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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235499	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Oaks Nursing Center	600 Denmark St Baldwin, MI 49304

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37573 This citation pertains to intake M100150227. Based on interview and record review, the facility failed to treat a resident in a dignified manner for one (R27) of three residents reviewed for dignity. Findings include: Review of a Facility Reported Incident (FRI) revealed on 1/31/25, a Certified Nursing Assistant (CNA) P went into R27's room and asked the resident Why you mean muggin' me? It was reported the staff member and R27 began arguing back and forth until CNA P left the room. R27 told CNA P to get over himself and he then jumped in the air and stated, I just got over myself. R27 told CNA P she was going to write him up and he answered, Good, can't wait. I see flaming daggers come out of your eyes. In an interview on 3/20/25 at 9:07 AM, R27 reported CNA P was not abusive, but he insulted her intellect and injury and would not elaborate any more because she already told the facility and did not want to stir up any problems. Review of a Corrective Action Form for the incident dated 1/31/25, CNA P was permanently dismissed from his position at the facility for severe violation of conduct/behavior on 2/10/25. There was no further action documented to prevent further occurrences from staff.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on observation, interview, and record review, the facility failed to ensure call lights were left within reach of 2 residents (R30 and R22) of 2 residents reviewed for availability of call lights. Findings include: R30 Review of an Admission Record revealed R30 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and weakness. Review of a Minimum Data Set (MDS) assessment for R30, with a reference date of 2/25/2025 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated R30 was moderately cognitively impaired. Further review of same MDS assessment revealed R30 required staff assistance with transfers. Review of a current functional mobility Care Plan interventions for R30, initiated 1/9/2024, directed staff that R30 required staff assistance with ambulation and directed staff to maintain personal items within her reach and encourage her to use her call light to alert staff of needs. In an observation and interview in R30's room on 3/18/2025 at 1:48 PM, R30 was in her wheelchair and her call light was hanging from the wall and out of her reach. R30 stated, I can't reach that. In an observation in R30's room on 3/19/2025 at 8:41 AM, R30 was in her wheelchair and her call light was on her bed and under her pillow, out of reach. In an observation and interview in R30's room on 3/19/2025 at 11:34 AM, R30 was in her wheelchair and her call light was on her bed and under her pillow, out of reach. R30 reported she did not know where her call light was located. In an observation in R30's room on 3/19/2025 at 11:45 AM, R30 was in her wheelchair and her call light was on her bed and under her pillow, out of reach. Registered Nurse (RN) G asked R30 if she knew where her call light was and R30 reported she was unable to find it. RN G clipped R30's call light to her blouse and asked R30 if she was able to press the call light. R30 responded by pressing the call light successfully. In an observation and interview in R30's room on 3/20/2025 at 8:59 AM, R30 was in her wheelchair and her call light was attached to her bed, out of reach. R30 reached for her call light and was unable to reach it. R30 stated, can you move it closer?. In an observation in R30's room on 3/20/2025 at 9:02 AM, the DON asked R30 if she could reach her call light. R30 tried to reach her call light and was unable. The DON moved R30's wheelchair closer to her bed where she could reach her call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/20/2025 at 9:05 AM, the DON reported R30 was able to use her call light and staff should leave the call light within reach. R22 Review of an Admission Record revealed R22 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and weakness. Review of a Minimum Data Set (MDS) assessment for R22, with a reference date of 1/6/2025 revealed a Brief Interview for Mental Status (BIMS) score of 11, out of a total possible score of 15, which indicated R22 was moderately cognitively impaired. Further review of same MDS assessment revealed R22 required staff assistance with transfers and ambulation. Review of a current functional mobility Care Plan intervention for R22, with a revision date of 4/11/2024, directed staff that R22 required staff assistance with ambulation. Another intervention revised 12/16/2024 directed staff to remind R22 to use her call light and leave it within reach. In an observation and interview in R22's room on 3/18/2025 at 12:25 PM, R22 was sitting in a bedside chair, and her call light was coiled up on her bed a few feet away and out of reach. R22 reported she did not know where her call light was located. In an interview on 3/20/2025 at 9:07 AM, the Director of Nursing (DON) reported R22 was dependent on staff assistance for ambulation and able to use her call light.

