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	09/19/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to ensure call lights were available and in reach for 2 (Resident #84 and #75) of 20 residents reviewed for accommodation of needs, resulting in the inability to call for staff assistance and the potential for unmet care needs. Findings include: Resident #84 Review of an Admission Record revealed Resident #84 was originally admitted to the facility on [DATE] with pertinent diagnoses which included difficulty in walking, muscle weakness, and dementia. Review of a Minimum Data Set (MDS) assessment for Resident #84, with a reference date of 9/1/24 revealed a Brief Interview for Mental Status (BIMS) score of 6/15 which indicated Resident #84 was severely cognitively impaired. Review of Resident #84's Care Plan revealed, (Resident #84) is at risk for fall related injury and falls R/T (related to): dementia, chronic back pain, weakness. Date Initiated: 08/26/2024. Interventions: . Keep the resident's environment as safe as possible with: even floors free from spills and/or clutter; adequate lighting; call light within reach, commonly used items within reach, avoid repositioning furniture and keep the bed in the appropriate position. Date Initiated: 08/26/2024 . (Resident #84) has a functional ability deficit and requires assistance with self care/mobility R/T: altered mental status Date Initiated: 08/26/2024. Interventions: .Encourage resident to use bell/call light to call for assistance. Date initiated: 8/26/24 . During an interview and observation on 9/17/24 at 12:01 PM, Resident #84 was lying in his bed. Resident #84 reported that he did use his call light to ask for help when he could find it. Resident #84 reported that he did not know where his call light was at. Resident #84's call light was noted to be on the ground under his bed and out of Resident #84's reach. During an interview and observation on 9/19/24 at 12:31 PM, Resident #84 was in bed. Resident #84's call light was observed sitting at the top of his bed and out of Resident #84's reach. Certified Nursing Assistant (CNA) W entered Resident #84's room with surveyor and confirmed that Resident #84's call light was out of his reach. CNA W reported that Resident #84 did use his call light to ask for assistance from staff. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #75 Review of an Admission Record revealed Resident #75 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia. Review of a Minimum Data Set (MDS) assessment for Resident #75, with a reference date of 8/1/24 revealed a Brief Interview for Mental Status (BIMS) score of 6/15 which indicated Resident #75 was severely cognitively impaired. Review of Resident #75's Care Plan revealed, (Resident #75) is at risk for fall related injury and falls R/T: dementia and history of psychosis with hallucinations. Date Initiated: 04/26/2024. Interventions: Keep the resident's environment as safe as possible with: even floors free from spills and/or clutter; adequate lighting; call light within reach, commonly used items within reach, avoid repositioning furniture and keep the bed in the appropriate position. Date Initiated: 04/26/2024 .Put the call light within reach and encourage him to use it for assistance as needed. Date Initiated: 04/26/2024 . During an interview and observation on 9/17/24 at 12:06 PM, Resident #75 reported that he would use a call light to ask for assistance from staff when needed, but he didn't have a call light in his room. It was noted that Resident #75's room did not have a call light for Resident #75 to use. During an observation on 9/19/24 at 12:36 PM, Resident #75 was sitting in his bed. It was noted that Resident #75 did not have a call light in his room. CNA W entered Resident #75's room and confirmed that Resident #75 did not have a call light. CNA W looked at Resident #75's room wall and noted that the room had a call light set up for a private room, so there was only one call light, and that was being used by Resident #75's roommate. CNA W reported that there was no reason for Resident #75 to not have access to a call light. CNA W was unable to report how long Resident #75 had been without a call light. 41027 In an interview on 09/19/24 at 01:18 PM, CNA Q reported that she was not aware that Resident #75 didn't have a call light. In an interview on 09/19/24 at 01:19 PM, Licensed Practical Nurse (LPN) M reported that Resident #75 should have a call light, and that she was not aware that he didn't. In an interview on 09/19/24 at 01:21 PM, Physician Assistant (PA) WW reported that Resident #75 is very anxious and constantly walking down to the nurse's station, and should have a call light accessible at all times. In an interview on 09/19/24 at 01:23 PM, Nursing Home Administrator (NHA) A reported that Resident #75 should have a call light, and that he would call maintenance immediately to have one installed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure an accurate do not resuscitate (DNR) order was updated timely for 1 (Resident #17) of 20 residents reviewed for advanced directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time), resulting in the potential for a resident's preferences for medical care to not be followed by the facility, or other healthcare providers. Findings include Resident #17 Review of an Admission Record revealed Resident #17 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia. Review of Resident #17's Electronic Health Record (EHR) revealed that Resident #17 was noted as a full code (health care term which indicates healthcare workers should perform all life saving measures in the event that the patients heart or lungs stop working). Review of Resident #17's DNR order dated 2/11/24 and signed by Resident #17's guardian revealed, I authorize in the event the ward's (Resident #17's) heart and breathing should stop, no person shall attempt to resuscitate the ward (Resident #17) During an interview on 9/18/24 at 3:47 PM, Licensed Practical Nurse (LPN) J reported that nurses would check the EHR to determine a resident's code status in the event of an emergency. LPN J confirmed that Resident #17 was listed as a full code. During an interview on 9/18/24 at 3:34 PM, Social Worker (SW) FF reported