STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235526	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Park Terrace	14676 W Upright Charlevoix, MI 49720

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 This citation pertains to intake MI00142921. Based on observation, interview and record review, the facility failed to ensure dignified care experiences for three Residents (R36, R20 and R39) of four residents reviewed for dignity. Findings include: R36 R36 was admitted to the facility on [DATE] and had diagnoses including stroke, aphasia (difficulty expressing and understanding speech), and hemiplegia (paralysis) and hemiparesis (weakness) affecting the right dominant side. A review of R36's Minimum Data Set (MDS) assessment, dated 3/19/2024, revealed R36 had intact long-term and short-term memory and required moderate independence [some difficulty in new situations only] with daily decision making. Further review of R36's MDS assessment revealed he required substantial/maximal assistance from staff to transfer to and from the toilet. An observation on 5/15/2024 at 12:31 p.m. revealed R36 seated in a wheelchair in his room facing the window. R36 was observed using his left arm to position his wheelchair toward the door. R36's right arm was tucked in close to his body with his right forearm resting on his lap. R36 conveyed he could not move his right arm or right leg. During an interview with R36 at the time of the observation, R36 was queried regarding toileting assistance. R36 pointed to the bathroom and then to the clock of the wall at the end of his bed. R36 was asked if he often had to wait in the bathroom for staff assistance after using the toilet. R36 was observed becoming visibly upset, nodding his head profusely while stating, yes, yes. When asked how long he had to wait on the toilet for staff assistance, he pointed to the clock again and said, all the way around. When asked if he was left sitting on the toilet for an hour before staff assisted him, R36 began nodding his head again while stating, yes, yes. R36 stated he just wanted to be treated like everyone else. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/2024 at 1:46 p.m., the Director of Nursing (DON) reported she was aware of an occurrence when R36 was left on the toilet for approximately 45 minutes after calling for assistance. The DON reported the incident occurred sometime last fall during the change of shifts from day shift to night shift. The DON reported when staff arrived to assist R36, he told them to go away because he was angry and had already called his brother to come to the facility to assist him. The DON stated an investigation was conducted to determine the reason R36 was left unassisted on the toilet. When asked how the call light system functioned, the DON reported when lights are activated from the bedside or in the bathrooms, a notice is sent to staff via a pager/phone and a light was activated in the hallway above the doorway of the respective room. The DON stated the call light notice went to Certified Nurse Aide (CNA) staff and if not answered/deactivated within around eight minutes, the notice would then be transmitted to nursing (Registered Nurse [RN]/Licensed Practical Nurse [LPN]) staff. A review of facility investigation documents titled [R36] Summary 9/19/2023 Event, revealed the following, in part: 9/19/2023: Statement from [CNA I]. She placed resident on stool [toilet] around 615p/630p [6:15 p.m./6:30 p.m.] . Gave report around 6:30 [p.m.]/6:40 [p.m.]. Told the oncoming aide during report he was on the toilet. She finished report, took out the trash and then assisted putting another resident in bed and then punched out. [R36] had been difficult throughout the day, yelling down the hall and very demanding . Statement from [CNA M]. Received report approx. [approximately] 6:30 [p.m.]/7:00 [p.m.] . At around 7:15 [p.m.] I heard [R36] hollering and went to assist him. At that time, he told me to go away. I immediately told the nurse. At that time is when she received a call from [R36's] brother . Statement from DON when she went in to assist [R36] around 7:15 [p.m.]. He was upset and angry and told her to leave. She stood by the door and was finally able to work with him and remove him from the toilet . Findings . the [night shift] call light was on 44 minutes before it was turned off. Aide was attending to another resident but should have communicated by asking for help. R20 R20 was admitted to the facility on [DATE] and had diagnoses including bipolar disease, anxiety disorder and mild cognitive impairment of uncertain or unknown etiology. A review of R20's MDS assessment, dated 4/2/2024, revealed R20 scored seven out of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicating she had severe cognitive impairment. Further review of R20's MDS assessment revealed she required substantial/maximal assistance for toilet transfer and was dependent upon staff for toilet hygiene. An observation on 5/14/2024 at 11:13 a.m., revealed CNA I transferred R20 from her bed to the bathroom using a sit-to-stand mechanical lift. Upon positioning R20 in front of the toilet, CNA I pulled R20's pants down past her knees and loosened the Resident's brief and lowering it down toward her knees exposing her buttocks and pubic area. CNA I made no attempt to close the bathroom door and left the Resident sitting on the toilet within sight of R20's roommate who was seated in a wheelchair on the side of the room opposite from R20. When R20 was finished urinating, CNA I lifted the Resident to standing position and with the Resident standing, proceeded to cleanse R20's genital area with the door open and R20 within direct sight of her roommate. R39 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39 was admitted to the facility on [DATE] and had diagnoses including macular degeneration (limited field of vision), urinary retention, urinary tract infection and generalized muscle weakness. A review of R39's MDS assessment, dated 3/19/2024, revealed R39 scored 11 out of 15 on the BIMS assessment, indicating he had moderate cognitive impairment. Further review of R39's MDS assessment revealed he was dependent on staff for toileting, lower body dressing, sit to stand transfers, and chair/bed-to-chair transfers. An observation of care provided by CNA L on 5/14/2024 at 11:21 a.m. revealed R39 lying in bed wearing a white, long-sleeved shirt, yellow socks, and a blue incontinence brief. R39 was not wearing any pants and was not covered with a sheet or blanket. CNA L was observed loosening R39's incontinence brief to check the Resident for cleanliness. Further observation revealed CNA L walk away from R39's bedside to go to the Resident's bathroom to perform hand hygiene, leaving R39 lying with his brief open and not covered with a sheet or blanket. R39 was heard stating I'm cold and this is uncomfortable. During this observation R39's room was noted to be at ground level and the window blinds were left open during care for R39. An observation of the courtyard outside R39's window revealed three unidentified residents in the courtyard, one of which was in a wheelchair on the sidewalk directly outside R39's room. After performing hand hygiene, CNA L returned to fasten R39's brief, placed a pair of pants on R39 up to his med-thighs and positioned R39 sitting on the right side of his bed, facing the window. CNA L then fastened a lift sling around the Resident and proceeded to lift R39 to standing position using a sit-to-stand mechanical lift. R39 was observed to be standing directly in front of the window with the blinds open with his pants at his knees with his incontinence brief exposed. CNA L then pulled R39's pants to his waist and seated him in a wheelchair next to the bed. CNA L made no attempt to close the blinds during R39's care. During the interview on 5/15/2024 at 1:46 p.m., the DON reported all resident should be provided a dignified care experience, regardless of cognitive status. The DON stated ensuring dignity included covering residents exposed body part during care, closing privacy curtains and closing window blinds. Review of the facility policy titled Quality of Life - Dignity, last revised 2009, revealed the following, in part: Each resident shall be care for in a manner that promotes and enhances quality of life, dignity, respect and individuality . Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures . Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist resident as needed by . promptly responding to the resident's request for toileting assistance .