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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** 37573 Based on observation, interview and record review, the facility failed to develop or implement care plan interventions for two (R6 and R39) of 20 residents reviewed for care plans. Findings include: Resident #6 (R6) Review of a Face Sheet revealed R6 originally admitted to the facility on [DATE] and has pertinent diagnoses of morbid obesity, dementia and mixed incontinence. Review of the Minimum Data Set (MDS) dated [DATE] revealed R6 is moderately cognitively impaired, has limited range of motion on bilateral lower extremities, and is dependent on staff for toileting and mobility. She is at risk for pressure ulcers but did not have any at the time of this assessment. During an observation and an interview on 3/19/25 at 1:15 PM, R6 was in bed for cares and her socks and puff boots were removed. There were 3 pressure ulcers observed on her left lateral foot. Certified Nursing Assistant (CNA) K placed R6's socks back on her feet and put the puff boots back on her before transferring back to her chair. When asked about repositioning or offloading R6 who is dependent on cares, CNA K reported that would be really hard because of her contractures and the fact that she is sitting in a chair (Broda chair). Review of a Skin Assessment for R6 dated 3/15/25 revealed: -Stage II pressure wound on left outer ankle, measured 1.1 x 0.7 x 0.1 cm (centimeters) -Stage II pressure wound on left lateral foot, measured 0.4 x 0.4 x 0.1 cm. Review of the Care Plan for R6 revealed no focus for active or prevention of pressure ulcers or leg contractures. Review of the Care Plan for R6 revealed interventions: -Assess postural alignment, weight distribution, sitting balance, & pressure redistribution on admit and prn (as needed). Initiated 2/1/23. -Encourage pressure relieving boots on at all times while in bed and up in chair. Initiated 1/31/23 and revised on 3/16/25. Resident #39 (R39) Review of a Face Sheet revealed R39 originally admitted to the facility on [DATE] and has pertinent diagnoses of dementia, cerebrovascular disease, and chronic kidney disease. (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 Electronic Medical Record (EMR) for R39 revealed he has frequent Urinary Tract Infections (UTI's) and benign prostatic hyperplasia (BPH) and a history of urethral strictures. Review of the Point of Care task documentation for bowel and bladder elimination for R39 revealed he is documented having 18 episodes of incontinence from 2/19/25 to 3/19/25 (a 30 day look back during this survey) and toileted an average of three times a day. Review of the ADL Care Plan for R39 revealed: ABLE TO LEAVE ON TOILET: No. AMBULATION: SBA (stand by assist) with 4 WW (wheeled walker) and gait belt.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on interview and record review, the facility failed to formulate and implement personalized Care Plan revisions for one facility resident (R17) of two residents reviewed with documented significant weight changes. Findings: R17 Review of the Electronic Medical Record (EMR) reflected R17 originally admitted to the facility 6/2/23 with pertinent diagnoses that included Congestive Heart Failure (CHF) and Morbid Obesity. Review of the Minimum Data Set (MDS) dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R17 was cognitively intact. On 3/19/25 at 12:19 PM an interview was conducted with R17 in her room. R17 reported a desire to lose weight. R17 reported she feels the facility is not giving enough support to help her with this. Review of the EMR Weight Summary for R17 reflected nine weights obtained from 10/15//24 to 1/29/25 each followed by a weight warning of weight increases with each weight. Each weight warning included a notation of comparative weight increases ranging from 7.5% to 12.9% from previous weights. Review of the Progress Notes for R17 reflected an entry on 12/2/24 Spoke with (name of R17) about her wanting to have small portions at her mealtimes. (name of R17) wanted to have this change due to expressing the need to lose weight. Ticket and Care Plan to Show small portions. Review of the Care Plan Focus of (name of R17) has the potential for an altered nutritional status primarily (related to) conditions associated with morbid obesity, CHF . Review of the Goals for this Care Plan Focus reflect (name of R17) will be provided adequate nutrition ., early identification and adjustment of her food consistency .early identification and treatment of abnormal glucose levels, And (name of R17) has a goal for gradual weight loss of 40 -50 pounds (lbs.) date initiated 6/6/23 and revised on 2/14/25, Review of the Interventions implemented for this Care Plan Focus to reach the Goals do not reveal any new interventions or revisions since 7/6/23 and did not reflect small portions as documented on 12/2/24. The Interventions reflected to Assess and document and to Evaluate laboratory levels, and Evaluate significant weight changes . and to follow orders. The interventions did not reveal any personalized, measurable actions or updated and revised efforts toward the Resident's stated desire to lose weight or to address the documented weight increases. During an interview conducted 3/20/25 at 9:56 AM Physician Assistant (PA) J reported the weight gain for R17 was a legit weight gain and was not fluid. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR Interdisciplinary Care Conference Documentation dated 2/26/25 at 9:03 AM reflected documentation by Nursing, Social Work, and a Registered Dietician. The documentation reflected R17 was Responsible and had Decision Making Capability. Section 1 identified as a Summary of Person-Centered Review of Measurable Goals and Individuated Interventions contains objective clinical information. The documentation reflected R17 was obese and, without input from the Resident, attributed her weight to Chronic Heart Failure and medications, Many of these can contribute to weight and fluid fluctuations. No documentation was identified that R17 participated in or was encouraged to voice what her concerns were or what she wanted. Although the medical record contained information of a significant weight gain the documentation of the Care Conference did not include a plan to revise the Care Plan with measurable or personalized goals or interventions. As of survey exit no additional information was provided by the facility

