STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235516	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivergate Terrace	14141 Pennsylvania Riverview, MI 48193

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview, and record review the facility failed to provide wheelchair footrests for two residents (R86 and R93) of 18 residents reviewed for accommodation of needs, resulting in the potential for injury to the lower extremities. Findings include: R93 On 2/24/25 at 9:30 A.M. during an observation and interview with Resident's family member Z (who was the resident's responsible party) complained the facility had given R93 a wheelchair without footrest. Family Member Z explained at home R93's primary caretaker and upon discharge no way could R93 be transported through the house without footrests on the wheelchair. On 2/25/at 2:30 P.M. R93 was observed being transported to therapy. R93's wheelchair did not have foot rests applied. R93's Family Member Z gestured while passing, pointing to R93's feet and stated, No footrests. Review of the clinical record for R93 revealed the resident was readmitted to the facility on [DATE] with diagnoses of dementia without behavioral disturbance, psychotic disturbance, sepsis and anxiety. According to the Minimum Data Set, dated dated dated [DATE], (R93) was moderately impaired in cognition and was totally dependent on staff for ambulation and transfer. R93 was wheelchair dependent and unable to propel himself. R86 On 2/25/25 at 12:30 P.M. during a lunch observation, R86 was observed being taken to the dining room in a wheelchair. An unidentified nurse aide directed R86 to lift both feet as the aide periodically stopped and cued R86 to, keep your feet up. Upon entering the dining room, R86 was told to lift both feet again to assist the aide in moving across an inclined area of the floor. R86 who had a BIMs (Brief Interview for mental score) of 12 (moderately impaired) in cognition, was interviewed concerning the missing footrests. The resident indicated not knowing what happened to the footrests and could not say the last time the footrests were used on the wheelchair. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Minimum Data Set, dated dated dated [DATE], R86 was admitted to the facility on [DATE], with diagnoses of epilepsy, diabetes mellitus, muscle weakness and contracture's. R86 was wheelchair dependent. On 2/26/25 at 10:00 A.M. during an interview with anonymous staff member A concerning the availability of footrests for the residents' wheelchairs, stated, We don't have enough footrests for all the residents with wheelchairs. This has been a concern since June 2024. The resident's footrests should be in their rooms in a bag, but we just do not have enough. On 2/26/25 at 1:00 p.m. R86's closet was checked for footrests for the resident's wheelchair. No footrests were found in the closet or room for R86 or R93. On 2/26/25 at 1:20 p.m. the Director of Nursing was interviewed concerning the footrests for resident wheelchairs and indicated further investigation would be needed. On 2/26/25 at 1:25 p.m. in a follow up interview, the Administrator acknowledged the facility did not have a policy specifically addressing footrests. A policy titled Preventative Maintenance -Wheelchair was provided with a revised date of 1/11/23 and reviewed 1/29/25. This policy did not address the availability of footrests but rather the maintenance of wheelchairs.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50634 Based on observation, interview, and record review the facility failed to properly secure protected health information for one resident (R128) of 26 reviewed for privacy, resulting in the potential for unauthorized disclosure and access. Findings include: On 2/25/25 at 10:59 AM, a computer on a medication cart on the Blue unit was observed opened to R128's Electronic Medical Record, (EMR). Whle observing the computer screen for approximately five minutes there were several residents and other staff down the hallway with the open computer. The Unit Manager, (UM) K exited their office with the Assistant Director of Nursing, (ADON) C and stopped when they obsserved the surveyor looking at the resident's information on the computer screen. UM K walked over to the computer and closed the screen. UM K was queried about what was on the computer screen. UM K acknowledged R128's medical record was open and anyone walking by could see it. On 2/2/6/25 at 10:35 AM, the Director of Nursing, (DON) was interviewed and said leaving a computer open with a resident's information visible to the public is a violation of HIPPA. Record review documentated R128 was admitted to the facility on [DATE]. R128's pertinent diagnosis were Memory Deficit following Cerebral Infarction (stroke), Cognitive Communication Deficit, Generalized Anxiety, Major Depressive Disorder, Epilepsy and Repeated Falls. R128's Minimum Data Set, (MDS) Admission assessment performed on 12/9/24 for Brief Interview for Mental Status was cognitively intact at (13/15).