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397 Based on observation, interview, and record review the facility failed to properly assess mental and physical capability for self-administration of medications for one resident (R42) of one resident reviewed for self-administration of medications. Resident #42 (R42) R42's electronic medical record (EMR) revealed an admitted [DATE]. R11's Minimum Data Set (MDS) assessment indicated a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated R42 was cognitively intact. R42 had medical diagnoses including muscular dystrophies (muscle dysfunction), congenital stenosis and stricture of esophagus (abnormal narrowing of esophagus), dysphagia (difficulty swallowing), and acute bronchitis. R42's orders indicated ipratropium-albuterol solution for nebulization; 0.5 milligram (mg)-3 mg (2.5 mg base)/3 mL(milliliters); inhalation twice a day, creatine monohydrate powder 100% 1 scoop reconstituted in 4-8 ounces (oz) of water daily, and Metamucil Fiber 1 scoop reconstituted in 4-8 oz daily. There was no order for medications to be self-administered. On 5/14/24 at 9:41 AM, licensed practical nurse (LPN) B was observed passing medications for R42. LPN B took one dixie cup of creatine monohydrate powder 100% reconstituted in water mixed with Metamucil Fiber, one dixie cup of MiraLAX (laxative) 3320 OTC (over the counter) 17 grams reconstituted in water and a medicine cup of pills, jellies, and capsule medications into R42's room. LPN B said R42 had her Ipratropium-albuterol solution for nebulization already. R42 took her pill medications with the MiraLAX liquid, R42 removed her calcium from medication cup and told LPN B she did not want to take it until she had lunch. LPN B took the calcium tablet from the resident. R42 took out her two gummy vitamins and put them on her bedside table next to the nebulizer for albuterol stating she would take it after her smoking. R42 started drinking the creatine/fiber mixture, when LPN B left the room with the calcium tablet. When LPN B left the room, R42 was still drinking her medication, albuterol had not been administered, and the gummy vitamins were left on bedside table. An interview was conducted with LPN B inquiring about length of time that R42 would be left alone in her room to take her medications, LPN B stated she typically waits 10 minutes before returning to R42's room to see if she has completed taking them. LPN B was not concerned with the possibility of R42 having difficulty swallowing her medications, or that she left prior to seeing if the resident had taken all her medications. On 5/14/24 at 1:58 PM, an interview was conducted with the DON who verified there was no assessment for self-administration of medications for R42. On 5/14/24 at 2:03 PM, while conducting an interview, R42 stated the nurse sets up the albuterol and sets it on the bedside table where she can administer it herself when ready. R42 then takes her gummy vitamins after her albuterol treatment that the nurse leaves with her. R42 stated that nursing staff often leave her to drink her creatinine and fiber on her own. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Self-Administration of Medications Policy Statement stated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy and Interpretation stated in part, As part of their overall evaluation, the staff and practitioner will assess the resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. In addition the staff and practitioner will perform a more specific skilled assessment. If the team determines that the resident cannot safely self-administer medications, the nursing staff will administer the resident's medications. The facility's Nebulizer policy stated in part, Observe resident during procedure for any change in condition (unless resident has an order to self-administer).

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. 40330 Based on interview and record review, the facility failed to review resident rights with eight confidential group Residents of eight residents reviewed for awareness of their rights. This deficient practice resulted in feelings of frustration due to the lack of awareness of basic rights. Findings include: During the group meeting on 5/14/24 at 1:30 p.m., eight confidential residents reported they were unaware of their resident rights, and their rights were not reviewed at the monthly resident council meetings. Residents collectively stated, What are our rights?, and asked Surveyor to explain their rights to them. Each reported they did not understand their nursing home rights and wanted this information. The resident council president confirmed resident rights were not reviewed at their monthly meetings. Several confidential group meeting residents reported outcomes related to resident rights, including undignified communication towards them from staff, such as when they requested call light assistance, for timely care and medications. Review of the resident council meeting minutes from March 6, 2024, April 3, 2024, and May 8, 2024, revealed no review of resident rights during the meetings. It was noted Staff N was the only facility staff member present each month. Review of the resident council meeting minutes showed concerns related to resident rights including dignified call light answering and missing items. During an interview on 5/14/24 at 3:48 p.m., Staff N was asked if they had reviewed resident rights with the resident council group attendees during the resident council meetings. Staff N stated, I have not done this every single month, when the meetings started getting longer and longer . When asked why, Staff N reported there was conflict between two residents at the meetings. Staff N reported they tried to redirect the residents, which caused the meetings to go longer. Staff N was asked if they had involved the Social Services staff, or asked nursing management to intervene. Staff N affirmed they had not. Staff N explained this conflict frustrated the other residents, and caused the meetings to be interrupted and described the one resident as longwinded. Staff N reported this frequently upset one confidential Resident who told another confidential Resident to stop interrupting the other residents. Staff N confirmed they did not have time to review resident rights the last few meetings, as they were spending considerable time redirecting Residents and trying to keep the meeting on track. Staff N indicated they would likely have the Social Services staff involved in the meetings going forward and confirmed they had not thought of that. During an interview on 5/15/24 at 4:38 p.m., the Nursing Home Administrator, (NHA) H, was asked about resident rights not being reviewed in the resident council meetings. The NHA was informed resident rights were confirmed not being reviewed in resident council meetings by Staff N. Resident's concerns with rights not being reviewed was also conveyed to the NHA, given the concerns discovered during the survey related to resident rights. The NHA H acknowledged they understood the concern. The NHA conveyed going forward, they would mail a copy of the residents' rights to the resident representatives and planned to review resident rights in the next resident council meeting. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy, Resident Rights, undated, received on 5/15/24, revealed, Your Rights and Protection as a Nursing Home Resident. What are my rights in a nursing home? As a nursing home resident, you have certain rights and protections under Federal and State law that help ensure you get the care and services you need. You have the right to be informed, make your own decisions, and have your personal information kept private. The nursing home must tell you about these rights and explain them in writing in a language you understand. They must also explain in writing how you should act and what you're responsible for while you're in the nursing home. This must be done before or at the time you're admitted , as well as during your stay .At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to: be treated with respect ., participate in activities ., be free from discrimination ., be free from abuse and neglect ., be free from restraints ., make complaints ., get proper medical care ., have your representative notified ., get information on services and fees ., manage your money ., get proper privacy, property, and living arrangements ., spend time with visitors ., get social services ., leave the nursing home ., have protection against unfair transfer or discharge ., form or participate in resident groups ., have your friends or family involved .

