STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235506	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelby Health and Rehabilitation Center	46100 Schoenherr Rd Shelby Township, MI 48315

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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 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** 44750 Based on interview and record review, the facility failed to obtain a physician's order for an advance directive (form designed to communicate health care treatments in advance) upon admission for one resident (R106) out of two reviewed for advance directives. Findings include: A review of the medical record revealed R106 admitted into the facility on [DATE] with the following medical diagnoses, Cerebral Infarction and End Stage Renal Disease. A review of the most recent Minimum Data Assessment set revealed a Brief Interview for Mental Status score of 8/15 indicating an impaired cognition. R106 also required staff assistance with bed mobility and transfers. Further review of the physician orders revealed there was no advance directive order in place. On 3/5/2025 at 9:15 AM, an interview was conducted with Social Worker (SW) J. SW J stated the admitting nurse puts the code status order in on admission and that social work reviews it at the care conference. SW J stated that the nursing staff is responsible for putting the advance directive orders in and confirming them. On 3/5/2025 at 12:03 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the advance directive order should be entered upon admission. The DON stated they were unaware of why it was not completed with R106. A review of a facility policy titled, Advance Directives-Code Status revealed the following, .If the resident and/or their legal representative has chosen for the resident's code status to be a Full Code: o The physician's order for Full Code status will be entered into Point Click Care (PCC) using the template in the order's tab. From the physician order the resident's Full Code status will auto-populate and be prominently displayed on the resident's chart header in PCC and will also populate to the resident's face sheet.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49102 Based on observation, interview and record review, the facility failed to complete an annual PASARR (Preadmission Screen and Resident Review) for one resident (R121) of two residents reviewed for PASARR screening. Findings include: On 03/03/25 at 09:45 AM, R121 was observed lying in bed finishing his breakfast meal. A review of R121's medical record revealed they were admitted into the facility on [DATE] with the following diagnoses of vascular dementia, major depressive disorder, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and dysphagia. A Minimum Data Set (MDS) assessment dated [DATE] and a Brief Interview for Mental Status (BIMS) score of 12, indicating an mild impairment with cognition. R121 also scored 9 on The Patient Health Questionnaire which indicates severe depression. Further review of R121 medical record revealed a PASARR dated 10/8/23. On 03/05/25 at 12:15 PM an interview occurred with Social Worker C regarding an updated PASARR for R121. Social Worker C confirmed there was not an updated PASARR completed and confirmed PASARR should be updated annually. A request for a facility policy related to PASARRs was requested and not received by the end of survey.

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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** 49102 Based on interview and record review, facility failed to ensure comprehensive care plans were developed and updated for two (R51 and R89) of six resident reviewed care plans. Findings include: R51 A review of R51's medical record revealed they were admitted to the facility on [DATE] with diagnoses including mild dementia, generalized anxiety disorder, adjustment disorder and hypertensive heart disease. A review of R51's Minimum Data Set assessment dated [DATE] revealed the Brief Interview for Mental Status score of 15 indicating an intact cognition. Further review of R51's medical record revealed increased behaviors of refusal of care and assistance. Per a nursing progress note dated 2/07/25, R51 had a behavior of speaking loudly to the roommate and being upset about a window being open. The medical record indicated R51 refused bathing and assistance at least weekly during the month of February 2025. Review of the behavioral care plan initated 7/9/24 with interventions revealed there was no review or updated interventions for increased behaviors noted on February, 2025. On 03/05/25 at 12:15 PM, Social Worker C was interviewed regarding R51's care plan and interventions for the increased behaviors and refusal of care. Social Worker C said resident care plans are updated by the interdisciplinary team and confirmed there were no updates added to the care plan to address recent behaviors. 