that the facility updated the code status to full code for residents each time they returned from the hospital until their re-admission paperwork was signed and scanned into the EHR. SW F reported that Resident #17 returned from the hospital on 7/29/24 and that the facility was behind on uploading documents into residents EHR, so the medical records department probably had the updated document, but it was not uploaded yet. SW F reported that she was responsible for verifying the accuracy of resident code status at care conferences. SW F confirmed that Resident #17 had a care conference in 8/2024. SW F could not report why Resident #17's code status had not been updated in Resident #17's EHR after the care conference which discussed Resident #17's desire to be noted as DNR. Review of Resident #17's Advance Care Planning Note dated 8/2/24 revealed, Guardian has stated (Resident #17) is to be a DNR . During an interview on 9/18/24 at 3:47 PM, Medical Records Staff (MR) EE reported that she did not know if she had an updated DNR order for Resident #17 and that she would need to look through her pile of forms. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 9/19/24 at 9:50 AM, MR EE reported that she discovered that she had emailed Resident #17's guardian on 7/29/24 requesting that she complete the updated DNR form for Resident #17. MR EE reported that she had not received the paperwork back from Resident #17's guardian. MR EE reported that she had not followed back up with Resident #17's guardian and that there was not a process in place for staff to ensure that pending forms are completed and received back. MR EE reported that she had gotten in touch with Resident #17's guardian on 9/18/24 after this surveyor inquired about the form, and she had received the updated advance care form which indicated that Resident #17's guardian desired for Resident #17's code status to be DNR.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on observations, interviews and record review, the facility failed to provide a clean and homelike environment that was free of pests and odors for one resident (Resident #9) of 20 residents reviewed for environment resulting in potential for decreased satisfaction of living conditions. Findings include: Resident #9 (R9) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R9 admitted to the facility on [DATE] with diagnoses of anxiety, depression and paranoid schizophrenia (mental disorder characterized by hallucinations, delusions, disordered thinking and behavior, flat or inappropriate affect). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R9 was cognitively intact (13 to 15 cognitively intact). On 9/17/2024 at 11:25 AM, R9 was sitting in his room in his wheelchair. R9's room smelled like feces and a dried-up red spill was noted along the floor by his bed. R9's hairbrush was observed under his bed with dust on it. On 9/17/2024 at 2:24 PM, it was noted that R9's room was cleaned by housekeeping and the spill was gone but R9's hairbrush was still under the bed in the same position and a white blanket was under his bed. R9's room smelled like feces. On 9/18/2024 at 9:00 AM, R9's room smelled like feces and the white blanket was under his bed in the same position. Gnats were flying by resident bedside table, on his bed and on the curtain divider. Review of the Resident Council Meeting Minutes dated 8/6/2024 revealed, III. New Business Discussed: Housekeeping: Under beds not being cleaned properly. (nothing should be under beds). Review of the Resident Council Meeting Minutes dated 7/9/2024 revealed, III. New Business Discussed: General: Objects that fall in between bed and wall stay down under bed for multiple days. During an interview on 9/18/2024 at 10:25 AM, Nursing Home Administrator A stated that housekeepers have a cleaning schedule and have a check off list. He said each resident room is cleaned every day and as needed and that they should clean under the beds. NHA A stated that he was aware of the resident council concerns regarding housekeeping and he had a staff meeting with the housekeepers and he conducts rounds and reminds them to clean under the beds. NHA A verified with surveyor that R9's room smelled like feces and that there was a blanket under his bed. NHA A said that R9's room smells like feces due to his roommate refusing to be changed. NHA A' also verified that there were gnats flying around in R9's area of the room. During an interview on 9/18/2024 at 12:00 PM, R9 was sitting in his wheelchair in his room and stated I hate gnats. They have been here off and on for the last month. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/2024 at 12:36 PM, NHA A stated that the gnats are flying around R9's room because his roommate has open snacks in his room and he was given Ziploc bags to put his food in. During an interview on 9/18/2024 at 1:15 PM, Licensed Practical Nurse (LPN) N stated she has seen gnats off and on in R9's room and there must be a reason for it such as open pop cans since you need moisture for gnats to be there. 38905 During a tour of resident room [ROOM NUMBER], at 11:34 AM on 9/17/24, it was observed that numerous gnats were present and congregating around the bedside stand of bed one and on the sheets and linen of bed two. It was observed that an open container of crackers was present on bed two. At this time, a strong odor was present in the room, but without a distinction for where the odor was emanating from. Observation of the shared bathroom found Bowel Movement on the underside of the commode seat. Exhaust fan in the shared bathroom was working but visibly covered in dust. During an interview with NHA A, at 2:35 PM on 9/18/24, it was found that cups of liquid were found in resident room [ROOM NUMBER] after staff went in to deep clean the area. NHA A stated that one of the residents in room [ROOM NUMBER] has a habit of keeping unfinished drinks from meal surface and keeping them in a drawer without letting staff clean routinely.