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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** 40330 Based on interview and record review, the facility failed to develop comprehensive care plans for two Residents (R9 and R23) of 14 residents reviewed for care planning. This deficient practice resulted in the potential to result in unmet activity needs for R9 and additional weight loss for R23. Findings include: R23 Review of R23's Minimum Data Set (MDS) assessment, dated 3/26/24, revealed R23 was admitted to the facility on [DATE], with diagnoses including diabetes, neuropathy (nerve disease), and wound treatment. R23 required maximal assistance for transfers, dependence for toileting, and was frequently incontinent of bladder and bowel. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R23 was cognitively intact. The assessment showed R23 was 65 tall and weighed 184#. During an interview on 5/13/24 at 10:46 a.m., R23 stated she was losing weight. Review of R23's weights showed significant weight loss: 5/08/24: 181.8# 5/07/24: 184.9# 4/09/24: 178.5# 4/08/24: 184# 3/23/24: 189.9# 3/19/24: 195# (admission weight) Review of R23's Care Plan showed no nutritional goals or interventions to address R23's significant weight loss, including supplements, diet preferences, and care planning. During an interview on 5/15/23 at 10:13 a.m., Certified Dietary Manager (CDM) Q was asked about the lack of any nutritional care plan section or care planned interventions to address R23's progressive weight loss. CDM Q acknowledged there should have been a nutritional care plan in place for R23 which reflected her weight loss, including dietary goals, interventions, preferences, supplements, etc. CDM Q reported they had only recently assumed the role of writing the nutritional care plans, which was formerly completed by the Registered Dietician (RD). CDM Q reported they understood the need for a nutritional Care Plan for R23, given R23's wound healing process and weight loss, and would be following up to complete the nutritional Care Plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, Care Plans, Comprehensive, Person-Centered, revised December 2016, revealed, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation. 1. The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . 40383 R9 Review of R9's MDS assessment dated [DATE], revealed an admission of 5/19/23 with diagnoses including fracture of the right femur (thigh bone), and heart disease. The BIMS assessment revealed a score of 12 out of 15, indicating moderate cognitive impairment. During a room visit on 5/13/24 at 10:34 AM, R9 was observed sitting in his room. The TV was not on, no music was playing, and R9 was not engaged in any activity. When asked if he went to activities, R9 stated, I didn't go to Bingo. I don't like bingo. I would like to have more options. On 5/15/24 at 11:49 AM, the medical record was reviewed with Activity Director (Staff N). A care plan for R9's preferred activities was not found. Staff N stated, I do not have a care plan in for him. Staff N said the standard is to have an activity care plan for each resident. Staff N said R9 was admitted for rehabilitation and now was planned to stay long term. Staff N stated, I have not gotten to him yet.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on interview, and record review, the facility failed to ensure care plans were updated and revised appropriately for two Residents (R5 and R39) out of 14 Resident care plans reviewed. This deficient practice resulted in care plans which did not reflect resident needs. Findings include: Resident #5 (R5) A review of R5's Minimum Data Set (MDS) assessment, dated 2/12/2024, revealed an admitted [DATE] and a score of 7 out of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicating severe cognitive impairment. R5's diagnoses included repeated falls, cerebral infarction (stroke), dementia, chronic pain, diabetes, and major depressive disorder. The progress notes for R5 from 2/12/24 at 7:30 AM reported the following, This nurse called into room [ROOM NUMBER]-1 by two floor nurses stating resident had fallen in her room. Care plan was followed. Resident was found near her roommate's bed/side of the room. 2 floor nurses were already in her room and had responded to alarm sounding. Alarm was sounding/resident had grippy socks on. Afghan at her feet. Lying on right side in front wheelchair with blood coming out of laceration on upper right eyebrow. Bruising of bridge of nose and resident reporting of right hand hurting .this nurse was calling an ambulance. A additional progress note for R5 on 2/12/24 at 7:40 PM reported the following, Tuck in visit completed . (R5) has just returned from the ER (emergency room) after her fall. She was out of it, and sleepy upon arrival. She has bruises around both of her eyes, a compression bandage on her forehead with sutures, and a rhino rocket (nose bleed packing) placed on her left nostril. Pain medication was given shortly after arrival. (R5) has broken part of her nose and will need to follow up with ENT (Ear/Nose/Throat Specialist). POC (Plan of Care) /safety measures discussed with (Facility Name) RN (Registered Nurse). The incident report of the fall with injury was reviewed. The report stated the care plan had been reviewed and was updated. The care plan in the medical record included a problem category: Falls (R5) is at risk for falls as evidenced by impaired vision, debility, poor cognition start date: 2/4/2021. Although several approaches were listed to meet the goal of remain free from injury of further falls ., the last approach added for this problem was dated 11/28/2023. During an interview on 5/14/24 at 3:58 PM, the care plan was reviewed with the Director of Nursing (DON). When asked when care plans were updated, the DON said, We update the care plans after each fall. I think we addressed the afghan around her feet. The DON reviewed the care plan and stated, I am not seeing it. They were supposed to be watching that the blankets were not tangled around her feet. That was what the intervention was supposed to be. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Care Plans, Comprehensive Person-Centered read in part, .13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . The facility policy Falls Clinical Protocol read in part, .If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. 