessment score of 00/15, indicative of significant cognitive impairment. An initial observation of R4 was attempted on 9/9/24 at approximately 10:20 AM. A staff member reported that R4 was in dialysis and they usually returned between 11:30 - 12:00 PM. On 9/9/24 at approximately 11:35 AM, R4 was observed in the dialysis chair with their eyes closed. At 2:00 PM, R4 was observed awake in bed with unintelligible speech. Review of R4's clinical record revealed a physician order dated 8/28/24 for lorazepam (anti-anxiety medication) oral tablet 0.5 MG (Milligram) - give one tablet every 12 hours as needed (PRN) for agitation/anxiety. The order did not have an end date. Review of R4's Medication Administration Record (MAR) for (lorazepam 05.mg) September-24 revealed the following: R4 received one dose of the medication on 9/1, 9/4, 9/5, 9/6, /7, 9/8, 9/9, and 9/10; and 2 doses on 9/2. Review of MAR for August-24 revealed that R4 and received the PRN lorazepam on most of the days between 8/2/24 to 8/31/24 and received 2 doses on 4 days. Review of MAR also revealed a behavior monitoring section that read Behaviors - Monitor for the following: Restlessness (agitation), hitting, increase in complaints, biting, cussing, delusions, hallucinations, aggression, refusing care - Document 'Y' if monitored and none of the above observed 'N' . Review of documentation revealed N on multiple days i.e. indicating that R4 did not exhibit any target behaviors however received the PRN lorazepam medication with no clinical rationale. Review of nursing progress notes revealed no documentation of behaviors. There was no evidence of any resident specific non-pharmacological interventions that were implemented for R4's target behaviors. Review of R4's care plan revealed interventions that included: document non-pharmacological interventions attempted prior to administration of PRN anti-anxiety medications dated 2/28/24 and monitor/record occurrence of target behaviors (yelling out, inappropriate response to verbal communication, violence/aggression towards staff/others etc. and document per facility protocol dated 4/22/24. During an interview with Social Worker (SW) A on 9/10/24 at approximately 3:40 PM, they were queried about why R4 had a PRN lorazepam (re) ordered on 8/28/24 with no end date. They reviewed the clinical record and confirmed that the order did not have any end date. They reported that R4 had agitation and had history of behaviors. When queried about how the floor staff (Certified Nursing Assistant - CNAs) monitored the target behavior and where they had documented SW A reported that they documented on the tasks in the EMR. Review of R4's clinical record by the SW A did not reveal tasks for CNAs to monitor and document target behaviors. They reported that they were not sure why there was no task to alert CNAs to document and they were not sure why there was no end date for the PRN order. They reported that they would follow up with the unit manager. Later that day at approximately 4:30 PM, SW A reported that R4 was admitted with an order for lorazepam PRN and it was re-ordered by the practitioner for the attending physician and should have an end date. SW 'A' reported that staff must document target behaviors and attempt non-pharmacological interventions prior to administration of PRN medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DON was completed on 9/01/24 at approximately 4:45 PM. The DON was queried about R4's order for PRN lorazepam that was ordered with no end date, no target behavior monitoring by floor staff, no implementation of non-pharmacological interventions, and had received the PRN medication almost every day. They acknowledged that it was a concern.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 9/9/24 at 8:50 AM, there were 2 10-pound packages of raw ground beef thawing under running water in the 2 compartment sink. The ground beef logs were in a metal pan, with approximately 1/3 of the meat submerged in water, and the rest of the meat was sticking out of the pan. The temperature of the running water was measured to be 92 degrees Fahrenheit. On 9/9/24 at 9:15 AM, Dietary Manager B was queried about the temperature of the running water when thawing meat, and stated that the water should have been cold. According to the 2017 FDA Food Code section 3-501.13 Thawing, Except as specified in (D) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be thawed: 1. (A) Under refrigeration that maintains the FOOD temperature at 5 C (41 F) or less; or 2. (B) Completely submerged under running water: 1. (1) At a water temperature of 21 C (70 F) or below . On 9/9/24 at 8:55 AM, in the walk-in cooler, there was an undated container of chicken tenders. In addition, in the Traulsen reach-in cooler, there was an undated 3.5 quart container of sliced peaches. According to the 2017 FDA Food Code section 3-501.17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. On 9/9/24 at 9:00 AM, in the dry storage room, the flooring underneath the racks was observed with a buildup of debris (flour, chocolate chips, cups, packages of snacks). On 9/9/24 at 9:10 AM, the ice machine located in the nourishment room, was observed with stagnant, standing water in the drainage bin. In addition, the flooring underneath the ice machine was wet and there was a black mold-like substance on the flooring. There was an accumulation of trash on the floor underneath the ice machine. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #'s MI00146644 and MI00146449. Based on observation, interview and record review, the facility failed to ensure enhanced barrier precautions were applied for one residents (R12) of two residents reviewed for Pressure Ulcers . Findings include: On 9/9/24 a concern submitted to the State Agency for review indicated the facility staff were not following infection control procedures. On 9/9/24 at approximately 9:52 a.m., R12 was observed in their room, up in their wheelchair. R12 was queried about having any open pressure ulcers/wounds and they indicated they had multiple open wounds on their heel and leg. At that time, R12's room was observed with no signage that indicated staff should be utilizing enhanced barrier precautions (EBP) when providing care to R12. On 9/10/24 at approximately 1:52 p.m., Nurse C was observed in R12's room providing treatment to their wound without a gown on. On 9/10/24 at approximately 2:03 p.m., Nurse C was queried regarding PPE (personal protective equipment) they used while changing R12's wound dressing and they indicated they used gloves. Nurse C was queried if they used a gown and they indicated they did not. Nurse C was queried if R12 required EBP due to their chronic wound and they indicated they did not and that there was nothing on R12's door indicating they should have used EBP. On 9/10/24 the medical record for R12 was reviewed and revealed the following: R12 was initially admitted to the facility on [DATE] and had diagnoses including Bipolar and Schizoaffective disorder. A review of R12's MDS (minimum data set) with an ARD (assessment reference date) of 7/23/24 revealed R12 needed assistance from facility staff with most of their activities of daily living. R12's BIMS score (brief interview for mental status) was 12 indicating moderately impaired cognition. A wound evaluation completed on 9/5/24 revealed the following: Wound #5 Right, Lateral Ankle is a Stage 3 (Full-thickness skin loss) Pressure Injury that was Not Healed. Further review of the medical record did not reveal any Physician orders for EBP. On 9/10/24 at approximately 2:30 p.m., during an interview with the infection control Nurse (ICN F) and the Director of Nursing (DON), ICN F was queried if staff should have been using enhanced barrier precautions including the donning of a gown when providing direct care and they indicated they should have been. ICN F was queried about why R12 did not have signage on their door indicating staff were to use EBP during care and they reported they would have to put up a sign so staff would be aware and place a PPE bin in their room.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 48680 Based on interview and record review the facility failed to operationalize an antibiotic stewardship program which consistently ensured appropriate clinical indication for use of antibiotic medications for three (R4,R8 and R63) of five residents reviewed for antibiotic stewardship program, resulting in the potential for increased antibiotic resistance. Findings include: On 9/11/24 at 10:30 AM an overview of the facility's infection control program was discussed with the Director of Nursing (DON) and the facility's Unit Manager(UM). And asked what was their process. The UM stated she makes sure the infection meets Mcgeers (a system that identifies if signs and symptoms meet the criteria of an infection and qualifies for an antibiotic) then placed the infection in the book. If it does not meet criteria, they would reach out to the provider and let them know that the criteria is not met (to discontinue the medication) and then do a line listing and mapping. The UM was then asked if these conversations were documented somewhere and if the provider declined to discontinue the medication were they to write a progress note stating the rationale for the continued antibiotic use. The UM stated, Yes, the provider is supposed to create a progress note that stated the benefits verse risk for prescribing an antibiotic that has no clinical indication for use and does not meet McGeers criteria. A review of the line listing with the UM revealed that R4, R8 and R63 did not meet McGeers The UM was asked to provide supporting documentation for three residents R4, R8 and R 63 as to why they were still on an antibiotic despite not meeting criteria (including labs, and symptoms). The UM was not able to locate any physician notes as to why they would continue the medications with no clinical indications. There was no additional information provided at the end of survey.