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47955 Based on interview and record review the facility failed to address resident grievance timely in 1 (Resident #61) of 2 resident reviewed for grievances resulting in feelings of frustration and anger related to missing personal items. Findings include: Resident #61 Review of an Admission Record revealed Resident #61 had pertinent diagnoses which included: cerebral infarction (stroke) and difficulty in walking. Review of a Minimum Data Set (MDS) assessment for Resident #61, with a reference date of 8/12/2024 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #61 was cognitively intact. During an interview on 9/17/24 at 1:25 PM., Resident #61 reported he was missing clothing and he had concerns with his clothes returning from laundry. Resident #61 reported he had been missing clothing for about a month. Resident #61 reported had completed a complaint form over a week ago and had no response from anyone yet. During an interview on 9/18/24 at 1:25 PM., Resident #61 reported he had not had any follow up from the management team regarding his missing clothing. In an electronic communication (email) on 9/18/24 at 10:05 AM., this surveyor requested from to the Nursing Home Administrator (NHA) A any grievance/concern forms Resident #61 submitted to the facility. In an interview on 9/19/24 at 9:08 AM., NHA A reported he was not aware of any concerns Resident #61 had, nor did he know that Resident #61 was missing any items. In an interview on 9/19/24 at 9:26 AM., NHA A reported Resident #61 spoke to Housekeeper (H) CC regarding his missing items, and H CC replaced items from the donation pile. NHA A reported Resident #61 was larger in size and he didn't believe anyone else would fit in Resident #61's clothes. NHA A reported the facility was unable to substantiate that any clothing of Resident #61 was missing. This surveyor asked NHA A for the concern form and investigation into Resident #61's missing clothing items. NHA A was unable to provide any documentation into Resident #61's missing clothing. In a telephone interview on 9/19/24 at 9:43 AM., H CC reported that Resident #61 did inform her that he was missing clothing, and she did not complete a grievance form. H CC reported she should have completed a concern form regarding Resident #61's reported missing items. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/19/24 at 11:48 AM., NHA A reported his expectations were that when a resident brought a concern to a staff member, the staff member should complete a concern form or provide a form to the resident to complete. In an email on 9/19/24 at 12:14 PM., NHA A disclosed there were no grievance forms for Resident #61.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47659 Based on interview and record review, the facility failed to provide written notification to the State Long-Term Care (LTC) Ombudsman of facility-initiated transfers/discharges since January 2023, resulting in the potential for all residents to be discharged without an advocate who can inform them of their options and rights. Findings include: On 9/13/2024 at 3:48 PM, an email was received from the State LTC Ombudsman (Ombudsman) TT which stated, . They have not provided the required notice of transfers and discharges since January of 2023 . During an interview on 9/19/24 1:47 PM, Nursing Home Administrator (NHA) A reported that he was not sure what the facility process was for notifying the ombudsman of transfers and discharges, and that he would need to check into this. NHA A reported that he was unaware of this regulation. During a follow up interview on 9/19/24 at 3:08 PM, NHA A reported that the facility used to have a nurse manager that was responsible for sending the discharge and transfer notices to the ombudsman. NHA A reported that the nurse manager that was responsible for this left the facility and the task left the facility with her and the facility did not have anyone else in the facility completing this.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to provide written notification of the facility bed hold policy upon discharge to an acute care hospital for 2 (Resident #8 and #17) of 2 residents reviewed for emergency hospital transfer resulting in the potential for unanticipated expense or the loss of desired room placement in the facility. Findings include: Resident #8 Review of an Admission Record revealed Resident #8 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness. Review of Resident #8's Progress Notes dated 9/8/24 revealed, . asked by (Resident #8) to go to hospital . called PA (physician assistant) on call and EMS (emergency medical services) transport . Review of Resident #8's electronic health record (EHR) did not reveal a bed hold document for Resident #8's discharge on 9/8/24. Resident #17 Review of an Admission Record revealed Resident #17 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia. Review of Resident #17's Progress note dated 6/18/24 revealed, . (Resident #17) will be sent out to psych hospital later this afternoon . Review of Resident #17's EHR did not reveal a bed hold document for Resident #8's discharge on 6/18/24. On 9/19/24 at 10:47 AM, a request for a copies of Resident #8 and Resident #17's bed hold documents were made via email to nursing home administrator (NHA) A. The facility was not able to provide copies of the bed hold document prior to survey exit. During an interview on 9/19/24 at 1:34 PM, Admissions Staff Member (ASM) II reported that she was responsible for reviewing each residents discharge when they were transferred out of the facility to ensure that the resident or their guardian received a bed hold policy. ASM II reported that she had missed ensuring that Resident #17 had received a bed hold policy, and that she was not aware that Resident #8 had been sent to the hospital. During an interview on 9/19/24 at 1:47 PM, NHA A reported that ASM II was responsible for ensuring all residents that were transferred out of the facility received a bed hold policy, and that ASM II had not been completing this task.