41978 R39 An observation of wound care provided by Registered Nurse (RN) D on 5/15/2024 at 10:16 a.m. revealed a ventral (underside) tear through the glans (rounded tip) of R39's penis extending approximately one and one-half inches through the penile shaft (portion leading from the body to the glans). An indwelling, urinary catheter was observed to be leading from the superior portion (nearest R39's body) of the tear to an adhesive, catheter securing device attached to R39's left upper thigh, with tubing leading to a dependent drainage bag attached to the left side of R39's bedframe. It was noted there was no date written on the catheter securing device to indicate when the device was last changed. RN D reported the catheter securing device was ordered to be alternated between the right leg and the left leg on a weekly basis to offload the pressure on R39's penis and urethra from the catheter tubing. RN D stated she was unsure when the catheter securing device was last changed. During an interview on 5/15/2024 at 1:46 p.m., the Director of Nursing (DON) reported R39's wound began as a small tear in his urethral meatus due to his catheter tubing becoming entangled in his feet while self-propelling in his wheelchair, causing his catheter to become dislodged. When asked if there was an incident report referencing the incident, the DON reported there was not. Review of R39's EMR with the DON at the time of the interview revealed the following, in part: 1/31/2024 12:06 p.m. Tip of the penis is noted to be slightly bloody . The DON reported this was due to R39's catheter dislodgement previously referred to. A review of R39's active physician orders revealed the following: TAO [triple antibiotic ointment] to penile meatus . Twice a Day. Start/End Date: 04/19/2024 - Open Ended. The DON stated the wound began as a small tear on the tip of R39's penis. A review of R39's care plan revealed the following, in part: Category: Pressure Ulcer/Injury. Resident is at risk for infection [related to] split in [penile] meatus. Problem Start Date: 05/15/2024. Further review of R39's care plan revealed approaches of TAO to penile meatus BID and Notify MD [physician] of [signs and symptoms] of infection. It was noted the care plan category and approaches were all dated 5/15/2024. During an interview on 5/15/2024 at 10:16 a.m., RN D reported while preparing to perform this Surveyor's wound care observation, she realized there was no focus area, goal or planned interventions related to R39's catheter-related pressure wound referenced in the Residents care plan. RN D stated she therefore added the information to the care plan on that day, 5/15/2024.

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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 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** 41978 Based on observation, interview and record review, the facility failed to provide appropriate care to prevent worsening of a catheter-associated pressure injury for one Resident (R39) of three residents review for pressure injuries. Findings include: R39 was admitted to the facility on [DATE] and had diagnoses including macular degeneration (limited field of vision), urinary retention, urinary tract infection and generalized muscle weakness. A review of R39's Minimum Data Set (MDS) assessment, dated 3/19/2024, revealed R39 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicating he had moderate cognitive impairment. Further review of R39's MDS assessment revealed he had an indwelling urinary catheter and was dependent on staff for lower body dressing (ability to dress and undress below the waist, including fasteners). An observation of wound care provided by Registered Nurse (RN) D on 5/15/2024 at 10:16 a.m. revealed a ventral (underside) tear through the glans (rounded tip) of R39's penis extending approximately one and one-half inches through the penile shaft (portion leading from the body to the glans). An indwelling, urinary catheter was observed to be leading from the superior portion (nearest R39's body) of the tear to an adhesive, catheter securing device attached to R39's left upper thigh, with tubing leading to a dependent drainage bag attached to the left side of R39 bed frame. It was noted there was no date written on the catheter securing device to indicate when the device was last changed. RN D reported the catheter securing device was ordered to be alternated between the right leg and the left leg on a weekly basis to offload the pressure on R39's penis and urethra from the catheter tubing. RN D stated she was unsure when the catheter securing device was last changed. When queried to where she documented R39's wound care, RN D reported she only documented the wound care was complete per the order on R39's Treatment Administration Records (TARs). RN D stated she did not measure the wound or document the characteristics of the wound, wound bed, or surrounding tissue. Immediately following the observation, review of R39's May 2024 Treatment Administration Record (TAR) with Licensed Practical Nurse (LPN) J revealed the following: Order: TAO [triple antibiotic ointment] to penile meatus [opening in penis where urine exits the body] . Twice a day . Start/End Date: 4/19/2024 - Open Ended. Review of R39's May 2024 Medication Administration Record (MAR) with LPN J revealed the following: Order: Change cath [catheter] secure weekly and prn [as needed]. Make sure sites are rotated . Once a Day on Fri [Friday] . Start/End Date: 02/22/2024 - Open Ended. Further review revealed the catheter securing device was changed to the left leg on 5/3/2024. A note in the MAR dated 5/10/2024 at 8:29 a.m., revealed the catheter securing device was not changed on 5/10/2024 with the following reason noted: cath to be changed this pm [p.m.]. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R39's May 2024 MAR revealed the catheter was not changed on 5/10/2024 as scheduled but recorded as changed on 5/12/2024. LPN J reported there was no documentation on the MAR of changing the catheter secure device to alternate sites after 5/3/2024 through the date of the review on 5/15/2024. Review of R39's progress notes with LPN J revealed the following: 5/12/2024 at 6:56 a.m. - Foley catheter changed . Stat-lock [adhesive, catheter securing device] replaced d/t [due to] old one was no longer attached to his leg. LPN J confirmed the location of the catheter secure device was not recorded. LPN J stated the last recorded location of the catheter securing device, on 5/3/2024, was R39's left leg. RN D, who was present during the record review, reported it appeared the catheter securing device was not rotated to the opposite leg per the physician's order. RN D stated concern regarding the potential of R39's wound worsening if the catheter securing device was not rotated between legs. RN D reported the location of the catheter securing device should be recorded when changed for reference to ensure alternating sites. RN D stated R39 did not have an indwelling catheter prior to his hospitalization in December 2023. Review of R39's electronic medical record (EMR) revealed R39 returned from the hospital on 12/14/2023 with an indwelling, urinary catheter in place. R39 had a trial removal of the indwelling catheter by urology on 1/5/2024 with subsequent replacement of the catheter on 1/7/2024. Review of R39's MARs and TARs from January 2024 through April 2024 revealed R39's catheter securing device was changed on five instances when location of the device was not recorded. Further review of the April 2024 MAR revealed R39's catheter securing device was changed and placed on his right leg on 4/12/2024. It was noted in review that the catheter securing device was not rotated from the right leg per the documented change of site on 4/5/2024. Further review of R39's EMR, including MARs and