STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235483	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Galesburg (the)	1080 N 35th Street Galesburg, MI 49053

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review the facility failed provide a dignified environment and ensure that staff treated residents with dignity and respect in 4 (Resident #105, #104, #106, and #108) of 7 residents reviewed for dignity, resulting in feelings of frustration and the potential for depression, loss of self-worth, and an overall deterioration of psychological well-being. Findings include: Resident #105 Review of an Admission Record revealed Resident #105 was originally admitted to the facility on [DATE] with pertinent diagnoses which included difficulty in walking. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 11/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident #105 was moderately cognitively impaired. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Incident Report dated 1/1/25 revealed, Incident Summary: Resident #105 alleged that (Certified Nursing Assistant (CNA) Q) verbally mistreated her when he attempted to ask for her smoking materials to properly store them . Investigation Summary: On the evening of 1/1/25, (Nursing Home Administrator (NHA) A) received a phone call from (Director of Nursing (DON) B) who expressed concern about (CNA Q) interaction with (Resident #105). (NHA A) spoke with (Resident #105), who alleged that (CNA Q) had been aggressive toward her . (CNA Q) was placed on suspension. Investigation: On 1/1/25, shortly after 5:00 PM, (NHA A)and (DON B) spoke with (Resident #105) via telephone, (Resident #105) described (CNA Q) as a F*cker and mentioned that she had liked him until the previous week. She expressed frustration, stating that he was the only staff member who continually asked her for her smoking materials . She characterized (CNA Q) repeated requests as harassment and felt that he had been aggressive with her . On 1/1/25, (NHA A) and (DON B)spoke with (CNA Q), he reported that he approached (Resident #105) to collect her smoking materials, she refused to hand them over, stating that other staff members had not required her to do so . (CNA Q) denied raising his voice or exhibiting aggressive behavior towards (Resident #105) .(CNA Q) also stated that his coworker (CNA O) approached him aggressively and began to interject herself in the situation and, in his opinion, (CNA O) was aggressive with him and raised her voice to him .On 1/1/24 (CNA O) was interviewed by (NHA A) and (DON B) via telephone. She stated that she observed (CNA Q) walking down the hall repeatedly telling (Resident #105) that she needed to turn in her smoking materials. (CNA O) reported that she followed (CNA Q) into (Resident #105's) room and that she interjected in an attempt to calm (CNA Q) down. (CNA O) stated that (CNA Q) left the room and a third CNA (CNA N) came into the room and was able to convince (Resident #105) to turn in her smoking materials. (Resident #105) continued to speak to (CNA O) and (CNAN) and she referred to (CNA Q) as a d*ckhead, and (CNA Q) was passing the door. (CNA Q) re-entered the room and began repeating the rules surrounding the safe storage of smoking materials. (CNA O) and (CNA Q) discussed who was assigned to (Resident #105) and (CNA O) stated that (CNA Q) was raising his voice and waving his hands while talking and she was asking him to get his hands out of her face During an interview on 3/4/25 at 2:12 PM, CNA Q reported that the facility had incidents with residents not turning in their smoking materials, and he was trying to ensure that residents turned them in so he had been keeping an eye on Resident #105. CNA Q reported that he just kept asking Resident #105 to turn in her smoking materials and following her to her room. CNA Q reported that CNA O and CNA N came into Resident #105's room when he was in Resident #105's room still attempting to get her smoking materials from her. CNA Q reported that he felt like he did nothing wrong, and that CNA O and CNA N escalated the situation. CNA Q confirmed that he did get into a verbal argument in Resident #105's room with CNA O. During an interview on 3/4/25 at 1:56 PM, Resident #105 reported that on 1/1/25 she was met at the facility entrance by CNA Q when she was coming in from smoking. Resident #105 reported that CNA Q immediately began asking her to give him her smoking materials and she told him to give her a minute. Resident #105 reported that CNA Q just kept asking her over and over and it started to upset her and she felt like she was being targeted. Resident #105 reported that she tried to get away from CNA Q because he was making her mad but CNA Q continued to follow her to her room and saying the same thing over and over. Resident #105 reported that she felt like CNA Q was getting more and more aggressive with her, and she just wanted him to leave her alone. Resident #105 confirmed that CNA O and CNA N came into her room to calm CNA Q down, and she gave CNA N her smoking materials. Resident #105 confirmed that once CNA Q left, she called him a name to CNA O and CNA N which caused him to return to her room where he continued to say the smoking policy over and over. Resident #105 reported that she felt like CNA Q was harassing her. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/5/25 at 12:44 PM, CNA O reported that she had witnessed CNA Q approach Resident #105 as soon as she entered the facility and saying to her give me your lighter, give me your lighter, it is the rules, it is the rules. CNA O reported that CNA Q was escalating and getting louder as he followed Resident #105 who was trying to get away from him. CNA O reported that she began to follow Resident #105 and CNA Q because she felt like she needed to interject herself and de-escalate CNA Q. CNA O confirmed that Resident #105 gave her smoking supplies to CNA N right away who also came into Resident #105's room to try to de-escalate CNA Q. CNA O reported that CNA Q continued to go over the policy to Resident #105 after she gave her supplies to CNA N and that is when she asked CNA Q to stop and leave Resident #105's room. CNA O reported that CNA Q left Resident #105's room, but returned as soon as he heard Resident #105 call him a name. CNA O reported that CNA Q then began to confront Resident #105 and he seemed so eager to be aggressive to her. CNA O reported that when she asked CNA Q to stop, he began yelling at her and he was putting his hands up in my face. CNA O confirmed that CNA Q was screaming at her in front of Resident #105 in her room. CNA O reported that Resident #105 was really shook up by the whole incident, and wanted to leave the facility after it happened. CNA O reported that she felt the whole incident was caused by CNA Q 's behavior, and she felt that it was uncalled for. CNA O reported that the way that CNA Q treated Resident #105 was not professional, and he should have left Resident #105 alone, and asked for someone else to come get her smoking supplies. CNA O reported that CNA Q was always mean to other staff, and she was scared of him and hated working with him because his behavior was unpredictable. During an interview on 3/6/25 at 2:01 PM, CNA N reported that she had gone to help CNA O help de-escalate CNA Q in Resident #105's room. CNA N confirmed that she was able to retrieve Resident #105's smoking supplies quickly by just talking to Resident #105 calmly and telling her we had to follow the facility rules. CNA N reported that she felt like CNA Q was aggressive with Resident #105, and was continuing to escalate the situation Resident #104 Review of Admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included alzheimers disease. Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 12/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #104 was severely cognitively impaired. Review of an Incident Report dated 2/14/25 revealed, On 2/14/25, Nursing Home Administrator (NHA) A received a phone call from Activity Director (AD) S. AD S reported that (Certified Nursing Assistant (CNA) Q) was observed swearing and slamming a resident room door. Investigation: On 2/14/25 shortly after 7:30 PM, (NHA A) spoke with (AD S). (AD S) reported that she was on the skilled hallway when and had just exited Resident #104's room and was walking towards the nursing station. (AD S) spoke to (CNA Q) to inform him that Resident #104 had an episode of emesis (vomit). (CNA Q) went into Resident #104's room to check on Resident #104 and then together they exited the room. (ADS) attempted to speak to (CNA Q), but he quickly walked away and didn't acknowledge her. (AD S) next observed (CNA Q) walking into Resident #104's room, turning on the light, and saying What the F*ck and then shut the door . Investigation Findings: The findings from the investigation suggest that the facility verified the incident occurred, however is unable to substantiate the allegations of abuse. Resident #104 was in bed at the time of the incident that occurred in her doorway, and the possibility of her having heard (CNA Q) cannot be confirmed due to her advanced dementia . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an Interview on 3/4/25 at 4:00 PM, AD S reported that on 2/14/25, she had answered a call light on the hall that CNA Q was working on. AD S reported that she went to let CNA Q know that Resident #104 needed assistance. AD S reported that CNA Q kept walking past her and ignored her. AD S reported that she followed him because he seemed very upset and she had concerns with how he was acting. AD S then saw CNA Q turn into Resident #104's room and yelled loudly Are you F*cking kidding me and he slammed the door shut. AD S reported that she did not feel safe going into Resident #104's room because of how CNA Q was acting, so she went to Unit Manager U immediately who went to check on Resident #104, and told her to report the incident to NHA A immediately. AD S reported that CNA Q always seemed upset and overwhelmed, but this was the first time she had witnessed him act that way in front of a resident. During an interview on 3/5/25 at 11:56 AM, CNA P reported that she worked with CNA Q frequently and that his attitude was horrible. CNA P reported that she felt like CNA Q was constantly complaining to staff and residents. CNA P reported that she felt like CNA Q was a loose cannon and not equipped to work in healthcare because he did not seem like he was able to regulate his emotions. During an interview on 3/5/25 at 12:11 PM, Licensed Practical Nurse (LPN) K reported that she had worked with CNA Q frequently and she did not like when he was at the facility. LPN K reported that CNA Q was abrasive with unpredictable mood swings, and constantly upset. LPN K reported that she had asked that CNA Q not be placed on the memory care unit, because she was fearful of him caring for residents that were unable to voice concerns about him. During an interview on 3/5/25 at 1:16 PM, Unit Manager (UM) U reported that she was at the facility on 2/14/25 when CNA Q swore in front of Resident #104. UM U reported that when she was informed of CNA Q swearing and slamming a door she immediately went to check on Resident #104, CNA Q was already out of her room. UM U reported that shortly after the incident NHA A contacted CNA Q and told him he was immediately suspended and asked him to leave the facility. UM U reported that CNA Q was disrespectful to staff and would often go off tangents. UM U reported that she was scared of CNA Q because of how unpredictable his mood was. UM U confirmed that CNA Q had previously been suspended due to a separate incident with another resident in the facility. During an interview on 3/5/25 at 2:55 PM: Director of Nursing (DON) B reported that she was at home on 2/14/25, but she was on a group call with NHA A when he called CNA Q to place him on suspension pending an investigation into his actions. DON B reported that CNA Q screamed at NHA A and said so many explicit things that they could not keep track of everything he said. DON B reported that it was like he had been planning to say all of this for some time. DON B reported that she and NHA A both called 911 as they were worried about staff and resident safety after they spoke to CNA Q and wanted to make sure he left the building. DON B reported that she had not seen CNA Q act that way before. DON B confirmed that CNA Q had previously been suspended due to a different investigation with another resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/4/25 at 2:12 PM, CNA Q reported that he was frequently upset and overwhelmed when working at the facility. CNA Q reported on 2/14/25 he got upset when he went into Resident #104's room because he found her lying in bed in her own feces wearing the same clothes that she had on the day before. CNA Q reported that he was pissed off because it was clear that staff had not been in to take care of Resident #104 all day, and he lost his cool and he did swear out. CNA Q reported that he was sure that someone had overheard him swearing, because he did say it loudly. CNA Q could not recall if he had slammed a door. CNA Q confirmed that he did swear in front of Resident #104, but he was not swearing at her. CNA Q confirmed that he should have not sworn in front of Resident #104, and that it was inappropriate to use foul language in front of a resident. During an interview on 3/4/25 at 12:31 PM, NHA A reported that he had been notified on 2/14/25 that CNA Q had sworn in front of Resident #104. NHA A reported that as soon as he was contacted about the incident, he called CNA Q and told him that he was being placed on suspension pending an investigation. NHA A reported that CNA Q began screaming all kinds of obscenities at him and ended the call so he was not able to interview him further. NHA A confirmed that he did call 911 to ensure resident and staff safety, and to make sure that CNA Q left the building. NHA A reported that CNA Q resigned that night. Using the reasonable person concept, though Resident #104 had decreased ability to verbally express their own thoughts due to medical diagnoses, any reasonable person would likely feel a decreased sense of self-worth and frustration in that situation. Resident #106 Review of an Admission Record revealed Resident #106 was originally admitted to the facility on [DATE] with pertinent diagnoses which included major depressive disorder. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 2/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #106 was cognitively intact. During an interview on 3/4/25 at 10:27 AM, Resident #106 reported that he had concerns with how staff at the facility treated him. Resident #106 reported that staff often made him feel like he was inconvenience when he would ask for assistance and it made him not want to ask for help. Resident #106 reported that several of the CNA'S had cold attitudes and they just were not nice. Resident #106 reported that he felt like the facility had a very low level of treatment towards the residents, and it did not feel like a healing environment. Resident #108 Review of an Admission Record revealed Resident #108 was originally admitted to the facility on [DATE] with pertinent diagnoses which included essential hypertension (high blood pressure). Review of a Minimum Data Set (MDS) assessment for Resident #108, with a reference date of 2/10/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #108 was cognitively intact. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/4/25 at 2:55 PM, Resident #108 reported that he had ongoing concerns with the way that staff treated him. Resident #108 reported that several of the CNA's would answer his call light and say things like what do you want in a rude tone. Resident #108 reported that he felt like several of the CNA's were rude and abrasive, and they just seemed like they did not want to be there. Resident #108 reported that it was hard to be cared for by staff that acted negative, and their behavior made him hate to ask for assistance when he needed it. During an interview on 3/4/25 at 4:00 PM, AD S reported that she had concerns with how some of the CNA's treated residents. AD S reported that she had residents complain to her about the CNA's being rude and hard to approach. AD S reported that several residents had concerns about CNA M. AD S reported that she had also witnessed CNA M caring for residents, and reported that her body language and the way she interacted did come off as rude in her opinion. AD S reported that she had voiced her concerns about the way that staff were treating residents to DON B and NHA A. During an interview on 3/5/25 at 10:44 AM, Registered Nurse (RN) G reported that he did have concerns with how some of the staff treated the residents. RN G reported that he felt like residents that were not able to speak up