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) for a level II OBRA evaluation was completed for 2 (Resident #77 and #27) of 2 residents reviewed for PASARR, resulting in the potential for unmet mental health care needs. Findings include: Resident #77 Review of an Admission Record revealed Resident #77 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: schizophrenia, unspecified psychosis, major depressive disorder, generalized anxiety disorder, and insomnia. Review of Resident #77's Physician Orders revealed the following medications: Aripiprazole (antipsychotic medication) for depression, Trazodone (antidepressant) for insomnia, Venlafaxine (antidepressant), Zyprexa (antipsychotic medication) for psychosis, and Clonazepam (antipsychotropic medication) for anxiety. Review of Resident #77's Preadmission Screening and Resident Review (PASARR) revealed, a level 1 screening dated 5/17/24 that indicated mental illness. There was no level 2 screening in the record. In an interview on 09/18/24 at 12:00 PM, Social Worker (SW) FF reported that Resident #77 had multiple known mental illness diagnoses and significant psychiatric medications were being administered. Also that Resident #77 had a PASARR level 1, but did not have a level 2 in her health record. SW FF reported that she would look in to these things. In an interview on 09/18/24 at 02:20 PM, MDS (Minimum Data Set) Nurse E reported that she had completed Resident #77's PASARR level 1 on 5/17/24. MDS Nurse E reviewed the OBRA (Nursing Home Reform Act, sets federal standards of care for nursing home residents) website and reported that Resident #77's PASARR level 2 was stuck in a cue to be completed. MDS Nurse E reported that the PASARR level 2 should have been submitted to OBRA in May 2024, but was not. In an interview on 09/19/24 at 10:27 AM, Medical Records Staff (MRS) EE reported that she was responsible for notifying the provider when there is a PASARR 2 required. MRS EE reported that the provider was notified the day before on 9/18/24, after this survey inquired about it. MRS EE reported that normally behavioral health providers come out to complete the level 2 when they receive the notification, but they didn't receive Resident #77's information until 9/18/24. 48637 Resident #27 (R27) (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R27 admitted to the facility on [DATE] with diagnoses of depression, mild cognitive impairment, adjustment disorder with mixed anxiety and depression and psychotic disorder with delusions (a belief or altered reality that is persistently held despite evidence of the contrary). Brief Interview for Mental Status (BIMS) reflected a score of 13 out of 15 which indicated R9 was cognitively intact (13 to 15 cognitively intact). Review of R27's medical record revealed a Preadmission Screening (PAS)/Annual Resident Review (ARR) level I screen form (screens for mental illness/intellectual disability/related conditions) dated 8/7/2024. Under Section II-Screening Criteria, question 1 was marked yes for mental illness and question 2 was marked yes for receiving treatment for mental illness. Under the explanation, (R27) has dx (diagnosis) of major depressive disorder, with recurrent severe with psychotic symptoms, psychotic disorder with delusions d/t (due to) physiological conditions The form indicated If any answers to items 1-6 in Section II is yes, send ONE copy to the local Community Mental Health Service Program (CMHSP) so a level II can be completed. During an interview on 9/18/2024 at 4:03 PM, Social Worker (SW) FF stated that R27 didn't need a level II completed since he didn't meet the criteria. During an interview on 9/19/2024 at 8:21 AM, Minimum Date Set nurse (MDS) E stated that R27 has a mental illness and has the diagnoses of depression, mild cognitive impairment and psychotic disorder so the level I should have been sent to CMHSP so they could complete a level II. Review of the Pre-Admission Screening and Guest/Resident Review - PASRR Michigan Policy with an origin date of 12/1/2017 and a revision date of 11/12/2021 revealed, Procedure: 5. An intellectual/developmental disability, or related condition, will always supercede a dementia diagnosis and will require an in depth screening (Level 2). 7. a Level 1/3877 is completed annually for all guests/residents and maintained in the electronic medical record. For those who screen positively for a mental illness/intellectual/developmental disability the facility submits the annual Level 1/3877 screen to the local community mental health program for comprehensive screening (Level 2).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on observation, interview and record review the facility failed to develop person centered care plans related to antipsychotic and antidepressant use and implement pressure ulcer interventions for 2 (Resident #44, Resident #36) of 20 residents reviewed for person centered care plans resulting in the potential for unmet care needs of the residents. Findings include: Resident #44 (R44) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R44 admitted to the facility on [DATE] with diagnoses of depression, anxiety, mild cognitive impairment and psychotic disorder (disconnection from reality). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R44 was cognitively intact (13 to 15 cognitively intact). Review of R44's care plan revealed there was not a care plan regarding R44's psychotic disorder or antidepressant diagnoses. During an interview on 9/19/2024 at 9:17 AM, Social Worker (SW) FF stated that she typically completes care plans on residents that have antipsychotic and/or antidepressant diagnoses. SW FF looked for these care plans in R44's chart and said that she couldn't find them either. 47955 Resident #36 Review of an Admission Record revealed Resident #36 had pertinent diagnoses which included: dementia, pressure ulcer (bed sore- wound that occurs on the skin surface due to prolonged pressure) of the sacrum and the right and left heels. Review of a Minimum Data Set (MDS) assessment for Resident #36, with a reference date of 9/3/2024 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #36 was severely cognitively impaired. On 9/17/24 at 11:42 AM., and 2:47 PM., Resident #36 was observed positioned on her back in her bed, no pillows were noted to assist with position maintenance, and Resident #36's right and left heels were unprotected and resting directly on the mattress. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Care plan for Resident #36 revealed Focus .functional ability deficit requires assistance with self-care . revised on 8/22/2024 .Goal . maintain current level of function . revised on 9/11/24 .Interventions . bed mobility .resident requires max assist with adls (activities of daily living) substantial maximal assistance with one, two helpers, this includes rolling side to side . initiated on 7/4/2024 .Focus .at risk for impaired skin integrity/pressure injury R/T (related to) decreased mobility .revised on 8/28/2024 . Goal .minimize risk in an effort to reduce likelihood of pressure injury development .updated 4/16/2024 . Intervention . prevalon boots bilateral (both) heels when in bed . initiated on 6/18/2024 . Focus .actual impairment to skin integrity . pressure areas bilateral heels and sacrum (bone at the end of the spine, area of the body at the end of the spine) .revised on 8/21/2024 .goal .will have no complications .revised on 4/16/2024 . Interventions . encourage and assist to elevate heels when in bed .initiated on 6/17/2024 .Encourage to turn and reposition every 2 hours and assist as allows .initiated on 6/17/2024 .Treatment as ordered .revised on 3/7/2024 . On 9/18/2024 at 8:36 AM., 10:41 AM., and 12:30 PM., Resident #36 was observed in bed, facing the wall, positioned on her right shoulder, no pillows were noted to assist with position maintenance. Resident #36's heels were noted to be directly touching the mattress. Resident #36's sacrum was noted to be touching the mattress. Noted under the blanket, at the foot of the bed, several inches from the resident's feet, and against the foot board of the bed were green in color prevalon boots (boot shaped padded pillows used to elevate feet from the mattress and to protect heels from skin breakdown). In an interview on 9/19/2024 at 12:21 PM., Certified Nurse Assistant (CNA) R reported Resident #36 was dependent for care and that she was to be turned and/or repositioned every two hours and she was to wear the boots on both feet when in bed. In an interview on 9/19/2024 at 12:39 PM., Licensed Practical Nurse (LPN) K reported Resident #36 was total care, dependent on staff to reposition her in bed, and was unable to make body adjustments in bed independently. LPN K reported Resident #36 should wear prevalon boots on both feet when in bed. In an interview on 9/19/2024 at 1:51 PM., Director of Nursing (DON) B reported her expectations were that care plan interventions were implemented and Resident #36 should be repositioned and have her prevalon boots in place when in bed. In an interview on 9/19/24 at 2:03 PM., Registered Nurse (RN) D reported Resident #36 had interventions in place for pressure ulcer prevention or worsening that included repositioning schedule and heel protectors and elevation of heels. RN D reported Resident #36 repositioning schedule should be every two hours, and pillows should be used to assist Resident #36 to maintain her position as she could not maintain her position on her own. RN D reported Resident #36 should not be positioned directly on her back and that her prevalon boots should be in place on both feet when in bed. RN D reported Resident #36's heels should not be directly on the mattress. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Planning Policy with an origin date of 9/1/2011 and a revision date of 6/24/2021 revealed Purpose: Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing and mental and psychological needs identified in the comprehensive assessments and prepared by an interdisciplinary team .Procedure 1. Resident's will be assessed as they are admitted and readmitted to the nursing facility to determine their physical, psychological, emotional, medical and psychological needs. The results of interdisciplinary assessments will be used to develop, review and revise the resident's comprehensive care plans.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to follow physician orders for use of oxygen in 1 (Resident #81) of 2 residents reviewed for respiratory care, resulting in inaccurate settings and the potential for respiratory infection. Findings include: Resident #81 Review of an Admission Record revealed Resident #81 was originally admitted to the facility on [DATE] with pertinent diagnoses which included adult failure to thrive. Review of Resident #81's Orders revealed, Oxygen 2 l/min (liters per minute) via nasal cannula as needed for SOB (shortness of breath). Start date: 8/23/2024. During an observation on 9/17/24 at 1:25 PM, Resident #81 was sitting in her room wearing oxygen via nasal cannula. It was noted that Resident #81's oxygen was running at 4 liters per minute. During an observation on 9/18/24 at 10:44 AM, Resident #81 was lying in her bed. It was noted that Resident #81's oxygen was running at 4 liters per minute. During an observation and interview on 9/18/24 at 10:50 AM, Licensed Practical Nurse (LPN) K reported Resident #81's oxygen was ordered to be set at 2 liters per minute. LPN K confirmed that Resident #81's oxygen was running at the incorrect rate. LPN K reported that she was unaware that Resident #81's oxygen was running at the incorrect rate, because she had not checked on Resident #81 yet that day. LPN K reported that she had not been told by the evening nurse that Resident #81 had reported any shortness of breath or need for her oxygen to be increased. LPN K confirmed that nurses were not able to increase Resident #81's oxygen rate without contacting the physician and obtaining a new order.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47955 Based on interview and record review the facility failed to ensure a RN (registered nurse) worked 8 consecutive hours on 4/13/2024, 4/27/2024, 5/25/2024, and 5/26/2024, resulting in the potential for unmet care needs for all residents who resided in the building on those dates. Findings include: Review of PBJ Report indicated staffing concerns, no RN coverage for 8 consecutive hours during quarter 3/year 2024. With staffing notes to include no RN hours on 4/7/24, 4/13/24, 4/27/24, 5/25/24, and 5/26/24. Review of Sign in Sheets work schedules provided by the facility dated 4/13/2024, 4/27/2024, 5/25/2024, and 5/26/2024, no registered nurse was scheduled nor did a registered nurse sign in on those dates. In an interview on 9/18/2024 at 2:09 PM., General and Administration (GA) GG reported she did know there needed to be a RN for 8 consecutive hours every day including weekends. GA GG reported she did not schedule a RN on 4/13/24, 4/27/24, 