STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235500	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Omni Continuing Care	5201 Conner Detroit, MI 48213

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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 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** Based on observation, interview, and record review, the facility failed to ensure Preadmission / Screening (PAS)/Annual Resident (ARR) Mental Illness/ Intellectual Disability/ Related Conditions Identification forms (DCH-3877 and/or DCH-3878) documents were reviewed, revised, and sent to the local state agency for review and/or evaluation for intellectual/ developmental disability needs in a timely manner for two residents (R32 and R54) of seven residents reviewed for PASSARs, resulting in the potential for unmet intellectual/ developmental disability care needs. Findings include: R32 Record review of R32's electronic medical records (EMR) revealed admission into the facility on [DATE] with a pertinent diagnosis of undifferentiated schizophrenia (mental illness). Further review of Brief Interview for Mental Status (BIMs) dated 3/12/25 revealed R32 scored 0 out of 15 (severe cognitive impairment). Record review of R32's PASSAR-ARR (Annual Record Review) revealed completion on 11/21/24 at 2:47 PM. A Level II Determination (an evaluation to verify mental illness, nursing home placement, and specialized services) was not documented in R32's EMR. An interview was conducted on 7/2/25 at 11:00 AM with Social Worker (SW) A, and was reported that although Form-3877 had been submitted, Form 3878 had not been completed by the physician, which 'was causing a delay' in the process. An interview was conducted on 7/2/25 at 11:15 AM with Physician G. Physician G reported being unaware that R32's 3878 form needed to be signed. An interview was conducted on 7/2/25 at 1:15 PM with the Nursing Home Administrator (NHA). The NHA reported that it was the responsibility of both the Social Work Department and the Nursing Department to notify the physician when Form 3878 needs to be completed in the system. It was further reported that this responsibility was not carried out in a timely manner. R54 On 6/30/25 at 12:17 p.m. R54 was observed throughout the day walking independently around the facility. R54 was pleasant and calm but did not engage much with staff or other residents. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/25 at 11:38 a.m. review of the electronic medical record documented R54 was initially admitted into the facility on 3/3/23 with a recent readmission from the hospital crisis unit on 6/3/25 with diagnoses that included dementia with behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, psychotic disorder with delusions and adjustment disorder with depressed mood. According to the quarterly MDS assessment dated [DATE], R54 had severe cognitive impairment (BIMS-4) and was independent with activities of daily living. Review of the Preadmission Screening (Level I Screen, 3877) dated 2/27/24, documented the following were checked Yes: 1. Mental illness and dementia were checked for current diagnoses and received treatment. (Dementia Psychotic Disorder with delusions) 2. The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. (Seroquel) 3. There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Further record revealed there was no annual 3877 in the medical record. Review of the Mental Illness/Intellectual Disability/ Related Condition Exemption Criteria Certification (3878) dated 3/5/24, documented R54 had Dementia Exemption checked Yes: 1.Has demonstrable evidence of impairment in short-term or long-term memory as indicated by the inability to learn new information or remember three objects after five minutes, and the inability to remember past personal information or facts of common knowledge. 2. Exhibits at least one of the following: Impairment of abstract thinking, as indicated by the inability to find similarities and differences between related words, has difficulty defining words, concepts and similar tasks. -Impaired judgment, as indicated by inability to make reasonable plans to deal with interpersonal, family and job-related issues. Other disturbances of higher cortical function, i.e., aphasia, apraxia and constructional difficulty. -Personality change: altered or accentuated premorbid traits. Disturbances in items 1 or 2 above significantly interfere with work, usual activities or relationships with others. Further record revealed there was no annual 3878 in the medical record. On 7/2/25 at 11:52 a.m. SW A was interviewed about the absence of the annual 3877 and 3878 in the medical record and the person responsible to ensure they are completed timely. SW A stated, The Corporate Social Worker has been doing since I'm not full time, but the social worker is responsible for completing them. I am waiting for the physician to sign the 3878. SW A was asked to provide evidence the annual 3878 was waiting for the physician's signature and was not able to. (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 facility's policy titled Pre-admission Screening and Guest/Resident Review- PASRR Michigan dated 11/12/21 documented in part the following: The PASRR process was established in 1987, as part of the OBRA ruling, to screen all individuals admitted for nursing care to ensure that needs are met to assist the individual in reaching their highest potential. All persons seeking admission to a nursing facility, who are seriously mentally ill and/or have an intellectual/developmental disability, are required to be evaluated to determine if a nursing facility is the appropriate place to receive services . A Level 1 3877 is completed annually for all guests/residents and maintained in the electronic medical record . As of September 20,2021, all Level 1 screenings are to be electronically received and submitted.