TARs, from January 2024 through 5/15/2024 revealed no documentation of assessments or tracking of healing or progression of R39's penile wound. During an interview on 5/15/2024 at 1:46 p.m., the Director of Nursing (DON) reported R39's wound began as a small tear in his urethral meatus due to his catheter tubing becoming entangled in his feet while self-propelling in his wheelchair, causing his catheter to become dislodged. When asked if there was an incident report referencing the incident, the DON reported there was not. The DON stated the wound began as a small tear on the tip of R39's penis. Review of R39's EMR with the DON at the time of the interview revealed the following, in part: 1/31/2024 12:06 p.m. Tip of the penis is noted to be slightly bloody . The DON reported this was due to R39's catheter dislodgement previously referred to. Further review of R39's record revealed no documentation of the DON's report of trauma to R39's penis from dislodgement of the catheter. The DON confirmed there were no assessments, including appearance of the wound, wound bed and surrounding tissue or measurements of R39's wound to track healing or progression of the wound.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation relates to Intake #MI00142921. Based on observation, interview, and record review, the facility failed to provide appropriate staffing of Certified Nursing Assistants (CNAs) to provide necessary care and services for three Residents (R18, R23, and R48) of 14 sampled residents, and six confidential interviewable Residents from the group meeting facility task. This deficient practice resulted in feelings of frustration related to delay in staff responding to call lights and the potential for adverse resident outcomes. Findings include: Review of R23's Minimum Data Set (MDS) assessment, dated 3/26/24, revealed admission to the facility on [DATE], with diagnoses including osteomyelitis (bone infection), diabetes, and kidney disease. R23 was dependent for toileting, required maximal assistance for transfers, and was frequently incontinent of bladder and bowel. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R23 was cognitively intact. Review of R48's MDS assessment, dated 4/10/24 revealed admission to the facility on [DATE], with diagnoses including stoke and atrial fibrillation (an irregular heart rhythm). R48 was dependent for toileting and transfers, frequently urinary incontinent, and always incontinent of bowel. The BIMS assessment revealed a score of 12/15, which showed R48 had moderate cognitive impairment. During the initial tour on 5/13/24 at 11:23 a.m., R48 reported they waited too long for their call light to be answered every day, and they experienced incontinence. R48 reported this occurred the most when there were only two Certified Nurse Aides (CNAs) for the entire building. During the initial tour on 5/13/24 at 2:20 p.m., R23 reported the facility did not have enough nursing aide staff, and they appeared rushed. R23 stated there should be more staff on their hall to meet the care needs of the residents who could not speak for themselves. During an observation on 5/14/24 at 10:07 a.m., the nursing staff posting sheet in the lobby showed a census of 54 residents. The posting further revealed from 6:30 a.m. to 6:30 p.m., there were two Certified Nursing Aides (CNA's) scheduled, and three nurses. This showed there were only two CNA's scheduled for the entire facility with approximately 27 residents each, a 1:27 ratio. During the confidential group meeting on 5/14/24 at 1:31 p.m., residents collectively reported concerns regarding staff answering call lights timely and not receiving water. Specific concerns were as follows: One confidential Resident described the staff were overwhelmed and sometimes they had a bad attitude, as there were not enough CNAs to care for the residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another confidential Resident described a few days ago they pushed their call light due to coughing at night and needed cough syrup, and nursing staff never came. They stated, The thing is, I am well .Someday I won't be able [to toilet themselves]. I worry about my old age, as I see what is happening around me. Someday, I won't be able to stand up . Another confidential Resident reported they waited 30 minutes for their call light to be answered, and sometimes they turned it off after this as nobody came to answer their call light, when they needed water on the night shift, which they stated continued to occur. Another confidential Resident reported they waited 40 minutes about a week ago in the bathroom as they needed help wiping themselves after toileting and no staff came to assist. They explained when this occurred [on several other occasions] they transferred back to bed and soiled their sheets, which bothered them. They stated, We got people [residents] that have dementia and they are yelling and screaming at night, and you never know if they need help, and people [residents] are getting out of bed [unsupervised when they needed assistance] . They described their neighbor (another resident) needed two person assistance for his care, and when staff were with him, there were no other aides available for 30 minutes while performing his care (when there were two CNAs on the night shift). Another confidential Resident reported they waited up to a half hour at night when they requested their medications. They clarified some nurses did not assist when there were only two aides in the building at night, which happened again about two days ago, and longer call wait times. They stated, My roommate had to be put on the bed pan and the nurse was standing right there .I said to her, [Roommate's name] has to go on the bedpan and she said, 'I can't you help you. I have got pills to pass.' I feel since there were only two CNAs [in the facility] she should have stepped in .At night we have sundowners [residents with dementia], and they [residents] are getting up out of their chairs [unsupervised] . They stated they believed falls were possibly occurring at night due to low staffing. Another confidential Resident reported they were frustrated as some CNAs had an attitude when someone called off work with little notice, and they heard them talking about it. Review of the resident council meeting minutes showed the following: May 2024: Three residents reported their call lights were not being answered timely, and one said sometimes it was not. April 2024: Two residents reported their call lights were not being answered timely and two said sometimes it was not. March 2024: One resident reported their call light was not answered timely and four residents stated sometimes it was not. February 2024: Four residents reported their call lights were not answered timely. Review of 4/4 of the resident council meeting minutes showed old business included notations of residents reporting their call lights were not answered timely. Further review of the April 2024 meeting minutes revealed residents (unspecified - 9 in attendance) stated that they were not consistently getting a water pass at night. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/14/24 at 3:48 p.m., Activity Director (Staff) N was asked about call wait times and water pass concern reported by residents. Staff N confirmed residents in the resident council meeting collectively reported extended call wait times of 20 to 45 minutes in the past few months, including this month (May 2024). Staff N reported they shared their concerns with the Director of Nursing (DON) when this was reported, and provided this Surveyor with one Resident Council response form, dated 4/30/24. Review of the Resident Council Department Response Form, dated 4/3/24, signed by the DON on 4/4/24, revealed, 1. Residents stated they are not consistently getting a water pass at night. 2. Four of nine residents are waiting 1/2 hour on their call lights. Mostly at night but sometimes in the day. The DON response was, Will speak with CNA and nurse on NOC [night shift] to ensure water pass is done every night and as well as call light response time. During an interview on 5/15/24 at 9:35 a.m., CNA R confirmed there were only two nursing aides on shift the night prior (5/14/24) for much of the shift. Review of staff postings for the past two weeks (from 4/30/24 through 5/12/24) received from Staff G showed low nursing aide staffing (two aides) on the night shift from 6:30 p.m. to 6:30 a.m. as follows: 4/30/24: Census: 55. Two CNA's. Three nurses. No call ins. 5/10/24: Census: 55. Two CNA's. Three nurses. No call ins. Review of call light logs for the prior two weeks (from 5/01/24 to 5/14/24) for resident council group meeting residents revealed two residents/rooms with extended call wait times. Call light wait times of over 20 minutes were noted below: One confidential Resident's bathroom call light activated: 5/04/24 at 10:27 a.m : Elapsed time to room: 22:28 (22 minutes and 28 seconds). 5/05/24 at 8:43 p.m :Elapsed time to room: 38:19. 5/05/24 at 6:10 a.m.: Elapsed time to room: 22:35. Another confidential Resident's bed call light activated: 5/02/24 at 12:11 a.m.: Elapsed time to room. 37:36. 5/02/24 at 5:41 a.m.: Elapsed time to room. 45:40. 5/03/24 at 4:01 p.m.: Elapsed time to room. 30:49. 5/04/24 at 2:02 a.m.: Elapsed time to room: 32:28. 5/04/24 at 2:43 p.m.: Elapsed time to room: 36:00. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/04/24 at 7:53 p.m.: Elapsed time to room: 40:44. 5/05/24 at 8:00 a.m.: Elapsed time to room: 32:31. 5/10/24 at 7:11 p.m.: Elapsed time to room: 24:04. 5/13/24 at 8:14 p.m.: Elapsed time to room: 34:01. In summary, the call light logs showed nine times (during a two week period) when call light wait times were verified in excess of 30 minutes for two residents/rooms. Review of the staff postings received on 5/15/24 from Staff G showed low staffing on the night shift as follows: 5/13/24: Census: 55. Two CNA's. Three nurses. One call in (CNA). 5/14/24: Census: 54. Two CNA's. Three nurses. One call in (CNA). It was noted on 5/14/24, a third CNA arrived at 11:00 p.m. to finish working on the night shift. It was later confirmed by the DON on 5/13/24 there were two CNAs on the night shift, and on 5/14/24 there were two CNAs on part of the night shift. During a phone interview on 5/15/24 at 3:29 p.m., CNA P was asked about staffing on the night shift. CNA P confirmed there were only two aides on the night shift on 5/10/24, two nurses, and another nurse, Licensed Practical Nurse (LPN) A, who helped with the medication pass. CNA P reported they regularly worked the night shift, and it bothered them when the staffing was low, because residents waited a long time sometimes for staff to answer their call lights. CNA P stated at times this was 30 minutes or longer when they were shorter staffed, especially with only two CNAs. CNA P explained it was difficult to answer resident alarms when sounding because they were providing care for another resident. CNA P reported while they changed their residents' clothes and briefs, they had found other residents put to bed by other staff in their clothes (no gown) and had observed them wearing the same clothes two days later. CNA P reported there were some residents who would take 30 minutes for their care, which made it difficult to answer another resident's call light. CNA P reported this bothered several of the facility residents, who reported feelings of frustration waiting for extended call light wait times. When asked about any outcomes, CNA P reported sometimes they found residents left wet who had not been changed timely, both on the night and day shift. CNA P clarified some of the nurses assisted the CNAs on the night shift with resident cares however there was one nurse who refused to assist them. CNA P reported some residents were not being repositioned appropriately by other staff, as they found some residents in the same position. They could not confirm or deny staff shortages caused falls or skin concerns but felt this placed residents at risk for both. During an interview on 5/15/24 at 3:52 p.m., LPN A reviewed the nursing schedule with this Surveyor, and confirmed they worked on 5/10/24 when there were two aides on the night shift. LPN A reported they could use more CNAs and declined to comment further when asked about the 1:28 CNA to resident ratio with two aides working at night. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/24 at 4:33 p.m., the Nursing Home Administrator, NHA H and the DON were asked about facility CNA staffing, per the facility assessment. Neither was able to clearly interpret the numbers of CNA staff required, whether it was actual nurse aides, full time equivalents, hours, or other. The DON was asked how they staffed, which was reported by both number of residents and resident acuity. The DON explained with a census of 61 and higher, they would staff at least 3 CNAs at night. Concerns were reviewed respective to resident council meeting minutes, the group meeting interview, staff posting sheets, call light logs, staff interviews, and reported resident outcomes. NHA H conveyed they understood the concerns, and they had no additional comment other than to say they had newly hired staff incoming. The DON acknowledged staffing deficits and stated on the night shift if no one picked up a shift then there were sometimes two aides and three nurses at night, which was not ideal. The DON acknowledged the concern and confirmed the three night shift nurses were assigned as nurses and not CNA's when they worked at night, although they were expected to assist the CNAs with resident cares. Review of the facility assessment, dated 1/01/24, revised 1/23/24, revealed the average daily facility resident census was 64. The facility resources section, Page 7, revealed, Part 3. Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies . Page 8 revealed, Describe your general staffing plan to ensure that you have sufficient staff to meet the needs of the residents at any given time. Consider if and how the degree of fluctuation in the census and acuity levels impact staffing needs. This page showed a column labeled Staff and showed Direct Care Staff [CNAs]. The adjacent column showed Plan: Days - 6 aides @ 12-hour shifts. Evenings [Night shift]: 4 aides @ 12-hour shifts. Given the census of 64 residents, it was noted with 4 CNAs, the CNA to resident ratio was 1:16, reflecting one CNA for 16 residents, per the facility assessment. When there were only two CNAs on the night shift, which was discovered during April 30th and May 15th (2024), the CNA to resident ratio was 1:27 or 1:28, given a census of 54 or 55 residents, respectively. This placed a significantly high resident care expectation on the two evening (night) shift CNAs. When there were three CNAs on the evening (night) shift, this ratio decreased to 1:18, which was still higher than the 1:16 facility assessment expectation. The facility assessment represented facility population acuity by revealing 45 residents required one to two person assistance,and eight were dependent for transfers, given an average census of 64 residents. The assessment confirmed resident and staff interviews which revealed there were residents who required two-person assistance and/or a mechanical lift for transfers in the facility due to dependence. Review of the policy Staffing, revised April 2007, revealed, 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan . 40383 Resident 18 (R18) R18 was admitted on [DATE] with a primary diagnosis of traumatic brain dysfunction. Review of R18's MDS assessment, dated 2/12/24 revealed R18 was dependent on staff for toileting, dressing, and personal hygiene. The BIMS assessment revealed a score of 9 out of 15 indicating moderate cognitive impairment. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the initial tour on 5/13/24 at 10:49 AM, R18 stated he had many staffing concerns. He stated there were some staff who did not seem to care and there were not enough staff. He often had to wait. On 5/15/24 at 2:17 PM, the call light in the hallway above R18's room was observed to be on. Upon entering the room this surveyor asked R18 if his call light was answered timely when he pushed it. R18 responded, I wish. He said he pushed his call light a while ago and he was still waiting. Every day I have to wait. The call light in the hall above R18's door continued to be on. A nurse was right outside the door standing at her med cart, but she did not look up or inquire what R18 needed. This surveyor then re-entered the room and asked R18 if he had to wait often. He stated, My job is to wait. The call light logs for the prior two weeks for R18 were requested and revealed the following examples of wait times exceeding 20 minutes: 5/1/24 at 8:04 AM elapsed time to room [ROOM NUMBER]:46 (24 minutes 46 seconds) 5/1/24 at 11:52 AM elapsed time to room [ROOM NUMBER]:42 5/1/24 at 1:57 PM elapsed time to room [ROOM NUMBER]:43 5/1/24 at 7:56 PM elapsed time to room [ROOM NUMBER]:52:10 (1 hour 52 minutes 10 seconds) 5/1/24 at 10:44 PM elapsed time to room [ROOM NUMBER]:23 5/2/24 at 4:55 AM elapsed time to room [ROOM NUMBER]:37:50 5/2/24 at 7:11 PM elapsed time to room [ROOM NUMBER]:12 5/2/24 at 9:56 PM elapsed time to room [ROOM NUMBER]:41 5/3/24 at 3:39 AM elapsed time to room [ROOM NUMBER]:41 5/3/24 at 12:55 PM elapsed time to room [ROOM NUMBER]:13 5/3/24 at 2:01 PM elapsed time to room [ROOM NUMBER]:39 5/3/24 at 7:52 PM elapsed time to room [ROOM NUMBER]:09 5/3/24 at 9:01PM elapsed time to room [ROOM NUMBER]:27 5/4/24 at 6:03 PM elapsed time to room [ROOM NUMBER]:42 5/4/24 at 6:45 PM elapsed time to room [ROOM NUMBER]:11 5/5/24 at 9:00 AM elapsed time to room [ROOM NUMBER]:33 5/5/24 at 8:08 PM elapsed time to room [ROOM NUMBER]:41 (continued on next page)

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	235526	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Park Terrace	14676 W Upright Charlevoix, MI 49720

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/6/24 at 3:56 AM elapsed time to room [ROOM NUMBER]:52 5/6/24 at 10:39 AM elapsed time to room [ROOM NUMBER]:45 5/6/24 at 1:13 PM elapsed time to room [ROOM NUMBER]:34 5/6/24 at 4:39 PM elapsed time to room [ROOM NUMBER]:57 5/6/24 at 5:52 PM elapsed time to room [ROOM NUMBER]:40 5/6/24 at 8:44 PM elapsed time to room [ROOM NUMBER]:36 5/7/24 at 7:02 PM elapsed time to room [ROOM NUMBER]:34 5/7/24 at 8:21 PM elapsed time to room [ROOM NUMBER]:09:06 5/8/24 at 12:45 AM elapsed time to room [ROOM NUMBER]:05:58 5/8/24 at 3:05 AM elapsed time to room [ROOM NUMBER]:07 5/8/24 at 5:45 AM elapsed time to room [ROOM NUMBER]:30 5/8/24 at 6:53 PM elapsed time to room [ROOM NUMBER]:29 5/8/24 at 10:00 PM elapsed time to room [ROOM NUMBER]:01 5/9/24 at 10:41 AM elapsed time to room [ROOM NUMBER]:34 5/10/24 at 7:10 AM elapsed time to room [ROOM NUMBER]:32 5/10/24 at 10:32 AM elapsed time to room [ROOM NUMBER]:32 5/10/24 at 1:52 PM elapsed time to room [ROOM NUMBER]:45 5/10/24 at 4:06 PM elapsed time to room [ROOM NUMBER]:44 5/10/24 at 6:35 PM elapsed time to room [ROOM NUMBER]:47 5/11/24 at 1:55 AM elapsed time to room [ROOM NUMBER]:54 5/11/24 at 5:13 AM elapsed time to room [ROOM NUMBER]:06 5/11/24 at 6:09 PM elapsed time to room [ROOM NUMBER]:22 5/11/24 at 8:40 PM elapsed time to room [ROOM NUMBER]:35:11 5/12/24 at 12:03 AM elapsed time to room [ROOM NUMBER]:29:53 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/12/24 at 4:44 AM elapsed time to room [ROOM NUMBER]:05:30 5/12/24 at 6:16 AM elapsed time to room [ROOM NUMBER]:36 5/12/24 at 7:07 AM elapsed time to room [ROOM NUMBER]:54 5/12/24 at 8:31 PM elapsed time to room [ROOM NUMBER]:12 5/12/24 at 9:22 PM elapsed time to room [ROOM NUMBER]:45:35 5/13/24 at 6:23 AM elapsed time to room [ROOM NUMBER]:20 5/13/24 at 7:09 PM elapsed time to room [ROOM NUMBER]:07:40 5/13/24 at 8:20 PM elapsed time to room [ROOM NUMBER]:38:31 In summary, the call light logs from 5/1/2024 to 5/13/2024 recorded R18 had to wait more than 20 minutes to get help when using his call light 49 times. Further, this report showed R18 waited more than an hour 10 times during these 13 days.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on interview and record review the facility failed to ensure timely physician response to Medication Regimen Review (MRR) pharmacy recommendations and failed to follow the physician orders after they were written for one Resident (R5) of five residents reviewed for MRR out of a sample of 14 residents. This deficient practice had the potential to result in excessive dosage, side effects, and adverse reactions. Findings include: Resident #5 (R5) A review of R5's diagnoses included gastro-esophageal reflux disease (GERD), dementia, diabetes, major depressive disorder, and chronic kidney disease. The Minimum Data Set (MDS) assessment for R5, dated 2/12/2024, revealed an admitted [DATE]. The electronic medical record revealed R5 had a current physician order for pantoprazole 20 milligrams (mg) daily for GERD. On 12/28/2023 the pharmacist performed a medication regimen review (MRR) for R5 which read in part, Please respond to the following . Resident is currently prescribed: pantoprazole 20 mg daily for GERD. For your review: State guidelines require clinical rationale/documentation be given to support continue treatment of any underlying chronic disease state. This