for themselves did not get as good of care from several of the CNA's at the facility. RN G reported that he had witnessed several of CNA's respond poorly to residents, answer call lights with rude tones, and just overall had poor attitudes. RN G reported that there were too many CNA's to name, and that it seemed like a facility wide problem. During an interview on 3/5/25 at 12:11 PM, LPN K reported that she had ongoing concerns with how staff interacted with residents. LPN K reported that she felt that some of the CNA's interacted inappropriately to residents, and did not provide the best care. LPN K reported that some CNA's would frequently leave the unit and not notify her which often delayed resident care needs. LPN K reported that she felt like she had to constantly check that CNA's were providing care to residents that were unable to communicate, and they often would not provide care unless she stayed on them about it. LPN K reported that she did think that several of the CNA's were rude and abrasive, and she noted CNA M as a staff member that she had the most concerns with. LPN K also noted that she had to talk to CNA V and U before about the way the talked to residents, because they would say things in a rude manner, like go to your room instead of offering some options for a confused resident. LPN K reported that she had brought her concerns about the way that staff were interacting with residents to DON B. During an interview on 3/5/25 at 2:18 PM, Social Worker (SW) W reported that she had not been made aware of concerns with how staff were treating residents from residents, but she had been made aware of concerns from other staff. SW W reported that she had been made aware that staff had concerns about some staff not taking as much time as they should with residents, and not taking time to make sure their needs are addressed. During an interview on 3/5/25 at 2:55 PM, DON B reported that the only recent dignity concerns in the facility that she was aware of were residents being upset about staff not knocking on door before entering, and staff using their phones on the floor. When this writer queried about resident concerns related to how staff were interacting with them, DON B asked What time frame? DON B then reported that she had not been aware of concerns that residents had related to how staff were interacting with residents. When this writer queried about CNA M and if staff or residents had brought up concerns related to her, DON B confirmed that CNA M had been written up for being on her phone and not knocking before entering resident rooms, but she did not know about any staff having concerns with her care towards residents. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/5/25 at 4:15 PM, NHA A reported that he was aware of resident and staff concerns related to CNA M and how she was interacting with residents. NHA A confirmed that CNA M had been wrote up previously for dignity concerns. NHA A reported that he was unaware of other staff and resident concerns related to how staff were interacting with residents. Review of the facility's Dignity policy last revised 3/28/24 revealed, Policy: The facility provides care for residents in a manner that respects and enhances each resident's dignity, individuality, and right to personal privacy. Information: Each resident's right to personal privacy includes the confidentiality of his or her personal and clinical affairs. Dignity means that when interacting with residents, staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 This citation pertains to intake #MI00149391 Based on interview and record review the facility failed to ensure an incident of neglect (resident received wrong medication) was reported to the State Agency in 1 (Resident #100) of 1 resident reviewed for reporting, resulting in Resident #100 being transferred to an acute care hospital emergency room for treatment and admission to a medical intensive care unit after receiving the wrong medication. Findings include: Review of an Admission Record revealed Resident #100 had pertinent diagnoses which included: Cerebral infarction (Stroke), dysphagia (difficulty swallowing), acute respiratory failure with hypoxia (significantly difficult breathing, hypoxia- decreased oxygen in the body's blood) and pneumonitis. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 1/5/2025 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 which indicated Resident #100 was severely cognitively impaired. Review of Nurses Note for Resident #100 dated 1/5/25 at 8:18 PM authored by Licensed Practical Nurse (LPN) O revealed This nurse observed resident to be very drowsy with sound of increased secretions at hs (evening) med pass. VS (vital signs) obtained and were 96.9-(temperature)83-(pulse)14-(respirations)85/56-(blood pressure)92% RA (Pulse ox on room air) at this time . Provider gave orders to send resident for eval/tx of respiratory distress and unresponsiveness. On-call guardian gave okay to send to ER (emergency room) . EMS (emergency medical services) was called for transfer, paperwork prepared for EMS/hospital and monitored resident until EMS arrived. (Name Omitted) EMS transferred resident via stretcher out of facility to (Name Omitted) at 4:25 AM. Review of Compliance Summary provided by the facility revealed Details : Summary- (Name Omitted) ED physician stated on January 5, 2025, around 4:45 AM, (Resident #100) patient, had arrived at the emergency room for being unresponsive and having difficulty breathing. (Name Omitted) ED physician stated she had provided (Resident #100) with Narcan as if she had an opioid or narcotic overdose. (Name Omitted) ED physician stated after (Resident #100) was provided Narcan she made a full recovery. (Resident #100) received a drug test and tested positive for opioids. (Name Omitted) ED physician stated (Resident #100)'s medication chart does not say she was prescribed any opioid or narcotic medication. Review of Care Timeline for Resident #100 revealed 1/5/2025 admitted to (Name Omitted) medical intensive care unit from ED (emergency department) 0917 (9:17 AM). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Drug Screen 8 for Resident #100 dated 1/5/25 and 1/6/25, revealed urine collection at 5:21 am on 1/5/25 with results indicating opiate screen positive, detects morphine at concentration of 300 ng/mL (nanograms per milliliter) and higher. Urine collection at 7:41 am on 1/5/25 with results indicating opiate screen positive, detects morphine at concentration of 300ng/mL and higher. Urine collection at 13:26 (1:26 pm) on 1/6/25 with results indicating opiate screen positive, detects morphine at concentrations of 300mg/mL and higher. Review of the National Library of Medicine, Does naloxone cause a positive urine opiate screen? revealed, Although the metabolites of naloxone hydrochloride are similar in structure to oxymorphone and are excreted in human urine for several days, naloxone was not associated with a positive enzymatic urine screen for opiates. https://pubmed.ncbi.nlm.nih.gov/7978599/ Review of Drug screen 8 for Resident #100 performed by additional non-local lab (Name Omitted) provided to the facility on [DATE] via fax revealed urine collection occurred on 1/5/2025 at 7:41 am. Opiate confirm urine, opiate interpretation positive, morphine count, 11,487 (normal range cutoff 25). Review of the facility Physician Orders for Resident #100 reveal no order for an opioid narcotic, including morphine. Review of Case Management Notes for Resident #100 dated 1/5/25 at 9:20 AM reveals .spoke to admissions Coordinator (AC) C, she confirmed the facility self-reported to the state . In an interview on 1/28/25 at 10:45 AM., Nursing Home Administrator NHA A reported they did not notify the state of the incident with Resident #100. NHA A reported they had determined that narcotics were not missing, and the hospital was going to notify the state. NHA A reported he did not need to report to the state, as it was determined there was no deficient practice. In an interview on 1/28/25 at 12:19 PM., Director of Nursing (DON) B reported the facility did not report to the state the incident. DON B reported she was not able to determine any deficient practice with her investigation and stated, what would I report? No report was made to the state agency involving Resident #100 and her diagnosis of drug overdose, positive urine drug screen, and subsequent hospitalization on [DATE].