50223 R89 On 3/03/25 at 10:45 AM R89 was observed lying in bed. R89 explained they get nutrition by tube feeding and they cannot have any food or water by mouth. R89 explained they only get out of bed into a chair when therapy is present and they are supposed to have hand splints but, no one applies them. A review of R89s record revealed they were admitted to the facility on [DATE] for Unspecified injury at unspecified level of cervical spinal cord. Further review revealed a Brief Interview for Mental Status Score of 15, indicating intact cognition. A review of R89's care plan revealed the following: Resident is NPO (nothing by mouth) with all nutrition and hydration provided via feeding tube dysphagia, bolus of Novasource renal. Dated 12/23/24 Encourage low fat, low salt intake. Dated 12/31/24 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monitor fluid intake to determine if natural diuretics such as coffee, tea, or cola is contributing to increased urination and incontinence. Dated 12/31/24 Resident is not able to use B/L UE/LE (bilateral upper extremeties/lower extremeties) due to paralysis.Dated 12/27/24 locomotion: gerichair (assistive device) with 1 person physical assist, with gait belt. Dated 12/21/24 Transfer: hoyer x2, cervical collar on at all times, cervical precautions. Dated 12/21/24 Bed mobility:x2, cervical collar on at all times cervical precautions. Dated 12/21/24 Assist resident with ADLs (activities of daily living) and ambulation as needed. Dated 12/31/24 Orthotics: (B) resting hand splints to be worn during the day. Remove & assess skin integrity and skin hygiene. 1/9/25 Restorative splint/brace1-B resting hand splints, to be worn at night as tolerated, remove for hygiene/skin checks. Dated 1/15/25 orthosis: neck brace to be worn at all times. Dated 1/15/25 A review of R89's physician orders revealed the following active orders: Enteral feed five times a day Enteral Nutrition Formula Name: TWOCAL HN 1 can (237ml) five times a day. Flush with 50ml water pre and post. dated 1/28/25. Orthosis/Splint to be applied to:B resting hand splints to be worn at night, as tolerated. Every shift on in the evening. Dated 1/15/25 On 3/04/25 at 3:12 PM, the Therapy Director (Staff K) reviewed R89's careplan when asked if R89 should be wearing a neck brace or hand splints. Staff K explained R89 was admitted on paraplegic cervical precautions and the neck brace was discontinued after R89's three month post operative doctor appointment around the 1st week of February. Staff K confirmed that the neck brace was still on the care plan and that it should have been removed. Staff K explained that R89 should be wearing hand splints during the day but explained they would have to get clarification due to conflicting information on the care plan. On 3/05/25 at 10:31 AM, the Director of Nursing (DON) explained careplans are a collaborative effort among the interdisciplinary team and they are created on admission and then they are updated in the morning meeting if there is a change. R89's care plan was reviewed with the DON and the DON confirmed R89's care plan was not updated nor did it reflect R89's current condition. A facility policy addressing careplans was requested and was not returned by the completion of the survey.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to provide sufficient feeding assistance for one resident (R142) out of one reviewed for Activities of Daily Living (ADL). Findings include: On 3/3/2025 at 12:07 PM, R142's lunch tray was observed sitting on the bedside table. R142 stated they were hungry but waiting for someone to help them eat. R142 stated they were visually impaired and needed feeding assistance. On 3/3/2025 at 12:14, 12:21 and 12:28 PM, R142's tray was still observed sitting on the bedside table, untouched. On 3/3/2025 at 12:31 PM, Physical Therapy was observed entering R142's room and mentioning R142 had not eaten lunch yet. R142 was heard stating they were still waiting for feeding assistance. On 3/3/2025 at 2:30 PM, R142 stated someone did come and help them eat, but the food was cold so they did not eat much. A review of the medial record revealed R142 admitted into the facility on [DATE] with the following diagnoses, Cerebral Infarction and Dysphagia. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 10/15 indicating an impaired cognition. R142 also required staff assistance with bed mobility and transfers. Further review of the physician orders revealed R142 was supposed to be a 1:1 feeding assist and were in a trial period. On 3/5/2025 at 8:45 AM, R142's breakfast tray was observed sitting beside their bed. R142 stated they were waiting for somebody to come back because they wanted more French toast. R142 stated they did not know how long they had been waiting for someone to come back, but it had been a while, and they were hungry. On 3/5/2025 at 9:00 AM, R142's breakfast tray was still observed in the room. R142 stated they were still waiting on assistance to finish their breakfast, and they were still hungry. On 3/5/2025 at 9:01 AM, Registered Nurse (RN) E was informed R142 was waiting for someone to help them finish breakfast. RN E stated someone was in there helping and they would go and see if R142 was still hungry. R142 was heard informing RN E that they were still hungry and needed further assistance. On 3/5/2025 at 9:20 AM, Registered Dietitian (RD) R. RD R stated R142 is a 1:1 feed because they are visually impaired. RD R stated R142 should continue to be a 1:1 feed because they just discontinued their tube feeding and should be encouraged to eat on a consistent basis. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/2025 at 12:06 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the staff should leave the tray on the cart until staff is ready to go in the room and provide feeding assistance. The DON stated they expect for staff to stay with the resident until they are done assisting the resident. A review of a facility policy titled, Assistance with meals noted the following, .It is the Center's Policy that all patient/residents shall receive assistance with meals in a manner that meets their individual needs and per Plan of Care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 Based on observation, interview, and record review, the facility failed to apply a hand splint as ordered for one resident (R89) of two residents reviewed for range of motion. Findings include: On 3/03/25 at 9:25 AM, R89 was observed lying in bed with arms folded and both hands on their chest. Two hand splints were observed on top of the dresser across the room. O3/03/25 at 10:45 AM, R89 was observed still lying in bed with their hands and arms still in the same position. Two hand splints were still observed to be on the dresser across the room. R89 explained they cannot use their arms or hands. R89 demonstrated attempting to move their right arm and was observed to lift it about 2 inches off of their chest and was unable to move their fingers. R89 explained when they were first admitted they were able to move their arms and hands more than they can now and stated, but due to neglect, now they are like concrete. When R89 was asked if they are supposed to wear the hand splints on the dresser R89 explained that they are supposed to but that no one ever puts them on. On 3/04/25 at 3:03 PM, R89 was observed lying in bed with arms folded and their hands on their chest. Two hand splints were observed on the dresser across the room in the same place and position as previously observed. On 3/05/25 at 8:34 AM, R89 was observed lying in bed with their arms folded and their hands on their chest. Two hand splints were observed on top of the dresser across the room in the same place and position as previously observed the day prior. When asked if anyone had put the splints on R89's hands overnight R89 explained that no one had put them on and that they never do. A review of R89s record revealed they were admitted to the facility on [DATE] for Unspecified injury at unspecified level of cervical spinal cord. Further review revealed a Brief Interview for Mental Status Score of 15, indicating intact cognition. A review of R89's physician orders revealed the following active order: Orthosis/Splint to be applied to: B (both) resting hand splints to be worn at night, as tolerated. Every shift on in the evening off in the morning. Dated 1/15/25 A review of R89's care plan revealed the following: Orthotics: (B) resting hand splints to be worn during the day. Remove & assess skin integrity and skin hygiene. 1/9/25 Restorative splint/brace1-B resting hand splints, to be worn at night as tolerated, remove for hygiene/skin checks. Dated 1/15/25 On 3/05/25 at 8:22 AM, Licensed Practical Nurse (LPN) J explained R89 reported to them that R89's hands are stiffening up because therapy refuses to help and they do not know if R89 has hand splints. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/05/25 at 8:31 AM, Certified Nurse Assistant (CNA) M explained R89 is paralyzed and did not know if R89 had hand splints. On 3/04/25 at 3:12 PM, Therapy Director (Staff K) explained R89 was admitted to the facility as a paraplegic with cervical precautions. Staff K explained Occupational therapy was working with R89 from 12/24-1/29 and was doing range of motion for all joints. On 3/5/25 at 9:11 AM, staff K confirmed R89 is supposed to have hand splints on and explained the splints should be applied at night by the nursing staff since the restorative aides are not here at night. On 3/5/25 at 11:58 AM, restorative Certified Nurse Assistant (CNA) N explained R89 wears hand splints at night. On 3/05/25 at 10:31 AM, the Director of Nursing (DON) explained if a resident has hand splints ordered they should be applied and it is a collaborative effort between nursing and therapy. A review of the facility's policy titled Medical Device-Internal and External revealed the following: It is the policy of the facility to accommodate residents who have internal and external medical devices that are within the staff members scope of practice.