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on interview and record review, the facility failed to follow through the continuity of care of frequent urinary tract infections for one (R39) of one reviewed for quality of care. Findings include: Review of a Face Sheet revealed R39 originally admitted to the facility on [DATE] and has pertinent diagnoses of dementia, cerebrovascular disease, and chronic kidney disease. Review of the Electronic Medical Record (EMR) for R39 revealed he has frequent Urinary Tract Infections (UTI's) and benign prostatic hyperplasia (BPH) and a history of urethral strictures. Review of a Hospital Record dated 1/18/25 for R39 revealed: Assessment & Plan: Severe sepsis. Source influenza, pneumonia, urinary tract infection. Recurrent UTI (urinary tract infection). Multiple UTIs in the past. Recently admitted [DATE] for sepsis due to urinary tract infection positive for Pseudomonas (bacterial infection). Urinalysis performed on 1/15 culture data returned positive for Enterococcus faecalis. Yesterday was started on amoxicillin. - At present antibiotics include cefepime and vancomycin. -Acute kidney injury superimposed on stage 3b chronic kidney disease. Assessment & Plan: . Likely prerenal due to fairly significant dehydration on arrival. -Urinary retention. Assessment & Plan: Has seen Urology. There was concern on of bladder mass seen on a renal ultrasound (sic). Cystoscopy performed 11/25/24 with no mass present. - continue Flomax. Review of a Consultation Report- Record of Consultation Services from Urology for R39 dated 10/28/24 revealed:1) Recurrent UTI 2) Moderate Urine Retention 3) History Urethral Stricture. Plan for cystoscopy in the urology office and kidney ultrasound. Review of an Order Summary from 10/1/24 to 3/31/25) for R39 revealed several orders for antibiotics as follows: -Amoxicillin 500 mg (milligrams) three times a day, ordered 10/14/24 and ended 10/21/24 for a UTI. -Amoxicillin-Pot Clavulanate (Augmentin) 875-125 mg two times a day ordered 1/17/25 and ended 1/24/25 for UTI. -Bactrim 800-160 mg ordered one time for 11/25/24 prior to cystoscopy. -Ceftriaxone Sodium injection 1 GM (gram) intramuscularly one time a day ordered 2/24/25 to 3/3/25 for UTI. - Ceftriaxone Sodium injection 1 GM (gram) intramuscularly one time ordered 10/2/24 and 10/3/24 for fever. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cipro (Ciprofloxacin) 250 mg, two tablets every 12 hours, ordered 11/12/24 to 11/17/24 for UTI. -Cipro 250 mg twice a day, ordered 11/26/24 to 12/3/24 for UTI. -Cipro 500 mg twice a day, ordered 10/17/24 for PSA (prostate specific antigen) UTI. -Cipro 500 mg twice a day, ordered 10/20/24 to 10/27/24 for PSA UTI. -Doxycycline Hyclate 100 mg twice a day for two days, ordered 1/24/25 to 1/26/25 for pneumonia. - Doxycycline Hyclate 100 mg twice a day, ordered 1/22/25 to 1/26/25 for UTI for 3 days and only given on 1/23/25. -Fosfomycin Tromethamine oral Packet 3 gm one time ordered 10/7/24 for UTI. -Levofloxacin 500 mg once a day for elevated temperature, ordered 1/15/25 to 1/22/25. -Sodium Chloride Intravenous (IV) Solution 0.9% (sodium chloride), use 100 ml/hr (milliliters per hour), use 500 ml intravenously one time only for bolus ordered 10/3/24. -Bumetanide (Bumex) (diuretic) 1 mg once a day every other day, ordered 11/12/24 to 1/11/25. -Bumex 1 mg every 24 hours as needed for LE (lower extremity) edema, ordered 1/11/25 to 1/20/25. -Bumex 1 mg every 24 hours as needed for LE (lower extremity) edema, ordered 1/22/25. -Tamulosin 0.4 mg once a day, ordered 11/12/24 prostate. Flomax (Tamulosin) 0.4 mg at bedtime for BPH (benign prostatic hyperplasia) ordered 1/22/25. Review of a urinalysis collected 10/15/24 for R39 revealed it was positive for protein (normal is negative), trace blood (normal is negative) Urine leukocyte esterase result small (normal is negative), WBC (white blood cells) result 50 (normal 0-5), hyaline casts result 1.16 (normal <3). Culture was pending, and no results in EMR. Was documented on form for R39 to have a new order for a Urology referral on 10/16/24. Review of a urinalysis collected 10/28/24 for R39 from a urine catheter revealed there was a trace of blood detected, and RBC (red blood cells) results were a 9 (0-3 is normal). Review of a urinalysis collected 11/19/24 for R39 revealed it was negative for infection. Review of a urinalysis collected 2/22/25 for R39 revealed it was positive for infection and the cultures resulted >= 100,000 CFU/mL Providencia stuartii (A) a gram-negative bacterium. Review of the Point of Care task documentation for bowel and bladder elimination for R39 revealed he is documented having 18 episodes of incontinence from 2/19/25 to 3/19/25 (a 30 day look back during this survey) and toileted an average of three times a day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the ADL Care Plan for R39 revealed: ABLE TO LEAVE ON TOILET: No. AMBULATION: SBA (stand by assist) with 4 WW (wheeled walker) and gait belt. ELIMINATION: . Prompt and assist, prn (as needed), with toileting before and after meals, with AM and HS (morning and evening) cares, and with rounds prn. Assist when verbal or non-verbal indicators communicate toileting needs. Assist with incontinence care as needed. Review of the requires OT (occupational therapy) related to decline in function secondary to: re-admit to facility after hospitalization due to UTI with sepsis Care Plan for R39 revealed: will perform toileting with SBA or better. Review of the Care Plan for R39 revealed no focus for urinary strictures or frequent UTI's. In an