would include disease being treated by PPIs (Proton Pump Inhibitors or medications that reduce the production of stomach acid) or H2 blockers (drugs that reduce stomach acids) beyond 12 weeks. The 2023 Beers criteria currently suggests discontinuation after 8 weeks, as risk is deemed greater than benefit . If use is to continue for this resident, please provide a risk-benefit statement, as well as a monitoring parameter. If medication is discontinued, it is suggested it be gradually reduced or a probiotic be considered, to diminish any potential acid-rebound. Recommendation: decrease pantoprazole to 20 mg every other day x (times) 2 weeks then discontinue. This MRR recommendation was written on 12/28/23. It was signed by the physician who checked the box Agree - I agree with this recommendation on 3/14/24. Although the physician did not respond to the 12/28/23 recommendation until 3/14/24, the Pharmacist performed further MRRs on 1/20/24 and 2/25/24, which both read in part, Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities . Although the physician did respond as agreeing with the MRR recommendation on 3/14/24 to decrease pantoprazole to 20 mg every other day x (times) 2 weeks then discontinue, the pantoprazole was not decreased or discontinued. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24 at 3:04 PM, the Director of Nursing (DON) reviewed the pharmacist recommendation and the physician signature in agreement with the MMR. The DON stated she would expect the pharmacist's recommendations to be signed by the physician within one week. The DON stated, I will go see if it was a nursing error or a physician error, as the current order remained 20 mg once a day after it was started on 12/22/2022. During an interview on 5/15/24 at 3:30 PM, the DON stated the MRR signed by the physician was never written as an order. A facility policy on MRRs including timeframe and process was requested but was not provided during the survey. A pharmacy procedure was provided and reviewed but this did not include the facility process or timeframe standards.

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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** 40383 Based on observation, interview, and record review the facility failed to follow up on routine dental services for one Resident (R5) of one resident reviewed for dental services. This deficient practice resulted in R5's diet being downgraded from a regular diet to a pureed diet with a potential for weight loss and dissatisfaction with meals while waiting for her dentures to be fixed. Findings include: Resident #5 (R5) A review of R5's diagnoses included complete loss of teeth, cerebral infarction (stroke), dementia, diabetes, major depressive disorder, chronic kidney disease, and gastro-esophageal reflux disease. The Minimum Data Set (MDS) assessment for R5, dated 2/12/2024, revealed an admitted [DATE] and a score of 7 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating severe cognitive impairment. This MDS recorded a height of 5 feet 2 inches and a weight of 82 pounds. During lunch rounds in the Main dining room on 5/13/24 at 12:25 PM, R5 was observed to be eating a pureed diet (all foods blended into a baby food consistency). The medical record for R5 revealed Physician orders which included 1/4/24 DIET: Downgrade to Puree, NCS (No Concentrated Sweets) d/t (due/to) spitting food out. May have soft foods per request. Waiting for dentures to come in. During an interview on 5/14/24 at 3:03 PM, the Director of Nursing (DON) stated R5 did not currently have dentures as they were at the dentist getting fixed. The DON stated when dentures were sent out for repair the max would be after a month they (the dentures) should be back. The medical record showed on 12/6/2023, R5 had a visit to the dentist, who took an impression of her mouth and performed dental services. An appointment to return was scheduled on 12/20/23. On 12/12/23 the Certified Dietary Manager wrote a progress note which read, Received diet slip to down grade diet to mechanical soft diet texture, until resident receives dentures. Changes made to reflect this change. On 1/4/24 at 11:53 AM a nursing progress note read, Care collaboration meeting with Hospice and (facility) IDT (interdisciplinary team). Appetite poor Gradual weight loss noted. Diet downgraded to Pureed until dentures come in . The Care plan for R5 included, EATING: Independently. Offer alternatives if she's not eating. DIET: Downgrade to Pureed, NCS diet d/t spitting food out. May have soft foods per request. Waiting for dentures to come in. Edited: 01/26/2024 (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24 at 10:00 AM, the DON looked but could not find a return dental appointment since 12/6/23, stating It does not show in the consult section . It (the follow up appointment) was supposed to be 12/20/23 but it was not made. The DON stated, Someone dropped the ball. There was no appointment made. During an interview on 5/15/24 at 10:22 AM, the Business Office Manager (Staff G) stated this appointment fell through the cracks. Staff G said there was poor communication between the dental office and our staff. The facility policy titled Dental Services read in part, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 41978 Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement committee met at least once per quarter with the required committee members resulting in the potential for quality-of-care concerns for all 55 residents in the facility. Findings include: On 5/15/2024 at 3:25 p.m. a review of the available attendance documentation for the QAPI meetings with the interim-Nursing Home Administrator (NHA H) and the Director of Nursing (DON), revealed the following: Meeting held on 4/30/2024: The Medical Director or designee did not attend. Meeting held on 1/10/2024: No attendance record found. The DON reported information from the third quarter (July - September) 2023 was included with the October - December 2024 meeting on 1/10/2024. No meeting was held for the Third-quarter 2023. NHA H reported she was new and unsure where the previous NHA kept the QAPI documents. The DON called the previous NHA in the presence of this surveyor and was yet unable to locate the QAPI information needed for review. The missing attendance records and confirmation of meetings were not provided by survey exit on 5/15/2024 at 5:45 p.m. Review of the facility Quality Assurance and Performance Improvement plan, last reviewed 8/22/2023 revealed the following, in part: It is the policy of [the facility] to develop, implement and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life . The QA Committee shall be interdisciplinary and shall: Consist at a minimum of: The Director of Nursing Services; The Medical Director or his/her designee; At lease three other colleagues, at least one of which must be the administrator . ; The Infection Control and Prevention officer; Pharmacy representative . Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary . [the facility] will maintain documentation and demonstrate evidence of its ongoing QAPI program .