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Galesburg (the)	1080 N 35th Street Galesburg, MI 49053

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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** 47659 Based on observation, interview, and record review, the facility failed to ensure residents received care in accordance with professional standards in 2 (Resident #101 and #103) of 3 residents reviewed for quality of care, resulting in 1.) Resident #101 receiving an enteral feeding (method of providing nutrition directly into the gastrointestinal tract through a tube) that did not reflect physician orders for 7 days 2.) not being re-weighed timely after a significant weight change 3.) A delayed assessment and treatment for Resident #103's complaints of pain. Findings include: 1.) Resident #101 Review of Admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia. Review of Resident #101's Orders revealed, Enteral feed (tube feed) order. Isosource (enteral feeding formula) 1.5. 50cc/hr (rate to run the feed) continuous feeding through G-tube every shift for nutrition. Start date: 2/24/25. Review of Resident #101's Care Plan revealed, (Resident #101) is unable to tolerate nutritionally adequate food and/or fluids by mouth requiring the use of a feeding tube R/T (related to): Dysphagia (difficulty swallowing) with G-Tube (tube inserted into the stomach to provide nutrition and fluids to those who cannot eat or drink on their own). Date Initiated: 04/11/2023. Interventions: Obtain weight at a minimum of monthly. Report significant weight changes of 5% x 1 month, 7.5% x 3 months or 10% x 6 months to the physician and dietitian. Date Initiated: 4/11/2023 .(Resident #101) is dependent with tube feeding and water flushes. See MD (Medical Doctor) orders for TF (Tube Feed) regimen. Date Initiated: 04/11/2023 . During an observation on 3/3/25 at 11:02 AM, Resident #101 was lying in her bed resting. It was noted that her tube feed was not running, and the machine was turned off. During an interview on 3/3/25 at 11:05 AM, Licensed Practical Nurse (LPN) L reported that Resident #101's tube feed was stopped between 10:00 AM and 2:00 PM every day, and that was why Resident #101's tube feed was not running. During an interview on 3/3/25 at 11:20 AM, LPN H reported that if a resident was ordered to have tube feed stopped for a time period of the day, the time period would be noted in the order. LPN H reviewed Resident #101's order with this writer and confirmed that Resident #101's tube feed order was continuous, and therefore the feeding should not be stopped for any time period during the day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/3/25 at 11:31 AM, Unit Manager (UM) U reviewed Resident #101's tube feed orders with this writer and confirmed that Resident #101's order was noted for the tube feed to run continuously. UM U confirmed that the order did not note a time frame for nursing staff to stop the tube feed. UM U reported that Resident #101's previous orders did indicate that the tube feed should be stopped from 10:00 AM- 2:00 PM daily, but since Resident #101 had returned from the hospital on 2/24/25, the order had been changed. UM U reported that when a resident is readmitted to a facility, the nurse that readmits the resident is responsible for reviewing the hospital discharge orders with the physician and entering the orders as the physician requested. UM U reported that it was her expectation that nurses were to follow the physician orders as indicated in the record. Review of Resident #101's Hospital After Visit Summary dated 2/24/25 revealed, Discharge orders: . Isosource 1.5 Continuous feed 50 ml/hr per G tube route continuous 50 ml.hr . During an interview on 3/5/25 at 2:36 PM, Registered Nurse (RN) F reported that she was the nurse that readmitted Resident #101 to the facility on [DATE]. RN F confirmed that she reviewed the hospital visit summary with Physician Assistant (PA) C, and that PA C did want Resident #101's order to be continuous, which was what the hospital discharge orders indicated. During an interview on 3/5/25 at 2:47 PM, PA C reported that she did review Resident #101's hospital discharge orders with RN F. PA C confirmed that she did want Resident #101's tube feed order changed to continuous, as the hospital discharge orders indicated. PA C reported that she would expect that nursing staff were contacting her for approval if they were going to stop the tube feed for 4 hours at a time. During an interview on 3/5/25 at 9:06 AM, LPN L reported that she had been the nurse caring for Resident #101 on 2/25/25, 2/26/25, 3/1/25, 3/2/25, and 3/3/25. LPN L confirmed that she did not know that Resident #101's tube feed order had changed, and that she had not followed the order as written, and had removed Resident #101 from the tube feed from 10:00 AM-2:00 PM on the above mentioned dates that she had cared for Resident #101. During an interview on 3/5/25 at 10:44 AM, RN G reported that he had been the nurse caring for Resident #101 on 2/27/25 and 2/28/25. RN G reported that he was not aware that Resident #101's tube feed order had been changed to continuous, and that he had removed Resident #101 on 2/27/25 and 2/28/25 from her tube feed between 10:00 AM to 2:00 PM. During an interview on 3/4/25 at 3:36 PM, Registered Dietician (RD) D reported that she was responsible for completing nutrition assessments for residents when they were readmitted to the facility. RD D reported that she was not aware that Resident #101 had been sent to the hospital, so she had missed completing a readmission assessment on Resident #101 until 3/3/25. RD D reported that a continuous tube feed order runs at a lower rate than orders that are not continuous. RD D confirmed that Resident #101's tube feed had been running at a lower rate as it was supposed to be continuous, and therefore, had the potential for Resident #101 to not meet caloric and nutritional needs. (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 facility's Enteral Nutrition policy dated 9/22/23 revealed, Policy: Residents maintain acceptable parameters of nutritional status, such as body weight and protein levels; unless the resident's clinical condition demonstrates that this is not possible. Each resident is provided with sufficient fluid intake to maintain proper hydration and health. Resident's who are unable to feed themselves receive the necessary services to maintain good nutrition, including at times, enteral nutrition . Guideline: 3. Based on review of comprehensive evaluations conducted by the interdisciplinary team members (nursing, nutritional services, therapy services, physician, social services and the guest's/resident's family or medical decision maker), a determination for the need to provide enteral nutrition is made . 