interview on 3/20/25 at 11:06 AM, the Infection Control Preventionist/Licensed Practical Nurse (LPN) B was queried about R39's frequent UTI's and potential root causes, and care assessments. LPN B reported R39 was seen by urology and diagnosed with a urinary stricture. When queried about the results from the cystoscopy and the kidney ultrasound that was planned from urology, she could not find any results and reported she will provide them. LPN B reported he is independent, continent and is independent when toileting, despite the care planning indicating differently. LPN B reported staff should be documenting his fluid intake. No information for root cause of frequent UTI's. In an interview on 3/20/25 at 1:34 PM, the Director of Nursing (DON) was notified of still needing the Urology consultation documentation for R39. Review of a Timeline for R39 provided by LPN B revealed there is frequent antibiotic use for UTI's and no follow up from Urology or planned interventions for frequent UTIs to improve the quality of care and prevent sepsis. Review of a Nurse Supervisor Job description revealed: The primary functions and responsibilities of this position are as follows: (You will be evaluated on your ability to perform these functions competently with minimal supervision and/or reminders. 1. Follow established standards of nursing practices and implement facility policies and procedures. 2. Supervise and evaluate all direct resident care and initiate corrective action as necessary. 20. Perform and document comprehensive assessment of residents as assigned. 21. Develop and implement an accurate comprehensive care plan based on each resident's needs and his/her comprehensive assessment. 24. Competently perform basic nursing skills. 34. Document resident progress notes as required/Electronic Documentation is provided as assigned. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	35. Document daily notes on unstable residents, Medicare residents and recently admitted residents.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview and record review, the facility failed to follow physician orders, prevent pressure ulcers, accurately assess and document, and implement treatment for one (R6) of two residents reviewed for pressure injuries. Findings include: Resident #6 (R6) Review of a Face Sheet revealed R6 originally admitted to the facility on [DATE] and has pertinent diagnoses of morbid obesity, dementia and mixed incontinence. Review of the Minimum Data Set (MDS) dated [DATE] revealed R6 is moderately cognitively impaired, has limited range of motion on bilateral lower extremities, and is dependent on staff for toileting and mobility. She is at risk for pressure ulcers but did not have any at the time of this assessment. Review of a Skin Assessment for R6 dated 3/15/25 revealed: -Stage II pressure wound on left outer ankle, measured 1.1 x 0.7 x 0.1 cm (centimeters) -Stage II pressure wound on left lateral foot, measured 0.4 x 0.4 x 0.1 cm. Review of a Healthcare Provider Wound Assessment note dated 3/15/25 for R6 revealed: Lt (left) Ankle Stage II pressure ulcer on L (Lateral) ankle: - Measures 1.1 cm x 0.7 x 0.1 cm. Lt Lateral foot Stage II pressure ulcer: - 0.4 x 0.4 x 0.1 cm. Reviewed current wound orders. Review of the March 2024 Treatment Administration Record (TAR) for R6 revealed the following orders: -Cleanse left outer ankle and left lateral foot with NS (normal saline), pat dry and apply comfort foam border dressing, every day shift every 3 days. Started 3/18/25. (3 days after provider assessment/orders) -Blue boots on at all times to prevent further breakdown to feet. Started on 3/16/25. During an observation on 3/19/25, R6 was observed in her Broda chair at 8:30 AM with puff boots on her bilateral lower extremities. Her left leg is contracted. She was observed in the same position in the Broda chair at 11:50 AM she is in the community room watching television. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and an interview on 3/19/25 at 1:15 PM, R6 was in bed for cares and her socks and puff boots were removed. There were 3 wounds with dark scabbed like appearances observed on her left lateral foot and no dressings in place. Certified Nursing Assistant (CNA) K placed R6's socks back on her feet and put the puff boots back on her before transferring back to her chair. The nurse was not notified of a missing dressing. When asked about repositioning or offloading R6 who is dependent on cares, CNA K reported that would be really hard because of her contractures and the fact that she is sitting in a chair (Broda chair). Review of the Care Plan for R6 revealed no focus for active pressure ulcers or leg contractures. Review of the Care Plan for R6 revealed interventions: -Assess postural alignment, weight distribution, sitting balance, &pressure redistribution on admit and prn (as needed). Initiated 2/1/23. -Encourage pressure relieving boots on at all times while in bed and up in chair. Initiated 1/31/23 and revised on 3/16/25. In an interview on 3/20/25 at 12:43 PM, the Director of Nursing (DON) reported she expects staff to report any new skin conditions to the nurse and confirmed R6 is to have a border foam dressing on the pressure ulcers on her left lateral foot. The DON confirmed the skin assessments documented in the computer are not accurate. The DON reported the Care Plan does reflect R6 was already to have the puff boots as an intervention, but she is more receptive now to having them on her feet, which is why no new intervention was put into place. Review of a policy titled Skin at Risk Assessment Documentation, Staging & Treatment last revised 1/2020 revealed: It is the policy of this facility to assess resident risk factors for the development of impaired skin integrity and intervene as indicated utilizing the admission assessment, plan of care, and Minimum Data Set as formal assessment tools. It is the policy of this facility to assess skin on a regular basis to determine whether changes in the patient's skin condition have occurred. Weekly measurements and narrative assessments are conducted on existing pressure injuries. Purpose: To provide prompt identification and intervention for residents at risk of impaired skin integrity corresponding to risk factors. To limit the development of avoidable pressure ulcers and provide evidenced based guidance on effective strategies to promote pressure ulcer healing. 