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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** 44750 Based on interview and record review, the facility failed to complete an initial Abnormal Involuntary Movement Scale (AIMS) assessment for one resident (R146) out of one reviewed for antipsychotic medication use. Findings include: A review of the medical record revealed that R146 admitted into the facility on [DATE] with the following diagnoses, Alzheimer's Disease and Brief Psychotic Disorder. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental status score of 99, indicating R146 was unable to complete assessment and required staff assistance with bed mobility and transfers. Further review of the physician's orders revealed R146 was prescribed Seroquel (Antipsychotic) once daily. Further review of R146's assessments on 3/4/2025 did not reveal an AIMS assessment to detect abnormal movements across the face, lips, tongue, upper extremities, lower extremeities and trunk caused by antipsychotics. On 3/5/2025 at 12:05 PM, an interview was completed with the Director of Nursing (DON). The DON stated the nursing staff should complete an AIMS assessment quarterly whether the resident is being followed by psychiatry or not, if they see the resident is on an antipsychotic. A request for a facility policy related to antipsychotics was requested and not received by the end of survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled for two residents (R51 and R78) of ten residents reviewed, three of thirteen medication carts. Findings include: R78 On 3/3/25 at 1:30 PM, an observation was made of a medicine cup filled with a red liquid on R78's dresser. R78 was interviewed and asked about the medicine cup on their dresser and stated, I think it's cough medicine. R78 was asked if they self-administered their medication and said nursing administered their medications to them. On 3/3/25 at 1:35 PM, Unit Nurse Manager, Licensed Practical Nurse (LPN) I was requested to come to R78's room and was shown the medicine cup on R78's dresser and asked about it. LPN I indicated the medicine cup contained a protein supplement and removed the medicine cup from R78's dresser and discarded it. A review of R78's electronic medical record (EMR) indicated the following physician's order, Start date: 1/22/25; End date: 3/5/25. Order: House Liquid Protein Source One time a day for Protein assistance. Further review of R78's EMR revealed R78 was most recently admitted to the facility on [DATE] with diagnoses that included, Sepsis (Infection) and Paroxysmal atrial fibrillation (Irregular Heartbeat). R78's most recent minimum data set assessment dated [DATE] revealed R78 had a moderately impaired cognition and was fully dependent and/or required maximum assistance for all activities of daily living (ADLs) other than toileting and eating. 49102 R51 On 03/03/25 at 9:25 AM, R51 was observed sitting up in bed finishing their breakfast tray. A bottle of Vitamin C and a bottle of Vitamin B-12 were observed sitting on the night stand. When asked about the bottles, R51 stated, Those are my bottles, I take one of each pill every day. On 03/04/25 at 1:15 PM, R51 was observed sitting up in the bed watching television. The same bottles of Vitamin C and Vitamin B-12 was observed on the nightstand. A review of R51's medical record revealed they were admitted to the facility on [DATE] with diagnoses including mild dementia, generalized anxiety disorder, adjustment disorder and hypertensive heart disease. A review of R51's Minimum Data Set, dated dated dated [DATE] revealed the Brief Interview for Mental Status score of 15 indicating intact cognition. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/25 at 1:18 PM, the Director of Nursing (DON) was asked to accompany surveyor to R51's room. Upon entering R51's room, the DON noted the two bottles of vitamins on the bedside table. The DON stated R51 has not been assessed for self administration of medications and should not have medications at the bedside. 