2.) Resident #101 Review of an Admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia. Review of Resident #101's Care Plan revealed, (Resident #101) is unable to tolerate nutritionally adequate food and/or fluids by mouth requiring the use of a feeding tube R/T (related to): Dysphagia (difficulty swallowing) with G-Tube (tube inserted into the stomach to provide nutrition and fluids to those who cannot eat or drink on their own). Date Initiated: 04/11/2023. Interventions: Obtain weight at a minimum of monthly. Report significant weight changes of 5% x 1 month, 7.5% x 3 months or 10% x 6 months to the physician and dietitian. Date Initiated: 4/11/2023 .(Resident #101) is dependent with tube feeding and water flushes. See MD (Medical Doctor) orders for TF (Tube Feed) regimen. Date Initiated: 04/11/2023 . Review of Resident #101's Weights indicated that on 1/17/25, Resident #101's weight was documented at 153.4 pounds. On 2/7/25, Resident #101's weight was documented at 166.4 pounds, which was a 13 pound weight increase in 22 days. It was noted that this was an 8.64 % weight change in less than one month. Resident #101's next weight was obtained on 3/4/25 and was documented to be 143.0 pounds. During an interview on 3/5/25 at 1:16 PM, UM U reported that the facility's dietician and Interdisciplinary team was responsible for monitoring resident's weight trends. UM U confirmed that she was not aware of Resident #101's weight change noted on 2/7/25. UM U reported that staff should have identified the significant weight change noted on 2/7/25 and reported this to the IDT team and the Registered Dietician. During an interview on 3/5/25 at 2:55 PM, Director of Nursing (DON) B reported that facility staff were supposed to follow to facility policy and obtain a re-weight measurement if a potential significant weight change was noted. DON B reported that nurses were not responsible for monitoring weights, and that the facility's dietician monitored resident weight trends and ordered re-weights when needed. DON B reported that the facility's Registered Dietician was aware of Resident #101's weight increase noted on 2/7/25. During an interview on 3/4/25 at 3:36 PM, Registered Dietician (RD) D reported that she was unaware that Resident #101 had a significant weight change noted on 2/7/25. RD D confirmed that she had not requested a re-weight to confirm that the weight noted on 2/7/25 was accurate. RD D confirmed that the facility had missed identifying this significant weight change. (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 facility's Weight Management policy dated 9/22/23 revealed, Policy: Residents will be monitored for significant weight changes on a regular basis .Practice Guidelines: 3. Re-weights are initiated for a five-pound variance if the resident is > than 100 lbs and for a three-pound variance if < than 100 lbs. If a resident's weight is > than 200 lbs. a re-weight will be done for a weight loss or gain of 3% or consult with the Dietary Manager or RD/designee. Re-weights will be done within 48-72 hours . 3. Resident #103 Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included fracture of one rib and fracture of first lumbar vertebra (area at the top of the spine). Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 2/24/25 revealed Section B Hearing, Speech, and Vision noted that Resident #103's speech clarity as noted as unclear, and that Resident #103 was usually able to make self understood and understood verbal content and had a clear comprehension. Review of Resident #103's Care Plan revealed, (Resident #103) is at risk for pain and/or has chronic pain . Date Initiated: 07/11/2023. Interventions: Observe and report any s/sx (signs and symptoms) of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out,silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy,constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking,curled up, thrashing). Report abnormal findings to the physician. Date Initiated: 12/06/2022 . During an observation on 3/5/25 at 11:34 AM, Resident #103 was lying in bed on his side. When this writer entered Resident #103's room and asked how Resident #103 was doing, he shook his head no. When this writer asked what was wrong, Resident #103 began pointing to his ribs. When this writer asked Resident #103 if he was in pain, Resident #103 shook his head yes and continued to point to his ribs. Resident #103 had tears in his eyes, and looked very restless. During an interview on 3/5/25 at 11:40 AM, this writer informed LPN L that Resident #103 was in pain and pointing towards his ribs. LPN L reported that Resident #103 had recently fractured his ribs, and that he did experience frequent pain, and he had pain medication for his rib pain. LPN L reported that she would go assess Resident #103 and offer him pain medication. During an interview on 3/5/25 at 1:15 PM, this writer queried about Resident #103, and how he was feeling. LPN L reported that she had never assessed Resident #103, and that Resident #103 had not received any pain medication yet. During an interview on 3/5/25 at 4:15 PM, Nursing Home Administrator (NHA) A reported that he expected nurses to prioritize a resident's complaint of pain, and to assess them and treat as soon as possible. NHA A confirmed that he did not think that Resident #103 should have had to wait from 11:40 AM to 1:15 PM to be assessed for pain.