6. The following guidelines are reviewed and implemented as indicated for each individual risk factors: a. Daily skin inspections with am and pm care e. Rehabilitation consultation to improve mobility, promote movement and receive recommendations for positioning support. f. Use of pressure relieving devices, i.e., chair cushions, pressure reduction mattresses, low air loss mattresses (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. Change the residents position every 2 hours and more frequently if redness or irritation of the skin develops q. Implement standing orders for impaired skin and / or consult the physician prn for treatment and orders for impaired skin integrity. 8. Individualize the resident goals and interventions as documented on the plan of care. 10. Document the appearance of the wound with considerations to the physical characteristics as applicable to the resident;

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview and record review, the facility failed to follow physician orders and provide timely incontinence care, and appropriately document and treat MASD (moisture associated skin damage) for one (R6) of two residents reviewed for bowel and bladder. Findings include: Review of a Face Sheet revealed R6 originally admitted to the facility on [DATE] and has pertinent diagnoses of morbid obesity, dementia and mixed incontinence. Review of the Minimum Data Set (MDS) dated [DATE] revealed R6 is moderately cognitively impaired, has limited range of motion on bilateral lower extremities, and is dependent on staff for toileting and mobility. She is always incontinent of bowel and bladder. Review of the Care Plan for R6 revealed: ELIMINATION: Wears incontinence products, check and change before and after meals, HS [at bedtime] with rounds and prn (as needed), assist when verbal or non-verbal indicators communicate toileting needs. Last revised 7/27/24. SKIN: Apply barrier cream with incontinence care prn; inspect skin with bathing and care; report impaired skin integrity to charge nurse. Last revised 3/16/25. Incontinence care with protective barrier ointment as indicated. initiated 2/1/23. During an observation 3/19/25 at 8:30 AM, R6 was observed in the assisted dining room for breakfast in her Broda chair. At 11:50 AM she was observed in the community room watching television. During an observation and an interview on 3/19/25 at 12:11 PM, R6 observed in the community room. Certified Nursing Assistant (CNA) K was asked when R6 will be toileted next and reported when R6 is done with her lunch. During an observation and an interview on 3/19/25 at 1:15 PM, CNA K and CNA L transferred R6 to bed via Hoyer lift. When R6 was lifted from her Broda chair, the chair was wet, and the sling was saturated with urine as well as her brief. There was a notable strong urine smell. Her brief was removed and a large area on her buttocks was red, macerated and blanchable. Her left upper thigh had one golf ball sized red macerated/excoriated area, and another tennis ball sized red macerated/excoriated area, and both were blanchable. CNA K reported R6 gets barrier cream twice a day and did not apply any cream to the resident after providing peri care at this time. R6 was then transferred back to her Broda chair when CNA K finished care. In an interview on 3/19/25 at 1:30 PM CNA K reported she thinks she last toileted R6 before breakfast but could not remember and reported R6 should not have gone that long without being toileted. CNA K reported R6 should be toileted every 2 hours and reported it was too hard to toilet her that often. CNA K reported she did not apply any barrier cream to R6 because she did not have any available. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the March 2025 Treatment Administration Record (TAR) for R6 revealed orders for barrier cream to be applied to MASD located to groin and bilateral posterior thighs every shift until resolved. Another order to apply moisture barrier cream every shift and as needed to bilateral posterior thighs excoriation. No start date on the TAR. Review of the Care Plan revealed no interventions for MASD. Review of the Bowel and Bladder Elimination task charting from 2/19/25 to 3/19/25 (a 30 day period) for R6 revealed she is toileted an average of 2-4 times a day with periods of 10-12 hours of no toileting in between. Review of a Skin assessment dated [DATE] for R6 revealed her right rear thigh to have MASD. Skin is pink dry and intact, site is healed, skin blanchable, free of odor or s/s (signs and symptoms) of infection. Preventative measures remain in place. (sic) In an interview on 3/20/25 at 12:43 PM, the Director of Nursing (DON) reported her expectation are residents are to be toileted at the bare minimum every 2 hours. Staff are to inform the nurse of any new skin conditions and apply barrier cream when needed. The skin assessment should have been this week and recognized the skin assessments for R6 do not reflect her conditions. Review of a policy titled Skin at Risk Assessment Documentation, Staging & Treatment last revised 1/2020 revealed: It is the policy of this facility to assess resident risk factors for the development of impaired skin integrity and intervene as indicated utilizing the admission assessment, plan of care, and Minimum Data Set as formal assessment tools. It is the policy of this facility to assess skin on a regular basis to determine whether changes in the patient's skin condition have occurred. Weekly measurements and narrative assessments are conducted on existing pressure injuries. Purpose: To provide prompt identification and intervention for residents at risk of impaired skin integrity corresponding to risk factors. b. C.N.A. reporting of abnormal skin inspections to the charge nurse c. Application of skin barrier ointment with incontinence care to form a protective coating to prevent skin maceration.