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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 - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230 Based on interview and record review the facility failed to ensure upon admission and annually the Preadmission Screening (PAS)/ Annual Resident (ARR) Mental Illness/ Intellectual Disability/ Related Conditions Identification forms DCH-3877 and DCH-3878 documents were reviewed, revised, and sent to the local state agency for review and/or evaluation for mental illness and dementia needs in a timely manner for four residents (R22, R52, R175, and R190) of five reviewed for PASSARs, resulting in the potential for residents not to receive care and services appropriate to their mental health and dementia care needs. Findings include: R22- On 2/24/25 at 1:28 p.m. review of the clinical record documented R22 was initially admitted into the facility on [DATE] with diagnoses that included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, major depressive disorder, epilepsy, and adjustment disorder with anxiety. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R22 had severe cognitive impairment (BIMS= 3), and required supervision for most activities of daily living. Review of the Preadmission Screening (Level I Screen, 3877) dated 4/13/24, documented the following were checked Yes: 1. Mental illness and dementia were checked for current diagnoses and received treatment. 2. The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. 3. There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. 4. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others. 5. The person has a diagnosis of an intellectual/developmental disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of 22. Upon further record review, there was no PASARR 3878 (Exemption Criteria- for dementia) in the electronic medical record or paper chart. The 3878 was required due to R22 having diagnoses of dementia, without behavioral disturbance and epilepsy. R52- (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/24/25 at 3:25 p.m. review of the clinical record documented R52 was initially admitted into the facility on [DATE] with the most recent readmission on 8/17/2024/2024 with diagnoses that included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, epilepsy, and psychotic disorder with hallucinations/delusions. According to the quarterly MDS assessment dated [DATE], R52 had severe cognitive impairment (BIMS= 3), and required supervision and set-up for most activities of daily living. Review of the Preadmission Screening (Level I Screen, 3877) dated 3/5/24, documented the following were checked Yes: 1. Mental illness and dementia were checked for current diagnoses and received treatment. 2. The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. 3. There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. 4. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others. 5. The person has a diagnosis of an intellectual/developmental disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of 22. On 2/25/25 at1:43 p.m. Upon further record review, there was no PASARR 3878 (Exemption Criteria- for dementia) in the electronic medical record or paper chart. The 3878 was required due to R52 having diagnoses of dementia, without behavioral disturbance and epilepsy. On 2/26/25 at 10:20 a.m. Social Service Director (SSD) D was queried about the absence of the 3878 in the medical records and said the 3878 were not signed by the physician. The 3878s are generated in the OBRA system (community mental health data base). The social workers complete their part, then physician must go into the OBRA system to electronically complete and sign the 3878s to certify the dementia exemptions. The Medical Director, other physicians, nurse practitioners, and physician assistants have access to the OBRA system. They have been made aware of this process. SSD D was not able to provide an answer why the physicians have yet to complete and sign 3878s timely. R175- On 2/24/25 at 3:01 p.m. review of the clinical record documented R175 was initially admitted into the facility on [DATE] with a most recent readmission on 1/27/25 with diagnoses that included schizoaffective disorder, paranoid schizophrenia, post-traumatic stress disorder, and bipolar disorder. According to the quarterly MDS assessment dated [DATE], R175 was cognitively intact (BIMS=14), and was independent with activities of daily living. Review of the Preadmission Screening (Level I Screen, 3877) dated 9/23/23, documented the following were checked Yes: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Mental illness for current diagnoses and received treatment. 2. The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. 3. There is presenting evidence of mental illness or dementia, including significant disturbances in thought. On 2/25/25 at1:30 p.m. Upon further record review, there was no annual PASARR 3877 in the electronic medical record or paper chart. The 3877 was required due to R175 having mental illness diagnoses: schizoaffective disorder, paranoid schizophrenia, post-traumatic stress disorder, and bipolar disorder. The annual OBRA Level II Evaluation was also not in the electronic or paper medical records. The last OBRA Level II Evaluation was completed and dated on 10/23/23. On 2/26/25 at 10:25 a.m. SSDD was queried about the untimeliness of the annual 3877 and Level II Evaluation. SSD D stated, It's a little late. The resident has had multiple hospitalization s, and it was missed between the readmissions and discharges. On 2/26/25 at 3:13 p.m. the Administrator said the social workers will be keeping better track of the PASARRs, so they won't be missed. According to the facility's policy titled Preadmission Screening and Resident Review (PASARR), reviewed 9/26/24 documented in part the following: The facility will ensure that potential admissions are be screened for possible serious mental disorders or intellectual disabilities and related conditions . A positive Level 1 screen necessitates an in-depth evaluation of the individual by the state- designated authority, known as PASARR Level II, which must be conducted prior to admission to a nursing facility . A record of the pre-screening should be retained in the resident's medical record . When a Level II PASARR screening is warranted, it must be obtained as well as determination letter prior to admission. The Level II PASARR cannot be conducted by the nursing facility . According to PASARR Mental Illness/Intellectual Developmental Disability/Related Conditions Identification Instructions for Completing Level I Screening (3/22): If any answer to items 1 - 6 in SECTION 3 is Yes, send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record . When there are one or more Yes answers to items 1 - 6 under SECTION II, complete form DCH-3878, Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or hospital exempted discharge. 50634 R190- (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of R190's Electronic Medical Record (EMR) noted R190 was admitted on [DATE]. R190's pertinent diagnoses included Dementia, Unspecified Behavior Disturbances, Falls, Bipolar Disorder, Cognitive Communication Deficit and Delirium. The Quarterly Assessment for Minimum Data Set from 1/15/25 for Brief Interview for Mental Status showed R190 was severely cognitively impaired with a score of (0/15). According to the clinical record review R190 had a PASSAR level I screening completed on 4/4/24. According to the PASSAR level I instructions by answering yes to any of the questions in 1-6, a PASSAR level II should have been completed. There was no PASSAR II in R190s EMR file. On 2/26/25 at 2:00 PM, Social Work Assistant T reported they were unable to locate R190s PASSAR II in the EMR.