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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** 47955 This citation pertains to intake #MI00149391 Based on interview and record review the facility failed to ensure that residents were free from significant medication errors in 1 (Resident #100) of 2 residents reviewed for medication errors resulting in Resident #100 being transferred to an acute care hospital emergency room for treatment and admission to a medical intensive care unit. Findings include: Resident #100 Review of an Admission Record revealed Resident #100 had pertinent diagnoses which included: Cerebral infarction (Stroke), dysphagia (difficulty swallowing), acute respiratory failure with hypoxia (significantly difficult breathing, hypoxia- decreased oxygen in the body's blood) and pneumonitis due to inhalation of food and vomit (infection in the lungs related to inhaling food or vomit). Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 1/5/2025 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 which indicated Resident #100 was severely cognitively impaired. Resident #102 - roommate of Resident #100 Review of an Admission Record revealed Resident #102 had pertinent diagnoses which included: Cerebral infarction (Stroke), abnormal posture, and pain. Review of Care Plan for Resident #100 revealed Need/Goal/Interventions/unable to tolerate nutritionally adequate food and/or fluids by mouth requiring the use of a feeding tube R/T (related to) dysphagia with G-tube (tube inserted into the stomach to be used for nutrition, hydration and medication administration) initiated 4/11/2023 .will remain free of side effects or complications related to tube feeding revised on 5/7/2024 .Will be free of aspiration (inhalation of food or fluid into the lungs) through the review date 5/7/24 . administer medications separately and flush between each medication 4/11/2023; administer tube feeding as ordered 4/11/2023; elevate the HOB (head of bed) 30 degrees while in bed 4/11/2023; observe for s/sx (signs and symptoms) of intolerance to the tube feeding such as Nausea, vomiting, abdominal discomfort, increased residual, abnormal lung sounds 4/11/2023; Observe/document/report to physician PRN (as needed) : Aspiration- fever. SOB (shortness of breath) tube dislodgement, infection at tube site, self extubation (removal of tube feeding) tube dysfunction, abnormal breath/lung sounds . initiated on 4/11/2023. Has a functional ability deficit and requires assistance with selfcare/mobility .total dependent in Broda chair (special high back padded wheelchair) for ambulation (movement) .bath shower total dependent, bed mobility total dependent, dressing total dependent, eating NPO (nothing by mouth) receives all nutrition and meds by peg tube (G-tube), total dependence 1/13/2025. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Medication Administration Record (MAR) for Resident #100 for January 2025 revealed Enteral Feed Order six times a day Bolus (a prescribed amount to be given at one time) tube feeding of 200 mL (milliliters) Jevity 1.5 for a total volume of 1200 mL daily/1800 kcal (calories) ordered at 0200 (2 am), 0600 (6 am), 1000 (10 am), 1400 (2 pm), 1800 (6 pm), and 2200 (10 pm). LPN O documented administration of bolus feeding for Resident #100 on 1/4/2025 at 2200 and 1/5/2025 at 0200. Review of Nurses Note for Resident #100 dated 1/5/25 at 8:18 PM authored by Licensed Practical Nurse (LPN) O revealed This nurse observed resident to be very drowsy with sound of increased secretions at hs (evening) med pass. VS (vital signs) obtained and were 96. 9-(temperature)83-(pulse)14-(respirations)85/56-(blood pressure)92% RA (Pulse ox on room air) at this time. This nurse raised resident's head and repositioned resident upright in bed. Resident appeared to breathe easier. This nurse administered rx'd (prescribed) hs meds and feeding with no issues. This nurse continued to monitor resident. Upon doing next scheduled feeding, this nurse noticed increased congestion and decreased responsiveness at which vs were obtained and to be 97.5-116-28-124/84-65% RA. This nurse contacted provider for oxygen and nebulizer tx (treatment) orders. Oxygen @ (at) 2L via NC (nasal cannula) applied & O2 (oxygen) improved to 95%. This nurse contacted nurse on call. DON (Director of Nursing), on-call guardian after lvm (left voice mail) for assigned guardian. Provider gave orders to send resident for eval/tx of respiratory distress and unresponsiveness. On-call guardian gave okay to send to ER (emergency room). Repeat vs after O2 administration and neb (nebulizer treatment) 97.5-115-32-96/67-91% via NC. EMS (emergency medical services) was called for transfer, paperwork prepared for EMS/hospital and monitored resident until EMS arrived. (Name Omitted) EMS transferred resident via stretcher out of facility to (Name Omitted) at 4:25 AM. Report called to (Name Omitted). Review of Compliance Summary provided by the facility revealed Details : Summary- (Name Omitted) ED physician stated on January 5, 2025, around 4:45 AM, (Resident #100) patient, had arrived at the emergency room for being unresponsive and having difficulty breathing. (Name Omitted) ED physician stated she had provided (Resident #100) with Narcan (an over-the counter medication that is used to treat opioid overdose) as if she had an opioid or narcotic overdose. (Name Omitted) ED physician stated after (Resident #100) was provided Narcan she made a full recovery. (Resident #100) received a drug test and tested positive for opioids. (Name Omitted) ED physician stated (Resident #100)'s medication chart does not say she was prescribed any opioid or narcotic medication. Review of ED Provider Notes for Resident #100 with a service date of 1/5/2025 at 5:08 AM., revealed . presenting for respiratory distress. Patient is somnolent (sleepy; drowsy) and not responding to any questions. Per EMS, the patient had worsening somnolence and respiratory distress since shift change last night. This acutely worsened with increased respiratory distress and hypoxia in the 60s (pulse ox readings, normal 88-100) around midnight. When they arrived, patient was gurgling and had copious secretions with concern for possible aspiration. At baseline, she has some aphasias (difficulty talking/forming words) but is able to complete conversations with simple short answers. After Narcan the patient is awake, alert, and answering limited questions. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of MDM (Medical Decision Making) ED Notes for Resident #100 date of service 1/5/2025 at 7:46 AM. , revealed .Patient was evaluated by respiratory therapy who recommended NP suctioning (Nasopharyngeal suctioning using the airway of the nose to suction secretions/phlegm). Patient was suctioned with copious (excessive) secretions. These looked creamy and white, similar to the tube feed in her G-tube . she also has pinpoint pupils and depressed respiratory status concerning for possible opiate overdose. Quick review of her medication list she does not have any opiate prescriptions. However, due to her clinical presentation, I did give her a dose of Narcan. She immediately became alert and responsive answering simple questions- confirming my suspicions of opiate overdose . UDS (urine drug screen) was positive for opiates and benzodiazepines .she has a prescription for lorazepam (a benzodiazepine) but does not have any opiate pain medications. This is very concerning as her somnolence and decreased respiratory drive likely contributed to her aspiration event and ultimately her respiratory distress . Of note, while awaiting hospitalist admission evaluation, the patient became more somnolent, hypotensive (low blood pressure) with decreased respiratory rate (slowed breathing). She was given an additional dose of Narcan with appropriate response. She had improvement of both her mentation as well as her blood pressure and respiratory status, so there is concern that she was possibly given a long-acting opiate . Narcan gtt (drip) initiated. Final diagnoses: hypoxia, opiate overdose, undetermined intent, aspiration pneumonitis. Review of Care Timeline for Resident #100 revealed 1/5/2025 admitted to (Name Omitted) medical intensive care unit from ED (emergency department) 0917 (9:17 AM). Review of Drug Screen 8 for Resident #100 dated 1/5/25 and 1/6/25, revealed urine collection at 5:21 am on 1/5/25 with results indicating opiate screen positive, detects morphine at concentration of 300 ng/mL (nanograms per milliliter) and higher. Urine collection at 7:41 am on 1/5/25 with results indicating opiate screen positive, detects morphine at concentration of 300ng/mL and higher. Urine collection at 13:26 (1:26 pm) on 1/6/25 with results indicating opiate screen positive, detects morphine at concentrations of 300ng/mL and higher. Review of Drug screen 8 for Resident #100 performed by additional non-local lab (Name Omitted) provided to the facility on [DATE] via fax revealed urine collection occurred on 1/5/2025 at 7:41 am. Opiate confirm urine, opiate interpretation positive, morphine count, 11,487 (normal range cutoff 25). Review of Physician Orders for Resident #100 reveal no order for an opioid narcotic, including morphine. In an interview on 1/27/25 9:58 Am., Resident #100 was sitting up in her Broda wheelchair, in her room, awake, and alert and able to answer simple questions. Resident #100 responded yes when queried about her recent hospital stay. Resident #100 did not provide any descriptions or details of her recent hospital stay. Resident #100 responded fine when she was asked how she was feeling. Resident #100 unable to continue to converse meaningfully with surveyor. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview on 1/27/25 at 10:01 LPN M reported Resident #100 was dependent on staff for all care and did not eat, drink or take any medications orally. Resident #100 received all her nutrition, hydration, and medications through her G-tube. LPN M reported Resident #100 was sent to the hospital on 1/5/25 for respiratory distress and unresponsiveness by the night shift nurse and Resident #100 was found to have a positive urine drug screen at the hospital. LPN M reported he cared for Resident #100 on Friday 1/3/25 and during his shift, she was at her baseline, alert, oriented to herself and responsive to conversations with one or two words. In an interview on 1/27/25 at 10:12 AM., LPN Q reported she did not directly care for Resident #100 prior to her transfer to the emergency department on 1/5/25. LPN Q reported Resident #100 was alert and oriented to herself and responded to conversations with one or two words and was confused at baseline. LPN Q reported Resident #100 could talk, not in complete sentences, but she could talk. In an interview on 1/27/25 at 10:24 AM., Registered Nurse (RN) K reported she cared for Resident #100 on 1/5/25, the shift prior to her transfer to the ED and did not recall anything out of the ordinary about Resident #100 that day. RN K reported that Resident #100 tested positive for opiates when she was in the hospital. RN K reported there was another resident, who used the same style Broda wheelchair as Resident #100, that did take opioid pain medications. RN K stated they (Resident #100 and the other resident) might even be in the same room. RN K reported DON B asked her if there was any way morphine concentrate could be mistaken as Tylenol. When queried, RN K reported that liquid Tylenol and morphine sulfate are similar in color. Review of Census for Resident #100 and Resident #102 revealed they were roommates on 1/5/2025. In an interview on 1/27/25 at 11:28 AM., Certified Nurse Assistant (CNA) E reported she was assigned to work with Resident #100 on 1/4/25 on the day shift. CNA E reported she recalled Resident #100 did not yell out for cares during that shift as she usually did. CNA E reported on first rounds and at 11:30 am when she went to provide care, Resident #100 was sleeping. CNA E reported at 11:30 am, Resident #100 was sleeping really hard. CNA E reported she had to do a sternal rub to wake Resident #100 up. CNA E reported when she provided care, Resident #100 was noodle like and limp when being turned or repositioned in the bed. CNA E reported she informed RN K who was Resident #100's assigned nurse that day, that Resident #100 was not herself and something was wrong. During an observation and interview on 1/27/25 at 11:38 AM., LPN M was observed preparing liquid acetaminophen, noted to be red in color for Resident #100. In a telephone interview on 1/28/25 at 8:25 AM LPN O reported she was the nurse who sent Resident #100 to the hospital on 1/5/25. LPN O reported Resident #100 was sleepy at the beginning of the shift which started at 6pm. LPN O reported when she administered Resident #100's evening medications, Tylenol and maybe another medication, Resident #100 was lethargic (drowsy) and not responding as she normally did. LPN O reported Resident #100 does not receive any narcotic medications during her shift. LPN O reported Resident #100 had a respiratory situation going on and she continued to decline during the shift. LPN O reported the reason Resident #100 was sent out to the hospital was for respiratory distress and unresponsiveness. LPN O reported she received the phone call from the ED, in the morning on 1/5/25, informing her that Resident #100 tested positive for opioids on a urine drug screen. LPN O confirmed that Resident #100 does not have any orders for, nor was she administered, opioid medications. LPN O was queried about possible medication error and LPN O stated I am not aware of any medication error I made. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235483	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Galesburg (the)	1080 N 35th Street Galesburg, MI 49053

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview on 1/28/25 at 10:01 AM., LPN J reported she was assigned to care for Resident #100 on 1/3/25 and Resident #100 was at her baseline; she responded, hi, when LPN J said hi to her before care. LPN J reported Resident #100 only gets Tylenol on my shift and that was given about 8:30 pm. LPN J stated DON B asked me if there was any way I had administered Resident #102's medication to Resident #100, I told her no. In an interview on 1/28/25 at 12:19 PM., DON B reported Resident #100 was transferred to the emergency roiagnom on [DATE] for respiratory distress and unresponsiveness. DON B reported she was included in a three-way phone call on the morning on 1/5/25 with the physician at the ED and the Nursing Home Administrator (NHA) A when she was made aware of Resident #100's signs and symptoms of a drug overdose and subsequent response to the administration of Narcan. DON B was made aware of Resident #100's positive urine drug screen in that phone call. DON B reported she requested a repeat urine drug screen test and DON B confirmed those test results were also positive and revealed significantly higher levels of concentrated morphine in Resident #100's system than the first test revealed. DON B reported she arrived at the facility on 1/5/25 and