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on interview and record review, the facility failed to ensure significant changes in weight were reviewed by the medical provider for 2 residents (R30 and R17) of 5 residents reviewed for nutrition services. Findings include: R30 Review of an Admission Record revealed R30 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and weakness. Review of R30's weights in the electronic medical record (EMR) revealed her weight was 203.2 on 2/13/2025, 188.1 on 3/4/2025, 185.3 on 3/6/2025, and 184.1 on 3/17/2025. Review of R30's Progress Note dated 3/6/2025 at 8:39 AM revealed Dietary Manager F noted R30 had a 7. 5% weight loss. Further review of the EMR did not reveal documentation that this weight loss was reviewed by the medical provider. Review of R30's Progress Note dated 3/18/2025 at 11:38 AM revealed Registered Dietician (RD) H noted R30 had significant weight loss for 1 month. Further review of the EMR did not reveal documentation that this weight loss was reviewed by the medical provider. In an interview on 3/20/2025 at 11:07 AM, the Director of Nursing (DON) reviewed the EMR and reported R30's recent weight loss was significant and should have been referred to the medical provider for review when reviewed by Dietary Manager F on 3/6/2025 and by RD H on 3/18/2025. In an interview on 3/20/2025 at 11:49 AM, the DON reported she had reviewed the EMR and there was no documentation that R30's recent significant weight loss had been reviewed by a medical provider. Review of facility policy/procedure Change in Resident Condition Physician/Family Notification, revised 3/2021, revealed .The health care practitioner will be promptly notified when . The resident has a significant change in physical, mental, or psychosocial status . 31771 Resident #17 (R17) R17 R17 Review of the Electronic Medical Record (EMR) reflected R17 originally admitted to the facility 6/2/23 with pertinent diagnoses that included Congestive Heart Failure (CHF) and Morbid Obesity. Review of the Minimum Data Set (MDS) dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R17 was cognitively intact. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 12:19 PM an interview was conducted with R17 in her room. R17 reported a desire to lose weight. R17 reported she had spoken with the Food Service Department and the medical provider and reported she was not getting any help with weight loss. Review of the EMR Weight Summary for R17 reflected nine weights obtained from 10/15//24 to 1/29/25 each followed by a weight warning- of weight increases with each weight. Each weight warning included comparative weight increases ranging from 7.5% to 12.9% from previous weights. Review of the medical record did not reflect documentation the medical provider had been notified of the Resident's weight changes. Review of the EMR reflected Resident encounters with the medical provider on 2/10/25 and 3/12/25. The documentation reflected the Resident's current weight along with other vital signs. However, no documentation was found that the medical provider was aware or notified of the weight changes. During an interview conducted 3/20/25 at 9:56 AM Physician Assistant (PA) J reported he expects to be notified of Resident weight changes. During an interview conducted 3/19/25 at 1:30 PM Registered Dietician (RD) H reported an entry in the medical record is expected when a resident had a notable weight change. RD H reported the provider was to be notified and the provider was expected to document in the medical record they were notified. RD H acknowledged she could not find documentation the medical provider was notified and that it is very surprising there isn't something in the record about the weight changes for R17. As of survey exit no additional information was provided by the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview and record review, the facility failed to provide appropriate hand hygiene during peri care for two (R6 and R48) of two residents reviewed for incontinence care. Findings include: Resident #6 (R6) Review of a Face Sheet revealed R6 originally admitted to the facility on [DATE] and has pertinent diagnoses of morbid obesity, dementia and mixed incontinence. Review of the Minimum Data Set (MDS) dated [DATE] revealed R6 is moderately cognitively impaired, has limited range of motion on bilateral lower extremities, and is dependent on staff for toileting and mobility. She is always incontinent of bowel and bladder. During an observation and an interview on 3/19/25 at 1:15 PM, CNA K and CNA L provided incontinence care for R6. CNA K removed the urine saturated Hoyer sling and urine saturated brief from R6. When CNA K completed incontinence care, she used the same gloves to put on a new brief, put new clothes on, and touched several other common surfaces in the room. In an interview on 3/19/25 at 1:30 PM CNA K acknowledged she did not change her gloves or sanitize her hands while providing incontinent care and moving from dirty to clean surfaces. CNA K reported her gloves were not visibly soiled. When asked if urine is dirty, CNA K reported yes and said she is really bad at that. Resident #48 (R48) Review of a Face Sheet for R48 revealed she originally admitted to the facility on [DATE] with pertinent diagnoses of morbid obesity, diabetes, and urine retention. During an observation and an interview on 3/18/25 at 12:12 PM, CNA M and CNA N provided peri care/catheter care for R48 who currently has a yeast infection and is in enhanced barrier precautions. CNA M checked her pockets for barrier cream with the same soiled gloves used for peri care. She then applied a new clean brief and touched other inanimate objects in the room before removing gloves and sanitizing her