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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** 15194 Based on observation, interview and record review the facility failed to develop and implement a comprehensive care plan for three (R85, R91 and R206) of 36 residents reviewed for care plans, resulting in the potential for unmet care needs and the lack of coordination of care. Findings include: R91 On 2/24/25 at 1:43 P.M. during and observation and interview R91 was observed in the room with his foley bag hanging from the garbage can positioned at the bedside. During the observation R91 commented he thought he was transferred to the facility for short-term rehabilitation and some services for the indwelling catheter. R91 indicated the indwelling catheter was new and staff had not educated him on the care required for the catheter. Review of the Admission Face Sheet revealed R91 was admitted to the facility on [DATE], with pertinent diagnoses of infection and inflammatory reaction due to indwelling urethral catheter, Urinary tract infection, diabetes mellitus, abnormality of gait, morbid obesity, benign prostatic hyperplasia, and acute cystitis with hematuria. According to the Minimum Data Set (MDS) dated [DATE], R91 had a BIMs (Brief Interview for Mental Score) of 13/15 meaning the resident was cognitively intact and required supervision and set up assistance for personal hygiene and toileting. On 2/24/25 at 1:53 P.M. and 2/26/25 at 9:49 A.M., review of the care plan section of the clinical record revealed there was no comprehensive care plan addressing the indwelling catheter. On 2/26/25 at 3:05 P.M. during interview with the Director of Nursing (DON) concerning no care plan related to the indwelling catheter, the DON reported, a care plan should have been in the resident's clinical record. No reason was given why the comprehensive care plan did not address R91's indwelling catheter. On 2/26/25 at 3:30 P.M. review of the facility's Comprehensive Care plan and Revision policy dated 9/11/2004, documente: A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment. 22349 R85 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 2/24/25 at 10:39 AM, R85 was observed seated in a wheelchair receiving a respiratory treatment with a nebulizer machine (medicine that is aerosolized and delivered directly into the lungs) connected to an oxygen concentrator (medical device that separates nitrogen from the air to deliver oxygen at 95%) that was at the bedside. The resident had oxygen tubing and nasal cannula resting on the bed, next to the wheelchair. R85 said, I had pneumonia and got antibiotics for it. I'm doing better but still feel short of breath sometimes and wear oxygen. Registered Nurse (RN) E was at the resident's bedside and said she had given the resident a prn (as needed) respiratory treatment for complaints of shortness of breath. RN E said R85's pulse oximetry (device that measures the amount of oxygen in the blood, normal range is 90-100%) was 96% and lung sounds were clear. RN E proceeded to remove the nebulizer treatment and place R85 on 2 l/nc (2 liters/per minute via nasal cannula.) According to the R85's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with multiple diagnosis that included asthma and chronic obstructive pulmonary disease. On 12/12/24, R85 had a physician's order to administer oxygen 2 l/nc to maintain pulse oximetry above 92%. A further review of the resident's EHR revealed there was no care plan for the resident's oxygen administration. On 2/25/25 at 10:16 AM Licensed Practical Nurse (LPN) X was asked to review R85's plan of care for oxygen delivery. LPN X said, Yes, the resident is prescribed oxygen and it is being administered. No there is no care plan for that. I will correct that immediately. LPN X acknowledged that R85 had oxygen prescribed on 12/12/24 and a care plan for oxygen administration should have been initiated at that time. R206 During an observation on 2/24/25 at 3:17 PM, R206 was observed with a large light brown liquid stain on the resident's gown in the abdominal area and sheet. R206 was unable to be interviewed due to severe cognition impairment with a non-verbal status. At this time Certified Nursing Assistant (CNA) Y came into the resident's room and said, The colostomy is leaking out. The nurse is going to change it now. Registered Nurse (RN) E came into the room and observed the resident's colostomy site. R206's ostomy bag was intact and half full of light brown liquid. The ostomy's barrier ring seal was compromised. Light brown liquid had leaked out of the lower portion of the barrier ring seal onto the resident's abdomen, gown, and linen. R206's skin was intact and without excoriation. RN E said, I'll need to replace this (the barrier ring seal and colostomy bag). This one is leaking around the seal. RN E was observed to change the ostomy's appliance and barrier ring without incident. According to R206's EHR the resident initially admitted on [DATE] with multiple diagnoses that included encephalopathy and necrotizing fasciitis. On 1/3/25 the resident readmitted to the facility with a diagnosis of 'colostomy.' The resident had orders for ostomy care every three days and as needed. There was no care plan for ostomy care as of 2/24/25. On 2/25/25 at approximately 3:00 PM, the Director of Nursing (DON) was interviewed and said, Yes, the resident should have had a care plan for the colostomy. The facility's policy for Comprehensive Care Plans and Revisions last reviewed on 9/11/2024 reads in part: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure 1. The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. 2. When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery, this can include; a. Additional interventions on existing problems, b. Updating goal or problem statements c. Adding a short-term problem, goal, and interventions to address a time limited condition.