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to follow the Physician order for administering medications through a Percutaneous tube (Peg Tube), a flexible tube surgically inserted directly into the stomach through the skin of the abdomen to deliver nutrition, hydration, and medication, for one resident (R87) of twenty eight residents reviewed for medication administration, resulting in residents not receiving the full amount of their prescribed medications and water, and the potential for PEG tube malfunction due to clogging. Findings include: On 7/1/2025 at 8:26 a.m. during medication administration, Licensed Practical Nurse (LPN) H was observed at the medication cart preparing eight cups of R87's medications individually. LPN H was observed to pour water from a large cup into each cup of individually crushed medication cup without measuring the amount of water poured in each. LPN H was asked how much water would be given with each medication? LPN H said I just use ten milliliters of water with each medication. The Surveyor then observed LPN H attempt to administer R87 mediation through the peg tube without attempting to flush the peg tube. LPN H said the R87's peg tube is clogged. LPN H used an opened tubing from R87 nightstand to unclog R87's peg tube without cleaning the tubing prior to use. LPN H successfully unclogged R87 peg tube and then continued to use an unmeasured amount of water in a calibrated piston syringe to flush the peg tube afterward. LPN H was unable to provide the amount of water used in the syringe. LPN H then used ten milliliters of water to flush the peg tube and continued to administer medications. LPN H was asked how much water will be used to flush the peg tube afterward. LPN said R87 gets water already all during the shifts without giving any water flushes afterward. LPN H was observed placing the tubing back in the resident's nightstand without cleaning the tubing. LPN H was asked should the tubing be cleaned before and after use due to the package was already opened. LPN H said yes, because I didn't know where it's been before I used it and it could cause infection. On 7/1/2025 at 8:40 a.m. the surveyor interviewed LPN H at the medication cart while reviewing R87 medications. LPN H was asked was R87 med pass completed. LPN H said yes. LPN H was asked why R87 multivitamin was not administered. LPN H said the medication is not in the med cart and did not know whether it was available in the med room. LPN H stated, I will check later if it's in there I will give it later and if it's not there I can't give it. Review of the morning medications were as follows: 1- Prostat two times a day 30ml via PEG. 2- Prochlorperazine Maleate Tablet 10 MG Give 1 tablet via PEG-Tube two times a day. 3- Norvasc Oral Tablet 10 MG Give 1 tablet via PEG-Tube two times a day. 4- Amantadine HCl Oral Solution 50 MG/5ML Give 5 ml via PEG-Tube every 12 hours. 5- Keppra Oral Solution 100 MG/ML Give 5 ml via PEG-Tube every 12 hours. 6- Insulin Glargine Subcutaneous Solution Inject 35 unit subcutaneously every 12 hours. 7- Sertraline HCl Oral Tablet 50 MG Give 1 tablet via PEG-Tube one time a day.8- Losartan Potassium Oral Tablet 25 MG Give 1 tablet via PEG-Tube one time a day. 9- Metoprolol Tartrate Oral Tablet 100 MG Give 1 tablet via PEG-Tube every 12 hours. 10- . Multivitamin & Mineral Oral Liquid Give 15 ml via PEG-Tube one time a day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN H was asked should the peg tube be checked for placement and residual before administering medications. LPN H said yes, I should have checked it first. LPN H was unable to provide documentation of the resident's peg tube being checked for placement and residual amount. The physician's orders were reviewed with LPN H and asked why ten milliliters of water was given with each medication instead of at least fifteen milliliters per the physician orders. LPN H stated, I thought it was ten milliliters and that's what I been using. LPN H acknowledged fifteen milliliters per the physician order should have been given. Physician's orders revealed as follows: Enteral Feed every shift Flush Peg Tube with at least 15cc of water before and after medication administration and at least 15cc of water in between each medication active date 5/21/2025. -every shift Check resident for residual, if greater than 250cc hold tube feeding for 1 hour and recheck, if still greater than 100cc call the physician. -every shift Check Peg Tube for placement by aspirating stomach contents and patency by instilling at least 15cc of water. On 7/2/2025 at 1:09 p.m. the Director of Nursing (DON) was asked about the facility's policy for administering medications through a PEG tube and stated, The nurses are supposed to check placement by using air in the syringe before med pass and the nurse should have cleaned the tubing used to unclog the peg tubing before it was inserted because it's a risk for infection. According to the facility's 10/17/2023 Medication Administration policy: Physician's orders- medication is administered in accordance with written orders of the attending physician.