hands. In an interview on 3/18/25 at 12:22 PM, CNA M was queried about her hand hygiene during peri care for R48. CNA M paused and nodded yes, indicating she should have changed her gloves and sanitize her hands. In an interview on 3/20/25 at 11:06 AM, Licensed Practical Nurse (LPN)/Infection Control Nurse B reported staff are to perform hand hygiene when moving from dirty to clean surfaces during incontinence/peri care. LPN B reported she has not done any hand hygiene audits lately and staff get hand hygiene education at least annually with their competencies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a hand Hygiene policy last revised 9/2022 revealed: It is the policy of this employer for staff members to frequently perform hand hygiene to It is the policy of this employer for staff members to frequently perform hand hygiene to assist with prevention / reduction of the spread of infection. The employer promotes hand hygiene using recognized techniques as the single most effective means of reducing the risk of cross-infection. Indications: 1. Hands may be cleaned using liquid soap and water or alcohol hand rub. a. Hands should be cleaned before and after work b. Before and after meals c. Before and after caring for different residents d. After using the restroom e. After handling contaminated environmental objects f. After sneezing or coughing 2. When to use liquid soap and water a. When hands are visibly soiled or potentially contaminated with dirt or organic material (e.g., following removal of gloves) b. Before preparing or eating food c. After using the toilet d. After caring for a resident with a diarrheal illness Review of the Clinical Safety: Hand Hygiene for Healthcare Workers. Clean Hands, Centers for Disease Control, 27 Feb. 2024, www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, accessed 20, Mar. 2025 revealed: KEY POINTS: Protect yourself and your patients from deadly germs by cleaning your hands. All healthcare personnel should understand how to care for and clean their hands. Why it matters: Hand hygiene protects both healthcare personnel and patients. Recommendations: Know when to clean your hands: Immediately before touching a patient. Before performing an aseptic task . Before moving from work on a soiled body site to clean a body site on the same patient. After touching a patient or patient's surroundings. After contact with blood, bodily fluids, or contaminated surfaces. Immediately after glove removal.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on interview and record review, the facility failed to follow policies and procedures and implement appropriate antibiotic stewardship for two (R39 and R48) of two residents reviewed for antibiotic stewardship and failed to have an affective system in place for assessing, monitoring and preventing unnecessary antibiotic usage. Findings include: Review of a policy titled Antimicrobial Stewardship last revised on 3/2020 revealed: It is the policy of this facility to utilize various antimicrobial stewardship strategies to improve the quality of antimicrobial therapy, minimize antimicrobial resistance, and optimize clinical outcomes. The facility will utilize antimicrobial stewardship strategies in combination with infection prevention and control efforts to limit the emergence and transmission of antimicrobial-resistant pathogens. Purpose: To preserve the effectiveness of antimicrobials, reduce avoidable adverse effects, minimize healthcare associated infection, and limit the emergence and transmission of antimicrobial-resistant pathogens. Definition: Antimicrobial resistance is a serious public health concern related to the emergence of multi-drug resistant microbial species for which there is no effective antimicrobial agents and the paucity of new antimicrobials being developed. Antimicrobial drugs include agents for treating bacterial, viral, fungal and parasitic infection. 2. Antimicrobial therapy should only be prescribed if clinically indicated according to signs and symptoms of infection and /or sepsis. 2b. Prompt antibiotic administration for septic residents can save lives; make every attempt to obtain appropriate cultures prior to administering antimicrobials. c. Residents who receive antimicrobial therapy are at increased risk of colonization and infection with Clostridium difficile, MRSA, and other multi-resistant pathogens. Residents should not be subject to this increased risk without reasonable evidence of infection or established prophylactic benefit. d. Document indications for antimicrobial therapy in the interdisciplinary note and or medication administration record including the indication for treatment. 3. Residents with orders for anti-infective medications will be screened for appropriate agent selection. 4. The infection control practitioner, pharmacist and / or licensed nurses will perform a prospective audit evaluating antibiotic orders to provide direct intervention and prescriber feedback if the order is deemed inappropriate for the condition, culture and sensitivity, renal function, and / or presentation of signs and symptoms. Resident #39 (R39) Review of a Face Sheet revealed R39 originally admitted to the facility on [DATE] and readmitted on [DATE] after a hospitalization . Pertinent diagnoses include cerebral infarction (stroke), vascular dementia, and chronic kidney disease. Review of the Electronic Medical Record (EMR) for R39 revealed he has frequent Urinary Tract Infections (UTI's) and benign prostatic hyperplasia (BPH) and a history of urethral strictures. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Hospital Record dated 1/18/25 for R39 revealed: Assessment & Plan: Severe sepsis. Source influenza, pneumonia, urinary tract infection. Recurrent UTI (urinary tract infection). Multiple UTIs in the past. Recently admitted [DATE] for sepsis due to urinary tract infection positive for Pseudomonas (bacterial infection). Urinalysis performed on 1/15 culture data returned positive for Enterococcus faecalis. Yesterday was started on amoxicillin. - At present antibiotics include cefepime and vancomycin. -Acute kidney injury superimposed on stage 3b chronic kidney disease. Assessment & Plan: . Likely prerenal due to fairly significant dehydration on arrival. -Urinary retention. Assessment & Plan: Has seen Urology. There was concern on of bladder mass seen on a renal ultrasound (sic). Cystoscopy performed 11/25/24 with no mass present. - continue Flomax. Review of the October 2024 Infection Control Resident Surveillance record revealed R39 was listed on the following dates: On 10/7, a urinary tract infection (UTI). The culture result was aerococcus. Treatment was 3 grams (gm) Fosfomycin x 1 dose. On 10/17, a UTI with pseudomonas culture. Treatment was Cipro 500 mg twice a day X 10 days. This month does not reflect the following antibiotics administered to R39: ceftriaxone on 10/3/24, amoxicillin on 10/14/24, and Cipro on 10/26/24 for UTI's as reflected in the Order Summary. Review of a Short Term Care Plan Urinary Tract Infection for R39 dated 10/14/24 revealed: UTI McGeer Criteria Review: Both 1 & 2 criteria must be met: (circle) (1) Acute dysuria; swelling or tenderness of the teste, epididymis or prostrate, Fever or Leukocytosis AND at least one of: Acute costovertebral angle tenderness, suprapubic pain, hematuria, increased incontinence, urgency or frequency. (2) >/=1000,000 CFU's/ML identified species of Microorganism:_____. Fever was circled and weakness was written in. Ordered medication: Amoxicillin 500 mg three times a day for 7 days and changed on 10/17/24 to Cipro 500 mg twice a day for 10 days. Review of an Order Summary from 10/1/24 to 3/31/25) for R39 revealed several orders for antibiotics as follows: -Amoxicillin 500 mg (milligrams) three times a day, ordered 10/14/24 and ended 10/21/24 for a UTI. -Amoxicillin-Pot Clavulanate (Augmentin) 875-125 mg two times a day ordered 1/17/25 and ended 1/24/25 for UTI. -Bactrim 800-160 mg ordered one time for 11/25/24 prior to cystoscopy. -Ceftriaxone Sodium (Rocephin) injection 1 GM (gram) intramuscularly one time a day ordered 2/24/25 to 3/3/25 for UTI. - Ceftriaxone Sodium injection 1 GM (gram) intramuscularly one time ordered 10/2/24 and 10/3/24 for fever. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cipro (Ciprofloxacin) 250 mg, two tablets every 12 hours, ordered 11/12/24 to 11/17/24 for UTI. -Cipro 250 mg twice a day, ordered 11/26/24 to 12/3/24 for UTI. -Cipro 500 mg twice a day, ordered 10/17/24 for PSA (prostate specific antigen) UTI. -Cipro 500 mg twice a day, ordered 10/20/24 to 10/27/24 for PSA UTI. -Doxycycline Hyclate 100 mg twice a day for two days, ordered 1/24/25 to 1/26/25 for pneumonia. - Doxycycline Hyclate 100 mg twice a day, ordered 1/22/25 to 1/26/25 for UTI for 3 days and only given on 1/23/25. -Fosfomycin Tromethamine oral Packet 3 gm one time ordered 10/7/24 for UTI. -Levofloxacin 500 mg once a day for elevated temperature, ordered 1/15/25 to 1/22/25. Review of the November 2024 Infection Control Resident Surveillance record revealed R39 was listed on the following dates: On 11/12/24, a UTI with pseudomonas aeruginosa. Treatment was Cipro 500 mg twice a day for 5 days. On 11/26/24, a UTI diagnosed by urologist (no cultures). Treatment was Cipro 250 mg twice a day for 7 days. On 11/25/24, Bactrim 800-160 mg ordered one time prior to cystoscopy. (Not reflected on tracking) Review of the December 2024 Infection Control Resident Surveillance record revealed R39 had no antibiotics. Review of the January 2025 Infection Control Resident Surveillance record revealed R39 was listed on the following dates: On 1/16/25, a UTI with enterococcus faecalis. Treatment was Augmentin twice a day for 7 days. On 1/23/25, a LRI (lower respiratory infection). Treatment was Doxycyline twice a day for 3 days. This did not reflect the hospital record that shows R39 had a UTI that was positive for pseudomonas. This month did not reflect the Levofloxacin 500 mg once a day for elevated temperature on 1/15/25. Review of the February 2025 Infection Control Resident Surveillance record revealed R39 was listed on the following dates: 2/22/25, a UTI with Provencia Stuartii. Treatment was Rocephin 1 gm x 7 days. (continued on next page)

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/20/25 at 11:06 AM, the Infection Control Preventionist/Licensed Practical Nurse (LPN) B reviewed her antibiotic tracking and trending report and was not correct/complete and LPN B agreed that it was not correct. A timeline was requested for R39 which reflected incorrect tracking and trending of his antibiotic use. No interventions or plans to prevent future UTI's or sepsis for R46 was revealed during this interview. Resident #46 Review of the EMR for R46 revealed he was discharged from the hospital 10/18/24 with antibiotics. In an interview and record review on 3/20/25 at 11:06 AM, the Infection Control Preventionist/Licensed Practical Nurse (LPN) B reported R46 was discharged from the hospital on antibiotics in October but did not have it tracked on the antibiotic tracking sheet. She reported she only works part time and the Clinical Coordinator, or the Director of Nursing (DON) will follow up on the appropriateness of antibiotics for residents when she is not there. She reported her system of tracking on the clinical dashboard disappears after a few days and may not have seen the antibiotics for residents if the system timed out. Another instance may be if the residents get an antibiotic over the weekend, she would not be able to follow up. Further review of the antibiotic tracking revealed one resident in October 2024 was ordered Ceftin 500 mg twice a day on 10/31/24 for a UTI with no culture and qualifying symptoms of fatigue and increased incontinence. In December 2024 another resident on 12/17/24 was ordered Keflex 500 mg twice a day for 7 days for a UTI with no culture and qualifying symptoms of altered mental status. LPN B reported the facility is to follow the McGeers Criteria for antibiotic stewardship.