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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** 22349 Based on observation, interview, and record review the facility failed to implement interventions used to prevent the development or worsening of pressure injuries for two of five (R206 and R155) residents reviewed for pressure ulcers. Findings include: On 2/24/25 at 9:39 AM, 11:01 AM, 1:40 PM, 2:50 PM, and at 3:16 PM, R206 was observed lying on their back in bed on an alternating mattress with posey boots (soft foam booties to protect heels) in place. An elongated triangle- shaped positioning wedge was observed on the resident's right side of the bed, not in use for positioning. The resident was lying on their back without use of a positioning wedge during all five observations (5.5 hours). On 2/24/25 at approximately 3:17 PM Certified Nursing Assistant (CNA) Y came into the room and was queried about R206's repositioning schedule. CNA Y said the resident had been repositioned a couple of times throughout the day shift. CNA Y said, I checked on the residents every couple hours, throughout the day. CNA Y could not say what position the resident was in earlier. CNA Y said the resident scoots off the positioning wedge. According to R206's Electronic Health Record (EHR) the resident readmitted to the facility on [DATE] with multiple diagnoses that included encephalopathy (brain disease that alters brain function/structure), and a large unstageable sacral pressure ulcer (full loss of skin and soft tissue with the extent of the tissue damage unable to be confirmed because it is obscured by slough/eschar.) The Minimum Data Set, dated dated dated [DATE] indicated R206 had severe cognition impairment and was dependent on staff for all Activities of Daily Living, including bed mobility. Section M documented R206 had one unstageable pressure ulcer that was present upon admission. A wound care note dated 2/18/25 indicated R206's pressure ulcer was a stage 4 (full thickness tissue loss with exposed muscle, tendon, cartilage, or bone) measuring 9.4 cm (centimeters) in length, 8.3 cm in width, with a depth of 1.0 cm. The wound was described as decreasing in size, improved, and no signs or symptoms of infection. A care plan for pressure ulcers initiated on 1/7/2025 included the following interventions; avoid positioning the resident on sacrum. The resident needs positioning wedge for positioning, please reposition frequently, turn/reposition at least every two hours, more often as needed or requested. The physician's orders for the pressure ulcer treatment dated 2/18/25 was as follows: Sacrum: cleanse with dermal wound cleaner, pat dry, apply dankins-soaked stretch bandage roll on wound bed, cover w/ folded ABD (large thick pad to absorb discharge drainage) pad and cover site x2 every day. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Treatment Administration Record (TAR) for February revealed the pressure ulcer treatment administrations for 2/23/25 or 2/24/25 were blank. There was no documentation to support the pressure ulcer treatments were administered on those days. On 2/24/25 at 3:18 PM, during an interview with R206's assigned nurse Registered Nurse (RN) F, she said, I'm in a class right now, talk to (name of nurse-RN E). She is covering me. RN E was approached at the nurse's station with Nurse Practitioner (NP) H present and asked about R206's pressure ulcer. RN E reviewed R206's EHR and confirmed that R206's pressure ulcer treatments had not been signed out as administered since 2/22/25 (two days ago.) RN E proceeded to prepare the medicine and supplies to administer R206's pressure ulcer treatment. At 3:42 PM during an observation of R206's sacrum pressure ulcer treatment with RN E, the sacral dressing was saturated with clear to light yellow drainage and was dated 2/22/25. RN E said, This dressing is ordered to be changed everyday. The date is 3/22 on this dressing. On 2/26/25 at 10:18 AM during an interview with NP H she said R206's pressure ulcer was measured today and has improved and there was no signs of infection. On 2/26/25 at approximately 12:00 PM, during an interview with the Director of Nursing (DON), they stated, The facility has a policy that residents are repositioned every 2 hours and as needed. There is no explanation for why the resident's (R206) pressure ulcer dressing wasn't changed on 2/23. According to the facility's policy for Skin Integriy and Presure Ulcer Injury last revised on 7/9/2024 in part reads; The facility must ensure that -- i. A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual ' s clinical condition demonstrates that they were unavoidable; and ii. A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 5. Measures to protect the resident against the adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care: a. reposition at least every 2-4 hours (per-National Pressure Injury Advisory Panel standards) as consistent with overall patient goal and medical condition; b. utilize positioning devices to keep bony prominences from direct contact; c. ensure proper body alignment when side-lying; d. heel protection/suspension if indicated; 34901 R155 (continued on next page)