5/25/24, and 5/26/24. GA GG reported there was no RN coverage on those dates. GA GG reported in April she had approximately 3 RN to work on the floor. GA GG reported she now has 5 RNs to work on the floor and has unit managers that can count as well. GA GG reported that she has not had any date since 5/26/24 that she did not have an RN to schedule for 8 consecutive hours. In an interview on 9/19/24 at 10:48 AM., Regional Clinical Coordinator (RCC) OO reported Nursing Home Administrator (NHA) A completed a past noncompliance for no RN coverage on 4 days during the third quarter. In an interview on 9/19/24 at 2:28 PM., NHA A reported he was aware a few months ago the facility was missing RN coverage on 4 days. NHA A reported the root cause was not enough RNs on staff and has since hired 5 more RNs. NHA A directed this surveyor to Director of Nursing (DON) B when he was asked how the residents who resided in the building during the time of no RN coverage were evaluated, as he was not clinical and unable to answer how residents were evaluated to determine if they were affected. NHA A reported the facility discussed the lack of RN coverage during QAPI (Quality Assurance Performance Improvement) meetings, but was unable to demonstrate any notes, minutes or other supporting documentation that this topic was discussed during QAPI meetings or documentation that residents were evaluated. In an interview on 9/19/24 at 2:40 PM., RCC OO reported there was more than one RN on call during the dates of 4/13/24, 4/27/24, 5/25/24, and 5/26/24 but no RNs in the building on those dates. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/19/24 at 2:52 PM., DON B was asked by this surveyor how the residents who resided in the building were assessed to determine if they had been affected by the noncompliance of no RN coverage on 4 days and DON B reported that she did not assess the resident in the building. DON B reported she did not contribute to the past noncompliance report and NHA A had completed it himself.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview, and record review, the facility failed to ensure 1 (Resident #77) of 3 residents reviewed for behavioral health, received behavioral health care services resulting in the potential for residents to experience a decline in their psychosocial well-being. Findings include: Resident #77 Review of an Admission Record revealed Resident #77 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: schizophrenia, unspecified psychosis, major depressive disorder, generalized anxiety disorder, and insomnia. Review of Resident #77's Physician Orders revealed the following medications: Aripiprazole (antipsychotic medication) for depression, Trazodone (antidepressant) for insomnia, Venlafaxine (antidepressant), Zyprexa (antipsychotic medication) for psychosis, and Clonazepam (antipsychotropic medication) for anxiety. Review of Resident #77's Care Plan revealed, no care plan developed for any of Resident #77's mental illness diagnoses, and/or the medications that she was being prescribed for these conditions. Review of Resident #77's health records at the facility revealed, no psychiatric service visit notes, no social service notes, no record of a behavioral health referral or provider in place or scheduled. Review of Resident #77's Preadmission Screening and Resident Review (PASARR) revealed, a level 1 screening dated 5/17/24 that indicated mental illness. There was no level 2 screening in the record. In an interview on 09/18/24 at 12:00 PM, Social Worker (SW) FF reported that Resident #77 had multiple known mental illness diagnoses and significant psychiatric medications were being administered. Also that Resident #77 had a PASARR level 1, but did not have a level 2 in her health record. SW FF reported that she would look in to these things. In an interview on 09/18/24 at 02:20 PM, MDS (Minimum Data Set) Nurse E reported that she had completed Resident #77's PASARR level 1 on 5/17/24. MDS Nurse E reviewed the OBRA (Nursing Home Reform Act, sets federal standards of care for nursing home residents) website and reported that Resident #77's PASARR level 2 was stuck in a cue to be completed. MDS Nurse E reported that the PASARR level 2 should have been submitted to OBRA in May 2024, but was not. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a subsequent interview on 09/19/24 at 11:06 AM, SW FF reported that Resident #77 should have been seen by psychiatric services monthly, but had not been referred by the facility to date. SW FF reported that she also could not find any evidence that Resident #77 had been referred to the facility's behavioral care services providers. SW FF reported that Resident #77 should have a mental illness and antipsychotic medication care plan in place to meet her immediate needs, but that there had not been one developed yet. SW FF did not have any further explanation for why these interventions had not been put in place immediately upon Resident #77's admission in May 2024. In an interview on 09/19/24 at 11:20 AM, Director of Nursing (DON) B agreed that Resident #77 had a mental illness diagnosis, and was currently taking multiple serious psychiatric medications, should have a care plan in place to reflect these needs, and should be followed by behavioral health services.

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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** 41027 Based on interview and record review, the facility failed to discontinue psychotropic medications prescribed as needed (PRN), after 14 days and/or document rationale to extend prn psychotropic medication use in 1 (Resident #75) of 6 residents reviewed for unnecessary medications, resulting in the potential for adverse side effects and inability to monitor the effectiveness of the prescribed treatment due to lack of documented supporting evidence. Findings include: Resident #75 Review of an Admission Record revealed Resident #75 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia. Review of a Minimum Data Set (MDS) assessment for Resident #75, with a reference date of 8/1/24 revealed a Brief Interview for Mental Status (BIMS) score of 6/15 which indicated Resident #75 was severely cognitively impaired. Review of Resident #75's Physician Orders revealed, Lorazepam (psychotropic medication used as a sedative) Tablet 0.5 MG Give 2 tablet by mouth every 4 hours as needed for anxiety. Do not give more than 4 mg daily. Start date: 8/28/2024. The order had an Indefinite stop date, and had been administered 10 times in September. The order was written by Physician Assistant (PA) WW. In an interview on 9/19/24 at 01:10 PM, PA WW reported that Resident #75's order for Lorazepam should have been written with a 14 day stop date and stated, we don't want him to be on that longer without getting reevaluated .