completed a full building narcotic count, and there were no discrepancies and no indication that the administration of an ordered narcotic medication to a resident was missed. When queried, DON B confirmed a narcotic medication administered to the wrong resident would not be reflected in the narcotic count. DON B confirmed Resident #100's urine drug screen was positive for the opioid morphine. DON B reported Resident #100's roommate (Resident #102) was administered two different types of morphine medications multiple times a day, and if Resident #102 had missed a dose of her scheduled morphine, it would have been reflected in her pain assessments. DON B reported she was unable to confirm that Resident #100 was administered any opioid narcotics prior to her transfer to the hospital on 1/5/25. Review of MAR for Resident #102 for January 2025 revealed Morphine Sulfate ER tablet extended release 30 MG (milligrams) Give 1 tablet by mouth three times a day for pain at 0800 (8am), 1200 (noon), and 2000 (8pm) with a start date of 10/22/2024. Documentation revealed Resident #102 was administered Morphine Sulfate ER tablet as scheduled on 1/3/25 and 1/4/25. Documented pain level for Resident #102 on 1/2/25 were 0 at 8am, 0 at 12pm, and 3 at 8pm; Pain level on 1/3/25 were 5 at 8am, 5 at 12pm, and 4 at 8pm; pain level on 1/4/25 were 3 at 8am, 4 at 12pm and 0 at 8pm. (pain level - 0 indicates no pain, and 10 indicates the worst pain). Morphine sulfate (concentrate) oral solution 20 mg/mL (morphine sulfate) give 1 ML by mouth every 2 hours for pain at 0000 (midnight), 0200 (2am), 0400 (4am), 0600 (6am), 0800 (8am), 1000 (10am) 1200 (noon), 1400 (2pm) 1600 (4pm), 1800 (6pm), 2000 (8pm), 2200 (10pm) with a start date of 12/13/24. Documentation revealed Resident #102 was administered morphine sulfate oral solution as scheduled on 1/3/2025 and 1/4/2025. Resident #102's documented pain level was rated a 5 for 10 of 12 doses of morphine concentrate, with a pain rating of 4 at 8pm and 0 pain at 10pm; and #102's documented pain level for morphine sulfate ER ranged from 0-4 on 1/4/2025. In an interview on 1/28/25 at 1:32 PM., NHA A reported the investigation completed by himself, DON, and conferred with medical director was unable to identify any deficient practices. NHA A confirmed that Resident #100 was sent to the hospital for respiratory distress and unresponsiveness on 1/5/25 and Resident #100 did have more than one urine drug screen that was positive for opioids after her transfer to the emergency department on 1/5/25. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview on 1/28/25 at 2:02 PM., LPN P reported she was working on 1/5/25 when Resident #100 was sent to the emergency room . LPN P reported that LPN O requested she assess Resident #100 related to her respiratory distress and unresponsiveness. LPN P reported as soon as she saw Resident #100 sometime between 1 and 4 am on 1/5/25 she could see that she was struggling to breathe. LPN P reported Resident #100 sounded like she had fluid buildup on her lungs and LPN P thought maybe she has aspirated. LPN P reported Resident #100 was not responding, her eyes were rolling into the back of her head, she was really struggling to breath and was not able to focus with a sternal rub. LPN P stated I have never seen her (Resident #100) this bad, I was told it was a drug overdose, but she doesn't take anything for pain, she had no order for morphine. In an interview on 1/28/25 at 12:30 PM., DON B reported Narcan was available in the facility back up narcotic box. Review of Case Management Notes for Resident #100 dated 1/5/25 at 9:20 AM reveals .spoke to Admissions Coordinator (AC) C, she confirmed the facility self-reported to the state . 14:52 (2:52pm) Pt was hospitalized on [DATE] for PNA (pneumonia), hypoxia, and opiate overdose .1/6/2025 11:12 am (Name Omitted) Social Worker spoke with Resident #100's guardian, pt (patient) is alert and oriented to self at baseline and did not know how the pt received opiates .1/6/2025 12:04 pm (Name Omitted) Social Worker spoke with AC C from the facility, it is unknown what caused the positive opiate screen. She (AC C) indicated that there may be blood pressure medications that would cause a false positive, however the patient would not have responded to Narcan if this was the case . (Name Omitted) AC C indicated that it was unknown if this was a medication error. She (AC C) confirmed that pt would not have been able to obtain opiates and would not be able to take these medications . 1/6/2025 1:18 pm (Name Omitted) AC C was here to see patient States she (Resident #100) does not look good, (Name Omitted) AC C reports patient does not receive visits from anyone outside of the facility, and is dependent on staff for all ADLs (Activities of Daily Living) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47659 Based on observation, interview, and record review, the facility failed to properly label, date, and store medications in 1 out of 2 medication carts reviewed for medication storage and labeling resulting in the potential for decreased efficacy of medications and the exacerbation of medical conditions. Findings include: During an interview on 3/5/25 at 10:44 AM, Registered Nurse (RN) G reported that they had concerns with the nurses at the facility not labeling insulin pens when they opened them. RN G reported that they had brought this concern to the Director of Nursing (DON) B and that DON B had told them the policy was for the nurses to contact pharmacy to determine the date that the pen had been delivered, so there was no need to do further education on labeling insulin with nursing staff. RN G reported that calling the pharmacy to determine the date an insulin pen was delivered wasted a lot of time, and was not an accurate way to determine when the insulin pen had pen had been opened. During an observation and interview on 3/5/25 at 12:07 PM, this writer reviewed the medication cart with RN T. In the cart, there was 1 opened humalog (brand of insulin) insulin pen that did not have a label on it to note when it was opened, 1 opened humalog insulin pen with a delivered date of 1/15/25 and no label to indicate when the insulin was opened, and 1 glargine (type of insulin) pen with a delivered date of 1/6/25 which had not been opened. RN T, who was the nurse dispensing medications from the cart reported that she was new to the facility and did not know the policy on labeling insulin, or if the insulin were supposed to be labeled. During an interview and observation on 3/6/25 at 12:11 PM, LPN K reviewed RN T's medication cart with this writer and confirmed that the three insulin pens found without labels were not dated with the open date, so they were not safe to use, and should be discarded. LPN K confirmed that the insulin pen that had not been opened should have been refrigerated until opened. LPN K reported that the facility had ongoing issues with nursing staff not labeling and dating insulin pens when they opened them. During an interview on 3/6/25 at 1:16 PM, Unit Manager (UM) U reported that nurses were expected to label and date insulin pens when they open them, and not remove them from the refrigerator until they needed the pen for use. During an interview on 3/6/25 at 2:55 PM, DON B reported that nursing staff needed to call the pharmacy to determine the date the pen was delivered. When this writer queried on how the the delievery date would indicate the date the pen was opened, DON B reported that she had misspoke, and that nurses were expected to date the pens when they were opened.