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	235516	A. Building B. Wing	02/26/2025

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Rivergate Terrace	14141 Pennsylvania Riverview, MI 48193

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/24/25 at 10:48 AM, R155 was observed awake and lying in the bed. R155 said she had a wound on her leg and granted permission for the wound on her leg to be observed. R155 asked for the bed remote which was at the foot of the bed. Licensed Practical Nurse (LPN) R was requested to provide R155 with the bed remote and facilitated observation of R155's wound. When LPN R lightly touched R155's foot when the bed remote was retrieved, R155 winced. R155 stated, It would be nice if I had pillows under my feet. R155's feet were resting directly on the sheet-covered mattress. LPN R acknowledged that R155's feet should not be resting directly on the bed. During an observation on 2/25/25 at 8:59 AM, R155 was observed awake and in bed. There was a pillow under R155's knees. However, R155's heels had direct contact with the sheeted mattress. During an observation on 2/26/25 at 10:13 AM, R155 was observed awake and lying in bed. There was no pillow or other device to elevate R155's heels off the mattress. During an observation on 2/26/25 at 12:19 PM, R155 was observed awake and lying in bed. R155's heels were observed resting directly on the sheeted mattress. During an observation on 2/26/25 at 2:15 PM, R155 was observed awake, lying in bed, and participating in a one-on-one activity with an activity aide. R155 complained of pain on her left foot. During an observation and interview on 2/26/25 at 2:19 PM, Certified Nurse Aide (CNA) V said she has provided care for R155. CNA V stated, (R155) does not resist care. She's a sweetheart. R155's feet were observed resting directly on the sheeted mattress. During an interview on 2/26/25 at 2:20 PM, CNA W said she provided care for R155 today. CNA W said she did not prop up R155's feet and that the nurse would let the CNAs know if the resident's feet needed to be propped up. During an interview on 2/26/25 at 2:23 PM, Unit Manager, Licensed Practical Nurse (LPN) O said R155's feet should be elevated. If a pillow was used to elevate the resident's heels, it should have been placed at the ankle area. A review of the clinical record for R155 documented an admitted [DATE] with diagnoses that included osteoarthritis of knee and Parkinson's disease. An MDS dated [DATE], documented moderate cognitive impairment. Record review of R155's risk for break in skin integrity care plan revised 6/2/23, documented to Offload heels while in bed as tolerated. A document titled, Braden Scale for Predicting Pressure Sore Risk, dated 2/6/25, documented R155 was at a high risk for developing a pressure sore. On 2/26/25 at 2:35 PM, a review of CNA tasks with the Director of Nursing (DON) documented that R155's heels were to be offloaded while in bed as tolerated. The DON said R155's heels should be offloaded because they were worried that R155 would experience a breakdown on her heels.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 22349 Based on observation, interview, and record review the facility failed to ensure an oxygen cylinder was stored properly in a resident's room (R85) resulting in the potential for fire hazards. This deficient practice had the potential to affect the two residents (R85 and R145) that resided in that room facility. Findings include: On 2/25/25 at 9:59 AM three oxygen tanks were observed in R85's room. R85 was not present in the room and R145 was laying in bed. One of the oxygen tanks was observed to be leaning against the resident's dresser and not inside a metal carrier. R145 was asked about the oxygen tank and said, It's not for me. It's for my roommate. I don't pay no attention to it. At this time Respiratory Therapist (RT) N entered R85's room and was interviewed about oxygen tank storage. RT N said, We do not store oxygen tanks like this! These tanks are flammable and must be stored in a metal carrier. This is a safety and fire hazard. RT N left the room to acquire a metal carrier to safely transport the oxygen tank to the oxygen tank storage area. On 2/26/25 at approximately 9:30 AM the Environmental Director (ED) U was asked about oxygen tank storage in the facility. ED U said they were made aware by staff that an oxygen tank had been unsafely stored in a resident's room yesterday. ED U said, The facility uses a metal carrier and cage to safely store oxygen tanks. They (oxygen tanks) are flammable and need to be stored in metal cage or carrier to prevent any safety issues. According to the facility's Oxygen Administration, Safety, Storage, and Maintenance policy last revised on 10/11/24 reads in part; To assure that oxygen is administered and stored safely within the healthcare centers or in an outside storage area. Safety: 2. Do not fasten oxygen tanks to a resident's bed. Tanks must be either installed on a stable, wheeled dolly or on a portable oxygen stand . Storage: 1. Assure that oxygen tanks kept in storage rooms are either chained to the wall or installed on a stable, wheeled dolly or floor stand.