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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. 38905 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents. Findings include: During a tour of the kitchen, at 9:02 AM on 9/17/24, observation of the two door reach in cooler found a container of sliced turkey dated 9/4 to 9/17, an open (half empty) gallon of milk with no date to indicate discard, an open container of hot dogs dated 9/10 to 9/17, a sheet tray with a dozen thawed Mighty Shakes and 10 Magic Cups with no date to indicate discard for these items. Mighty Shakes state they are good 14 days from thaw and the Magic Cups state under refrigeration Consume within 5 days. During a tour of the Activity refrigeration units, at 10:20 AM on 9/17/24, observation of the kitchen fridge found an open container of thickened lemon water with no date. The item states it is good for 4 days after opening. An interview with Dietary Manager (DM) BB found that nursing staff normally dates items when they open it. During a tour of the SCU dining room, at 10:27 AM on 9/17/24, it was observed that an open container of med pass 2.0 was found with no date to indicate discard. Further observation found 12 unopened half gallons of chocolate milk held passed the best by date. Five half gallons were dated 9/9/24 and seven were dated 9/16/24. An interview with DM BB found that they had an issue with their supplier recently and were delivered milk close to the best by date. During a revisit to the kitchen, at 9:50 AM on 9/18/24, inside of the walk-in cooler observed a box of 20 mighty shakes with no date to indicate when the items should be discarded. Further observation found a container of cut watermelon dated 9/13 to 9/16. According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY 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 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED 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, based on the temperature and time combinations specified in (A) of this section 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 . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . During a tour of the kitchen, 9:28 AM on 9/17/24, observation of general cleaning around the ice machine, juice machine, and two door cooler area of the kitchen, found an increase accumulation of items on the floor, including: crumbs, dirt, butter packets, a yogurt container, a plastic bowl and plastic tops, packets of salad dressing and a plastic ramekin of salsa. An interview with DM BB found that staff pulled all this equipment out and cleaned awhile ago. Further review of the wall next to the juice machine found an increased amount of orange splash and debris accumulation streaking down the side of the wall. An interview with DM BB found that they had a leak in of their juice bags they didn't know about that made a mess. During a revisit to the kitchen, at 11:25 AM on 9/18/24 observation of the kitchen found increased accumulation of dirt and grime around and underneath the dish machine line as well as the cook line corner at the hand sink. These areas have added debris on the floor juncture and walls as well as behind the cook line. Some of these areas also have vinyl coving loose or missing from the perimeter of the floor, or have places where the coving is no longer protecting the floor juncture from accumulation of moisture (open and gapped at the bottom like behind ice machine). After cleaned, these areas should be repaired to fully sweep water away from the junctures and leave a protected seam. Further observation of the kitchen, at 11:55 AM on 9/18/24, found an accumulation of dusty debris on the lights over the preparation and cook line area. Observation found a ceiling vent in this area that has added accumulation. Also, the tower fan that is near the office door was found with increased amounts of dust and debris. According to the 2017 FDA Food Code section 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair. 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 . During a tour of the kitchen, at 9:10 AM on 9/17/24, it was observed that the bottom of the two door refrigeration unit was found with an accumulation of red sticky debris from a juice spill. During a tour of the kitchen, at 9:13 AM on 9/17/24, an interview with [NAME] VV found that clean utensils get stored in a colander pan on the drying rack and then get put away in a drawer on the cook line. Observation of mechanical scoops and metal spoons stored in two different colander pans found an increased amount of crumb and plastic debris inside of the pans. When asked how often these get cleaned, [NAME] VV was unsure. During a tour of the kitchen, at 9:25 AM on 9/17/24, observation of the inside of the microwave found an increased amount of dried debris accumulation on the ceiling and sides on the inside of the unit. (continued on next page)