49699 On 03/04/25 at 02:10 PM, during a review of the low numbered medication cart with Licensed Practical Nurse (LPN) A, on Unit 100, a narcotic (Norco) tablet was found in a medicine cup, partially dissolved. LPN A revealed they had given a resident the narcotic with they're other medication and the resident spit it out. LPN A explained they were waiting for a second nurse to dispose of the medication appropriately. On 03/04/25 at 02:35 PM, during review of the high numbered medication cart for unit 300 with LPN F, A KwikPen Humalog insulin pen was noted without a label or date. LPN F indicated the KwikPen should have a label and date. On 3/4/2025 at 03:00 PM, review of medication storage and labeling for Unit 400 medication , low number cart with LPN B, two KwikPen Humalog insulin were found without identifying label or open date. On 03/04/2025 at 2:30 PM, an interview with the Director of Nursing (DON) revealed that wasted narcotics are to be wasted in the container that renders the medication harmless, at the time the medication is not going to be used after removing from the medication cart. The DON revealed this process requires two licensed nurses. On 3/5/25 at 11:04 AM, the Administrator (NHA) was interviewed regarding their expectations for medication storage and labeling. The NHA indicated that all medications should be stored safely. A review of a facility policy titled, Medication and Treatment Storage Issued Date: 8/7/2023 revealed the following, Policy Overview: It is the policy of this facility to ensure accurate labeling and dating of medications for safe administration and safe secure storage .of all medications and treatments. Labeling of medications and biologicals dispensed by the pharmacy will be consistent with applicable federal and State requirements and currently accepted pharmaceutical principles and practices including expiration dates . Medications designed for multiple administration, the label will identify the specific resident for who it was prescribed. Multi-use vials will be dated when the vial is first accessed. All medications requiring refrigeration are stored in refrigerators in the medication room .logs are kept on each refrigerator and temperature levels are recorded daily .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to honor food preferences for one resident (R142) out of one reviewed for food. Findings include: On 3/3/2025 at 12:28 PM, R142's lunch tray was noted to be sitting on their bedside table. A review of their dietary ticket had dislikes-no cucumbers with it highlighted in a pink color. An observation of the side salad revealed cucumbers on the salad. R142 stated they do not like cucumbers, and the kitchen staff often put them on even though they've said they do not want them. A review of the medical record revealed R142 admitted into the facility on [DATE] with the following diagnoses, Cerebral Infarction and Dysphagia. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 10/15 indicating an impaired cognition. R142 also required staff assistance with bed mobility and transfers. On 3/5/2025 at 9:43 AM, an interview was conducted with Dietary Manager (DM) Q. DM Q stated the dietary staff should read the tray ticket, and they highlight it to make sure it is seen. DM Q stated that floor staff should also be checking before they give the resident the tray. A review of a facility policy titled Food Preferences and Select Menus noted the following, The facility will provide meals that accommodate resident allergies, intolerances, and food preferences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235506	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelby Health and Rehabilitation Center	46100 Schoenherr Rd Shelby Township, MI 48315

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to stock, demonstrate sufficient Infection Control practices, and don/doff (put on/take off) Personal Protective Equipment (PPE- gown, gloves, and masks) for three residents (R141, R17 and R106) in isolation and precautions out of three reviewed for Infection Control (IC). Findings include: R141 On 3/3/2025 at 11:57 AM, R141's call light was activated, and their intravenous (IV) machine was heard beeping. R141 had a PPE caddy on their door, with a sign stating they were on contact isolation (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident ' s environment) and should don gloves, mask, and gloves when entering room. On 3/3/2025 at 12:01 PM, a nurse was observed entering R141's room without putting on any PPE. The nurse was then observed to silence the IV machine, come back out and grab supplies to disconnect the IV machine from R141. The nurse was then observed to reenter R141's room without putting on PPE and disconnected R141's IV machine from the resident only donning gloves. A review of the medical record revealed R141 admitted into the facility on [DATE] with the following medical diagnoses, Osteomyelitis, Left Ankle and Foot. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 3/15 indicating an impaired cognition. R141 also required staff assistance with bed mobility and transfers. On 3/5/2025 at 11:30 AM, an interview was completed with Infection Control Preventionist (ICP) D. ICP D stated their expectation of staff entering a contact isolation room is that they don all appropriate PPE and stated the signs on the door clearly list what they should be putting on prior to entering the room and performing care. ICP D confirmed the nurse that entered R141 should have put on all appropriate PPE needed for contact precaution, including a gown, prior to disconnecting their IV. 38207 R17 On 3/3/25 at 10:53 AM, an observation of R17's room revealed signage which indicated R17 was on EBP (Enhanced Barrier Percautions -set of infection control practices). A PPE caddy (storage unit for PPE) on R17's door was observed to contain no gloves or face masks. On 3/4/25 at 11:00 AM and 3:52 PM, R17's caddy was observed to contain no face masks. On 3/4/25 at 3:56 PM, R17 and confidential family member S were interviewed and asked if staff consistently wore PPE when providing care for R17. R17 and family member S stated, I don't think so. On 3/5/25 at 9:38 AM, R17's caddy was observed to contain no gowns or face masks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/5/25 at 11:47 AM, ICP D was interviewed about their expectations for PPE which should be available in the door caddy of residents on EBP. ICP D indicated that the caddy should be fully stocked with gloves, gowns, and face masks. ICP D indicated the nurses on the units should be replacing the PPE in the caddy as needed. A review of R17's EMR revealed that R17 was most recently admitted to the facility on [DATE] with diagnoses that included Kidney failure and Post traumatic stress disorder (PTSD) (Mental health condition). R17's Nursing Admission Evaluation completed on 2/26/25 revealed that R17 had an intact cognition and required assistance for all activities of daily living (ADL's) including catheter care. 49699 R106 On 03/20/2025 at 07:35 AM, Licensed Practical Nurse (LPN) B retrieved the glucometer tray from medication carts bottom drawer and entered R106's room that had a PPE [NAME] on the door with a sign specifying what PPE to don (gown, gloves, and mask) for the room. LPN B was observed to place glucometer tray and blood pressure cuff on R106's bed without a barrier, hand hygiene was not performed, PPE was not used. LPN B was not satisfied with the reading obtained for R106's blood pressure and left the room to obtain a wrist blood pressure machine. No hand hygiene performed. Upon completion of these tasks LPN B took the equipment and left R106's room. Hand hygiene was not performed. Blood pressure equipment was returned to nursing station, the glucometer tray replaced in medication cart without cleaning. No hand hygiene was performed upon leaving R106's room. On 3/4/2025 at 2:00 PM, LPN B was asked what the cleaning protocol was for the glucometer and blood pressure cuffs. LPN B stated the glucometer tray, the glucometer, and the blood pressure cuffs were supposed to be cleaned with bleach wipes. The Equipment cleaning policy was requested but not received by end of survey.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for six residents (R1, R15, R41, R53, R78, and R110) of six residents reviewed for call light accessibility. Findings include: Resident R1 On 3/3/25 at 11:15 AM, R1's call light was observed on their wheelchair out of reach. An interview was conducted with R1 and confidential family member O and they were asked about the call light being out of reach. Family member O confirmed that [R1's] call light had been observed to be out of reach on multiple occasions when they had visited them. A review of R1's electronic medical record (EMR) revealed that R1 was most recently admitted to the facility on [DATE] with diagnoses that included Cellulitis (Bacterial skin infection) of left lower leg and Heart failure. R1's most recent minimum data set assessment (MDS) dated [DATE] revealed that R1 had a moderately impaired cognition and was dependent and/or required maximum assistance for all activities of daily living (ADLs) other than eating. R78 On 3/4/25 at 4:35 PM, R78's call light was unable to be located in their room. R78 was interviewed regarding the location of their call light and did not know where their call light was located. Upon further observation, R78's call light was located in a shut dresser drawer out of reach and sight. A review of R78's EMR revealed that R78 was most recently admitted to the facility on [DATE] with diagnoses that included, Sepsis (Infection) and Paroxysmal atrial fibrillation (Irregular Heartbeat). R78's most recent minimum data set assessment dated [DATE] revealed that R78 had a moderately impaired cognition and was fully dependent and/or required maximum assistance for all activities of daily living (ADLs) other than toileting and eating. R110 On 3/5/25 at 10:22 AM, R110 was observed in bed with their call light hanging underneath their bed on the floor out of reach and sight. On 3/5/25 at 10:30 AM, Nurse/LPN (Licensed Practical Nurse) P was interviewed and asked what their expectations were for call light accessibility in residents' rooms. Nurse P stated, The call light should be in reach of the resident. A review of R110's EMR revealed that R110 was most recently admitted to the facility on [DATE] with diagnoses that included Epilepsy (Brain Disorder) and Asthma (Inflamed Airways). R110's Nursing Admission Assessment (NAA) dated 2/27/25 revealed that R110 had a moderately impaired cognition and required assistance for all ADLs. 49699 (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15 At 03/03/25 at 09:28 AM, R15 was noted sitting in a wheelchair, on the window side at the foot of bed, with call light located at top of the bed just below the pillow. When queried whether R15 could get to the light, R15 indicated it is real hard because the room is tight in this area (foot of bed on window side of bed). On 03/03/25 at 09:28 AM R15 was facing the window in a wheelchair, consuming thier lunch from the overbed table. There was not room for R15 to turn the wheelchair around in order to access the call light located on the opposite side of the bed up near the pillow. On 3/4/2025 a review of the Electronic Medical Record (EMR) revealed R15 was admitted on [DATE] with diagnoses of Alzheimer's Disease, Anxiety, and Cardiac Disease. The EMR further revealed a Basic Inventory of Medical Status score of 13, indicating intact cognition. R41 On 03/03/25 at 09:17 AM, R41's call light was out of reach, secured on the night stand's top drawer handle. R41 was looking for it. When R41 saw it, they were unable to reach it. On 03/03/25 at 01:07 PM, R41's call light was attached to the night stand's top drawer handle out of reach. On 03/04/25 at 11:08 AM, R41's call light was noted to be woven between two pillows against the head of the bed. When R41 was queried regarding the location of their call light they began to look for it and was unable to find it becoming frustrated. A review of the EMR revealed R41 was admitted on [DATE] with diagnoses of Urinary Tract Infection, Cervical Disc Disorder with Myelopathy, and Anxiety. The EMR further revealed a BIMS score of 14 indicating intact cognition. R53 On 03/03/25 at 10:23 AM, R53 was sitting in their wheelchair. Call light was noted on opposite of bed from resident. R53 was asked where the call light was and was unable to locate it. A review of the EMR revealed R53 was admitted on [DATE] with a diagnoses of Diabetes, Type 2 Dementia, Mood Disorder and Anxiety. The EMR further revealed a BIMS score of 03 indicating severe impaired cognition. On 3/5/25 at 11:04 AM, the Administrator (NHA) was interviewed regarding call light accessibility for the residents. The NHA indicated the call light should be within reach of the resident. A facility policy titled Call Light Accessibility and Timely Response, Issued Date: 8/16/2023 was reviewed and revealed the following, Policy Overview: The purpose of this policy is to assure that the facility is adequately equipped with a call light at each residents' bedside .to allow residents to call for assistance. Staff will ensure that call lights are within reach of residents' .The call system will be accessible to residents in their room at bedside .