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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** 22349 Based on observation, interview, and record review the facility failed to provide adequate and appropriate care for indwelling urinary catheters (foley) for one (R211) of three residents reviewed for catheter care resulting in R211's indwelling catheter not being changed or securely anchored as prescribed and a urology consult not being scheduled in accordance with physician's orders. Findings include: During an observation on 2/24/25 at 10:48 AM, R211 was lying in bed on their left side. The resident was wearing a brief with the foley catheter's tubing pulled out through the top of the brief and over their right leg. There was no anchoring device in place to secure the catheter. R211 said they have had several urinary tract infections that are not resolving. R211 was upset and said, I called my family. They are coming up here and taking me to see my doctor. They give me pills here that aren't helping me and make my stomach sick. On 2/24/25 at 12:49 PM, Nurse Practitioner (NP) H and Registered Nurse E were at R211's bedside reviewing the resident's test results and medications with the resident and their family from the Electronic Health Record (EHR). R211's family identified the resident has had a urinary tract infection for over a month and the facility had not treated it properly, had not changed the resident's catheter, and had not made an appointment for a urologist yet. NP H said the resident was currently being treated with antibiotics for the UTI, could not determine if the resident's urinary catheter had been changed, and confirmed that no urologist appointment for the resident had been scheduled at this time. NP H ordered the resident to be sent to the emergency room per the request of the resident and their family. According to the Electronic Health Record (EHR), R211 had admitted to the facility on [DATE] with multiple diagnoses that included urinary retention, urinary tract infection, and had a foley catheter. On 1/6/25 the physician ordered; foley catheter, catheter care every shift, keep catheter bag below the level of the bladder, change catheter bag, and secure catheter with anchoring device to prevent tension on the catheter, and change device when clinically indicated. A care plan for indwelling catheter initiated on 1/6/25 included interventions that included cath care every shift and to report signs of UTI to the physician. On 2/11/25 at 2:04 PM a progress documented by Licensed Practical Nurse (LPN) J, indicated that R211 had gross hematuria (large amount of blood in the urine) and notified the physician. The physician's orders were as follows; irrigate the foley catheter every shift for 2 days with 250 ml (milliliter) of sterile water, obtain a urinalysis (urine sample), urology consult, and abdominal ultrasound, and change catheter bag. A review of a urinalysis report dated 2/11/25 R211's urine sample was collected and received by the lab on 2/11/25. On 2/13/25 the results were positive for a UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/17/25 at 7:30 AM a progress note documented by LPN I indicated R211 complained of pain in the lower abdominal area and the resident had a urinary output of only 100 ml (milliliters) during the night shift. A bladder scan was performed (ultra sound to determine the amount of urine in the bladder) and revealed the resident had over 500 ml remaining in the bladder. The foley catheter was irrigated and 900 ml of urine flowed out in the collection bag. The Nurse Practitioner (NP) H was notified. The NP's orders were as follows; macrobid 100 mg (milligrams) every 12 hours for UTI for 7 days and change the collection bag. On 2/24/25 at 1:27 PM the NP H reviewed R211's EHR and said that both LPN J and LPN I should have changed the entire foley catheter, not just the collection bag. NP H said that her verbal order to LPN I was to change the foley, not just the collection bag. NP H said, I would never say to just change the collection bag. That makes no sense. If it (the foley) is getting obstructed and there is an infection I would order for the entire catheter and the collection bag to be changed. I believe that is a standing order for the facility. NP H confimed an order was given on 2/11/25 for the resident to see a urologist and there was no documentation to support the resident had an appointment for that at this time. On 2/25/25 at 11:35 AM during an interview and with the Assistant Director of Nursing, RN C R211's EHR was reviewed. RN C said the resident's foley catheter should have been changed, not just the collection bag after the resident had gross hematuria on 2/11/25 and also on 2/17/25 when obstruction of urine output was evident. RN C could not provide an explanation why the nurse only changed the collection bag and said, We will be conducting educational in-services on this. RN C confirmed that R211 had a positive UTI per the urinalysis collected on 2/11/25 with the results on 2/13/25 and was prescribed antibiotics on 2/17/25. RN C could not provide an explanation for the delay. On 2/25/25 at 12:40 PM both LPN J and LPN I were left voice messages to request an interview. No no return call had been made prior to the survey exit date of 2/26/25. On 2/25/25 at 12: 45 PM RN E was interviewed regarding R211's urine collection bag change on 2/11/25 and again on 2/17/25. RN E said, The resident's foley catheter wasn't changed because we did not want to introduce more bacteria into the bladder with re-inserting a catheter. The collection bag was changed. On 2/26/25 at 1:03 PM, the Director of Nursing (DON) reported that R211 had not readmitted to the facility at this time. The DON said they had reviewed R211's EHR and the nurses should have changed the resident's entire foley catheter system and not just the collection bag. The facility has purchased urinary catheters that are closed and the collection bag can not be disconnected from the catheter to keep a closed system. The facility follows [NAME] Guidelines and CDC guidelines for CAUTIs (catheter associated urinary tract infections) and the policy reflects that. According to the facility's Indwelling Urinary Catheter (Foley) Management policy last revised on 9/10/2024 in part reads: General Urinary Catheter Maintenance guidelines (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CDC/HICPAC - rev 06.06.2019) 1. Following aseptic insertion of the urinary catheter, maintain a closed drainage system a. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment. b. Consider using urinary catheter systems with preconnected, sealed catheter-tubing junctions. 5. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Additional care practices related to catheterization 1. Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter; and 2. Securing the catheter to facilitate flow of urine, preventing kinking of the tubing. Refer to [NAME] on Procedural Guidance on Routine Care Indwelling urinary catheter (Foley) care and management. According to the CDC.gov/infection/cauti/index.htm, HICPAC (Healthcare care Infection Control Practices Advisory Committee) for CAUTI 2009 page 13/61. E. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised.