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	235483	A. Building B. Wing	09/19/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the kitchen, at 9:33 AM on 9/17/24, it was observed that accumulation of debris was evident on the spout of the juice dispenser. When the spout was taken off, debris was easily wiped away with a clean paper towel. An interview with DM BB found that staff soak the juice dispensers nightly, but dont take off the spout to wipe the inside. During a tour of the kitchen, at 9:40 AM on 9/17/24, observation of the drying rack, with DM BB, found that a stack of eight large sheet pans were stored on the bottom of the rack. Upon feeling if the sheet pans were stacked wet, it was found that the pans were greasy and contained excess carbon accumulation on the perimeter, sides, and corners of the pans. An interview with DM BB found that some of the pans have been here awhile and that staff don't like using them all the time because they don't fit in the dish machine and have to be washed by hand. During a tour of the Activity refrigeration units, at 10:20 AM on 9/17/24, an interview with DM BB, found that kitchen staff help date items and log temperatures in this area, but activities also oversees the units. Observation of the refrigeration units found some increased debris from juice spills on the door and bottom pull out drawers of the units. During a tour of the ice room, at 12:56 PM on 9/17/24, found that the ice scoop holder had slimy debris in the bottom of the container and the ice scoop was stored right side up. Although holes were drilled in the bottom of the ice scoop holder for draining, staff are using the holder on its side, and placing the scoop right-side up, not allowing for proper draining of water. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47955 Based on interview and record review the facility failed to ensure complete documentation in treatment administration records for 1 (Resident #36) of 20 residents reviewed for complete documentation in treatment administration records. Findings include: Resident #36 Review of an Admission Record revealed Resident #36 had pertinent diagnoses which included: dementia, pressure ulcer (bed sore- wound that occurs on the skin surface due to prolonged pressure) of the sacrum and the right and left heels. Review of a Minimum Data Set (MDS) assessment for Resident #36, with a reference date of 9/3/2024 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #36 was severely cognitively impaired. On 9/17/24 at 11:42 AM., Resident #36's feet were observed wrapped with gauze. No date was noted in the dressings. Review of Physician Order Summary revealed . rt (right) heel cleanse with normal saline, pat dry, apply collagen matrix, cover with 4 x 4 and wrap with kerlix (gauze) change m-w-f (Monday, Wednesday, Friday) ordered 8/16/2024 . left heel wound cleanse with normal saline, pat dry, apply collagen matrix, cover with 4x4 and wrap with kerlix, change m-w-f and prn (as needed) ordered 8/16/2024 .Sacrum wound: cleanse with normal saline, pat dry gently, apply medihoney to wound bed, apply calcium alginate to wound bed, cover with a foam dressing change daily and as needed for soiled or dislodgement ordered 8/16/2024 . Review of 'Treatment administration Record (TAR) dated July 2024 for Resident #36 revealed .apply betadine soaked 4x4s to lt (left) heel, cover and wrap with kerlix, change q (every) day prn . started 6/20/2024 ended 7/24/2024. No documentation noted on 7/4/2024, 7/21/2024, and 7/22/24. Review of 'Treatment administration Record (TAR) dated August 2024 for Resident #36 revealed .left heel wound: cleanse with normal saline, pat dry apply collagen matrix, cover with 4 x 4 and wrap with kerlix change m-w-f. No documentation noted on 8/23/2024. Review of 'Treatment administration Record (TAR) dated August 2024 for Resident #36 revealed .scrum wound: cleanse with normal saline, pat dry gently, apply medihoney to wound bed, apply calcium alginate to wound bed, cover with foam dressing change daily and as needed for soiled or dislodgement, start on 8/17/2024. No documentation noted for 8/17/2024, 8/22/2024, 8/23/2024, and 8/31/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of 'Treatment administration Record (TAR) dated September 2024 for Resident #36 revealed .scrum wound: cleanse with normal saline, pat dry gently, apply medihoney to wound bed, apply calcium alginate to wound bed, cover with foam dressing change daily and as needed for soiled or dislodgement, start on 8/17/2024. No documentation noted for 9/15/2024. In an interview on 9/19/24 at 12:51 PM., Licensed Practical Nurse (LPN) K reported if the TAR was left blank it indicated the task was not completed. In an interview on 9/19/2024 at 1:51 PM., Director of Nursing (DON) B reported her expectations were that TARs were completed when the dressing changes were completed. DON B reported that if the TAR was not signed, the treatment did not happen. In an interview on 9/19/24 at 2:03 PM., Registered Nurse (RN) D reported Resident #36 dressing changes should be documented in the TAR after completion. If there was no documentation it indicated the dressing changes were not completed.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38905 Based on observation and interview the facility failed to properly protect the potable water supply from plumbing cross connections. This resulted in the potential for increased illness and possible contamination of the domestic water. Findings include: During a tour of the kitchen, at 10:17 AM on 9/17/24, it was observed that the mop sink in the kitchen janitors' closet was found left on and connected to a pre-dispense chemical system. The mop sink faucet has an internal atmospheric vacuum breaker (AVB) that is not approved for constant back pressure. The current set up puts undue back pressure on the faucets internal AVB (when its left on and connected to a pre-dispense system that has a stop valve downstream). During a tour of the beauty shop, at 1:30 PM on 9/17/24, with Maintenance Director UU, it was found that the spray to the hair washing sink was replaced with a kitchen dish sprayer that controls the pressure with a thumb valve (which creates a stop downstream of the faucets atmospheric vacuum breaker). Currently the spray was laying in the bottom of the sink near the drain. When asked if this was something he had worked on, Maintenance Director UU stated no. A sprayer that does not turn the water on and off at the spray (have a stop downstream) would need to be used to maintain integrity of the AVB and properly protect the potable water supply. During a tour of the SCU janitor sink, at 1:48 PM on 9/17/24, it was observed that the janitors sink wasting tee was plugged, not allowing the device to relieve undue back pressure on the faucets internal AVB. It was also observed that the AVB was leaking at this time with visibly heavy corrosion on the outiside of the facuet. When asked if he could see the leaking water from the back of the sink, Maintenance Director UU stated yes.