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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** Based on observation, interview and record review the facility failed to ensure respiratory care equipment was stored in a sanitary manner for one resident (R8) out of four residents reviewed for storage of respiratory equipment, resulting in the potential for a decline in of respiratory health. Findings include: On 6/30/25 at 10:48 A.M., R8 was observed in the resident's room. On the resident's bedside tables a CPAP machine (a continuous positive airway pressure device used for treating sleep apnea disorders), face mask and assorted tubing were observed among the resident's personal care items. The resident's face mask was uncovered positioned on the table among the assorted, used/unused tubing, one gallon container of open, undated sterile water and plastic covers. R8's visitor who interjected during the observation stated, They leave that mask and oxygen tubing like that, its not clean. R8 stated, I am supposed to use it twice a day, but they take it off and just throw it there. Throughout the interview and observation R8 indicated when her favorite nurse returned from vacation, he would clean off the table and put the mask and other equipment like it should be. On 7/1/2025 at 8:34 A.M. during an observation R8's CPAP machine, face mask and tubing was stored among used paper towels/napkins, personal care items, and an opened gallon container of water the face mask was uncovered and stored on top of the used paper towels/napkins. On 7/2/25 at 1:12 P.m. while checking the filter of the oxygen canister with nurse E the nurse was made aware of the storage of the resident's respiratory equipment. Nurse E acknowledged the equipment was not stored properly and the face mask should not be left in the manner observed. Review of the Physician Orders dated 10/23/24 documented: BiPAP 14/5 5 Liters oxygen 02 @ HS (bedtime) and naps once a day. Review of the Physician Orders and care plans did not identify any method, frequency of cleaning, or storage of the respiratory equipment. Review of the Care Plan documented: R8 has a potential, SOB and risk for respiratory complications R/T h/o respiratory failure, COPD, Obstructive Sleep Apnea. Interventions .Administer medication and treatment per physician order .provide supplemental oxygen via nasal cannula to maintain oxygen saturation greater than 92% PRN, BPAP at night. Review of the clinical record documented R8 was readmitted to the facility on [DATE], with pertinent diagnoses: chronic obstructive pulmonary disease, chronic respiratory failure, obstructive sleep apnea and dependence on supplemental oxygen. According to the Minimum Data Set (MDS) dated [DATE], R8 had a BIMS (Brief Interview for Mental Status of 14, was cognitively intact, required one to two person assist for Activities of Daily Living (ADL'S) and was always incontinent of bowel and bladder. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy was requested and provided, referenced: AARC Clinical Practice Guidelines Policy 1:8 was provided, titled: Small volume nebulizer (SVN) Handheld Nebulizer: After treatment rinse equipment with tap water and dry. Place in storage bag that is labeled with resident's name, and the date equipment was issued (do not seal damp equipment in a plastic bag).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure routine dental services were provided to one resident (R16) of one resident reviewed for routine dental services, resulting in unmet oral health needs and discomfort. Findings include: On 6/30/25 at 12:00 p.m. R16 was observed in the room, sitting at the bedside. R16 presented as alert and oriented to person, place, situation, and makes all needs known verbally. During the resident interview, R16 had a complaint about mouth discomfort due to teeth pain and needed to see a dentist. R16 asked staff to see the dentist and has waited for quite some time now. R16 was edentulous apart from a few back teeth. The resident opened the mouth, and the back teeth were discolored. The gums appeared swollen and red. R16 stated, There's certain things I like to eat but can't, so I eat soft things like Jello and mash potatoes. I am tired of it. R16 said the dentist removed most of the top teeth months ago but has not come back to remove the rest for unknown reasons. Review of the electronic medical record documented R16 was admitted into the facility on 7/20/23 with diagnoses that included seizures, obesity, benign prostatic hyperplasia without lower urinary tract symptoms, dysarthria and anarthria, major depressive disorder, and hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. According to the annual Minimum Data Set (MDS) dated [DATE], R16 was cognitively intact (BIMS-14) and required assistance activities with daily living. The MDS also documented mouth or facial pain, discomfort or difficulty with chewing. Review of the physician order, dated 1/24/25 documented: Consult to dentist. The dental care plan was not in the medical record or available for review. Review of the social service progress notes documented in part the following: 1/21/2025- Social Services Note: SW informed by unit medical records that resident's insurance only covers oral surgery at (named dental office), requires (named in-house dental company) to fax referral directly to them. SW informed dental company who stated they would send referral. Writer was notified that referral was sent and medical records can schedule an appointment. SW provided medical records with contact to schedule appointment . SW will continue to assist as needed. 1/15/2025- Social Services Note: SW sent referral to dental company for an emergency dental visit. Dentist scheduled to come to facility 2/4/25. Resident states he is having tooth pain. Referral for emergency dentist sent to np. SW will continue to assist as needed. Review of the Emergency Dental Care Request dated 1/10/25 documented in part the reason for the referral was for right sided facial swelling and right upper tooth pain with visible decay . Issues with teeth and gums to top right . Evidence of pain (constant) . Swelling of the face (signs of infection). Antibiotic and pain medication was prescribed . Review of the following dental consult dated 2/4/25, documented in part the following: (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/4/2025- Doctors note summary: room visit, teeth, 15 and 16 are now hurting him, add those to the refer to be extracted by outside dentist. Next visit plan: exam, possibly future partial denture when teeth are extracted. Next visit: dental recall based on pay source frequency . 2/4/2025- X-rays not taken. X-rays were not taken because the resident was seen in their room. Recommend the resident be taken to the dental clinic on their next visit. Review of the nurse progress notes dated 3/14/25 documented in part: .dental services on 3/4/25. There was no record of the dental service provided to R16. On 7/2/25 at 11:27 p.m. Medical Records Clerk B was interviewed and asked the reason R16 has not had a follow up dental appointment for teeth pain in four months of the last referral. Medical Records Clerk said the dental appointment for March did not occur due to the dental company that services the facility needed to send a referral to the only dental office that would accommodate the resident which did not have any available appointments due to having a backlog. Medical Records Clerk B also said the one specific dental office was the only office that could accommodate the resident's wheelchair. The last call to the dental office was at the end of March. There have been no recent inquiries. On 7/2/25 at 11:45 a.m. the dental company that provides in house dental services, Care Coordinator D was contacted via telephone and stated, We provide referrals to any dental office. We don't refer to just one office. Residents can go to any dental office. On 7/2/25 at 12:00 p.m. Social Worker (SW) A was interviewed. SW A and stated, We usually use the one dental office because they accept Medicaid insurance. We have tried other places, but the resident would have to pay out of pocket. SW A was asked how they were notified when residents need dental services. SW A stated, I don't know when residents need dental services unless the MDS department tells me after they do their assessment. On 7/2/25 at 12:10 p.m. the Nursing Home Administrator (NHA) and Medical Records Clerk B was interviewed. Medical Records Clerk B was asked was R16 referred to another dental office that would see the resident immediately contacted. Medical Records Clerk B said another dentist office was called but the resident was not seen because the resident did not have the money to pay for services. The NHA stated immediately, If I would have known the resident needed to be seen, the facility would have paid for it. Review of the facility's policy titled Dental Services dated 10/25/23 documented in part the following: The facility will provide, or obtain from an outside resource, routine and twenty-four (24) hour emergency dental to meet the needs of the resident and when requested by the resident. The facility will assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the state plan . Follow up visits will be scheduled as needed.