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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** 22349 Based on observation, interview, and record review the facility failed to administer oxygen as prescribed to one (R206) of six residents reviewed for oxygen therapy resulting in R206 sustaining a low pulse oximetry reading of 82% (device that measures the amount of oxygen in the blood, normal range is 90-100%). Findings include: On 2/24/25 at 9:39 AM, 11:01 AM, 1:40 PM, 2:50 PM, and 3:16 PM, R206 was observed lying in bed without oxygen in place via a nasal cannula (flexible tube that delivers oxygen through the nose) in place. The undated oxygen tubing and nasal cannula was observed on the floor underneath the resident's bed on all five observations (5.5 hours). The oxygen concentrator was at the resident's bedside, turned on, and set at 3 liters per minute with an undated empty humidification bottle. R206 was unable to be interviewed due to severe cognition impairment and non-verbal status. R206 was resting comfortably with normal respirations and did not appear to be in any distress on all five observations. On 2/24/25 at approximately 3:17 PM Certified Nursing Assistant (CNA) Y came into the room and was asked about the resident's oxygen. CNA Y said they would notifiy the nurse the resident needs new oxygen tubing, since this one is on the floor. According to R206's Electronic Health Record (EHR) the resident readmitted to the facility on [DATE] with multiple diagnoses that included encephalopathy (brain disease that alters brain function/structure), and pulmonary embolism (a blood clot in the lung.) The Minimum Data Set, dated dated dated [DATE], identified R206 to have severe cognition impairment with a Brief Interview for Mental Status (BIMS) score of '00'. R206 was identified to be non-verbal and dependent on staff for all Activities of Daily Living, including bed mobility. The physician's orders included; oxygen 4 liters per minute continuously per nasal cannula (4l/nc), pulse oximetry monitored and documented every shift. The Medication Administration Record (MAR) revealed the last pulse oximetry reading was on 2/24/25 at 5:35 AM and read 99%. No further documentation was noted in the resident's EHR regarding respiratory status monitoring. On 2/24/25 at 3:18 PM, during an interview with R206's assigned nurse, Registered Nurse (RN) F she said, I'm in a class right now, talk to (name of nurse-RN E.) She is covering me. RN E was approached at the nurse's station with Nurse Practitioner (NP) H present and asked about R206's oxygen orders. Both RN E and NP H confirmed that R206 was prescribed continuous oxygen at 4 liters per minute via nasal cannula. RN E went to the resident's bedside and checked R206's pulse oximetry reading, and said It's only 82% right now, that is too low. At 3:31 PM, the Respiratory Therapist (RT) N confirmed that R206's pulse oximetry reading was still low at 84%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:45 PM the resident's pulse oximeter remained at 84%. NP H was notified and prescribed a stat (immediate) respiratory treatment (Albuterol 0.5-2.5 via nebulizer). On 2/25/25 at 9:10 AM, NP H said a stat chest x-ray had been ordered on 2/24/25 for R206 and the results was normal. The resident had no changes in their chest x-ray and the pulse ox has been within normal range all night. The resident needs to have continuous oxygen at 4l/nc or they will de-sat (decrease blood oxygenation level). On 2/25/25 at approximately 12:00 PM, the Director of Nursing (DON) was interviewed about R206's oxygen levels and replied, Yes, that resident (R206) should have had the nasal cannula on at all times. I can't explain why that didn't happen. The DON acknowledged that the oxygen was not administered per the physician's orders for R206 and education had been given to the facility's nursing staff on 2/24/25 and continuing on 2/25/25. According to the facility's Oxygen Administration policy last revised on 10/11/2024 reads in part: Oxygen Administration 1. Oxygen order should be written for specific liter flow required by the resident. 2. Humidifiers are required on NC (nasal cannula) with liter flows 4 liters or greater. Infection Control 1. Change oxygen supplies weekly and when visibly soiled. Equipment should be labeled with patient name and dated when setup or changed out. 2. Humidifier/ Aerosol bottles should be dated and replaced every 7 days regardless of H20 level. a. Prefilled humidifiers are recommended. If re-usable humidifier is used, refill using sterile water only. Water is to be emptied and replaced daily. Re-usable humidifiers should also be replaced every 7 days. 3. Store oxygen and respiratory supplies in bag labeled with resident's name when not in use.

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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** 50634 This citation includes two DPS. Deficient Practice Statement #1: Based on observation, interview, and record review the facility failed to don appropriate personal protective equipment (PPE) for one resident (R206) of one resident reviewed for enhanced-barrier precautions resulting in the potential for the transmission of infectious organisms. Findings include: On 2/25/25 at 1:20 PM, Certified Nurse Aide (CNA) L was observed to enter R206's room with License Practical Nurse (LPN) J. Observations were made of staff gathering wet towels and performing hygiene on R206 without any PPE. CNA L exited the room with the soiled items. On 2/25/25 at 1:30 PM, LPN J was observed administering medications to R206 through their peg tube without the indicated PPE. LPN J was queried about the enhanced barrier sign posted on R206's door. LPN J said CNA L should have worn a gown when providing hygiene care. LPN J added they should have also worn a gown when administering medications through R206's peg tube. On 2/25/25 at 1:40 PM, CNA L was queried about the care they gave to R206. CNA L said they had changed R206's colostomy bag. CNA L reviewed the EBP sign on R206's door and said because they had performed personal hygiene, they should have put on a gown. On 2/25/25 at 1:45 PM, the Assistant Director of Nursing (ADON) C, was interviewed and acknowledged there was a concern with staff not wearing PPE with a resident on EBP. Review of facility EBP Policy revised on 3/21/24, documented: EBP was indicated for residents with wounds and indwelling medical devices. The policy noted Wounds may include but are not limited to skin tears, pressure ulcer, diabetic foot ulcers, and unhealed surgical wounds. In addition, the policy noted Indwelling medical devices may include but are not limited to central lines, urinary catheters, feeding tubes, tracheostomy, and a peripheral intravenous line . when performing high contact care. According to the policy high contact care was defined as the following: hygiene, dressing, bathing, wound care, changing lines medical device care or use. The policy went on to note When performing the above care, the proper PPE is to be worn which includes a gown and gloves. Deficiency statement #2: Based on observation, interview, and record review the facility failed to implement preventative measures for one resident (R221) of one reviewed for IV antibiotics resulting in the potential for the transmission of infectious organisms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include: On 2/25/25 at 11:37 AM, License Practical Nurse, (LPN) R was observed administering R221's IV antibiotics. The connector for the IV- line was connected into the IV-line port. LPN R unscrewed the line from the port and connected the IV-line to R221. Record review showed R221 was admitted on [DATE]. R221's diagnosis included Intracranial Abscess, Disorder of the Brain, Cerebral Edema, Anxiety Disorder, Cognitive Communication Deficit, Disorientation Respiratory Disorder (Acute Respiratory Distress), and Pneumonia. Record review of R221's Admission Assessment on 2/11/25 for Minimum Data Set (MDS) for Brief Interview for Mental Status is cognitively intact at (12/15). On 2/25/25 at 3:20 PM, LPN R was interviewed after they reviewed the facility policy on administration of intermittent infusions. LPN R agreed the IV-line should not have been connected into the IV-line port. On 2/25/25 at 3:20 PM, the Assistant Director of Nursing, (ADON) was interviewed. After reviewing the policy ADON agreed that the IV-line should have been capped off with a sterile cap in between IV use. 2/25/25 at 3:20 PM, during an interview, Unit Manager (UM) M reported they recognized that by LPN R removing the connector piece from the IV-line port and connecting it to R221 could cause an infection due to poor sterile technique. On 2/26/25 at 10:35 AM, the Director of Nursing, (DON) was interviewed and said LPN R should have known to cap the IV-line with an IV cap after use. The DON said the nurse on the previous shift had capped the line improperly. The DON reported LPN R should have recognized that the line was improperly capped and should not have used it. The DON said they have plenty of caps in the supply room and the staff should have utilized them instead. Record review of facility policy Administration of an Intermittent Infusion, last reviewed on 6/1/21 noted, Nurses should maintain aseptic non touch techniques. In addition, the policy noted, When administration of medication is completed a new sterile end cap should be placed on the end of the administration set if it will be used again within 24 hours.