STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235529	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Novi	24500 Meadowbrook Rd Novi, MI 48375

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 34208 Based on observation, interview, and record review the facility failed to protect personal health information for nine residents (R#'s 89, 45, 266, 71, 73, 26, 38 and 42) of nine residents reviewed for personal privacy. Findings include: On 1/28/25 at 9:18 AM and 1/29/25 at 4:15 PM, an observation of the nursing station on the A unit revealed a bulletin board visible from anyone passing by that listed R89, R45, R266, R71, R73, R26, R38, and R42's names and the times they were to attend dialysis treatments. On 1/30/24 at 10:45 AM, an interview was conducted with the Director of Nursing regarding resident's private health information observed on the A unit and they indicated the Unit Manager posted the schedules but it should not be visible to anyone passing by and could have had a privacy cover placed over it. According to the facility's policy titled HIPAA (Health Insurance Portability and Accountability Act) Policy Regarding Use and Disclosure of PHI (Protected Health Information) for Treatment dated 9/30/2021: .Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records . 30675

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure appropriate use of restraints, documented medical symptoms for the use of restraints, and consent for use for two residents (R#'s 59 and 67), of two residents reviewed for restraints. Findings include: R59 On 1/29/25 at 10:05 AM, R59 was observed in their room seated in a Merry [NAME] (a wheeled walker with a seat surrounded by a frame containing a hinged gate and belt to secure the user in the device that is not considered a restraint if the resident can exit the walker). At that time, R59 was asked of they could unbuckle the belt, lift the gate, and exit the framed walker. R59 responded Yes. They were asked to demonstrate their ability to exit the walker and repeated Yes. They were asked again to demonstrate their ability to get out of the walker and again repeated Yes, showing no indication they understood the request or their ability to physically complete the request. A review of R59's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: dementia without behavioral disturbances, psychotic disturbance, mood disturbance, anxiety, and high blood pressure. Their most recent Minimum Data Set assessment dated [DATE] revealed they had severely impaired cognition and was not coded for the use of a restraint. Continued review of the record revealed a, Physical Device Evaluation- V 6 dated 7/17/24 indicated the use of a Merry Walker. Section three on the evaluation read, Restraint/Enabler and a box that read, Cannot easily be removed by the resident (cannot be removed intentionally) was checked. The evaluation further documented, release during supervised activities. A review of R59's physician's orders was conducted and revealed an order dated 7/17/24 for a Merry [NAME] that read, .to increase mobility dx (diagnoses) Dementia and ALZHEIMER's DISEASE, release during supervised activities . On 1/29/25 at 10:28 AM, an interview was conducted with the facility's Director of Nursing (DON) regarding R59's Merry Walker. They were asked if it was considered a restraint and said no because, It promotes ambulation. They were then asked if R59 could intentionally remove themselves from the Merry [NAME] and said, No, she needs staff assistance to get in and out of it. R67 On 1/28/25 at 11:30 AM, R67 was observed in their room seated in their wheelchair. A seatbelt was observed buckled across their lap. They were asked if they could undo the seatbelt and made no verbal or physical demonstration they understood the question or could unbuckle the belt. On 1/28/25 at 12:48 PM, R67 was observed in the dining room being given one-to-one feeding assistance with the seatbelt observed to be buckled across their lap. On 1/29/25 at 8:24 AM, R67 was observed in the dining room asleep in their wheelchair with the seatbelt buckled across their lap. Six staff members were present in the dining room serving breakfast. At 8:50 AM, Nurse 'L' was observed providing one-to-one feeding assistance to R67 with the seatbelt buckled across their lap. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R67's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: kidney disease, falls, cataracts, delusional disorder, major depressive disorder, anxiety disorder, stroke, dementia and a femur fracture. Their Minimum Data Set assessment dated [DATE] revealed severely impaired cognition, substantial/maximal assistance with activities of daily living including transferring, wheelchair mobility, and bed mobility. It was further revealed R67 was coded as having a restraint in place. Continued review of R67's record revealed an order created 7/18/24 revised on 12/20/24 that read, .Seatbelt dx (diagnosis) Dementia .release restraint during supervised activities . R67's care plan for the use of the seatbelt was reviewed and read, (R67) is at risk for complications due to they require the use of a: non-releasing seatbelt the devices is SPECIFY: restraint; related to Dx dementia .Interventions: Release and reposition q2 (every two) hours, with supervised meals, supervised activities and with toileting . R67's Kardex (Nurse Aide Care Guide) was reviewed and also indicated release of the the seatbelt every two hours, with supervised meals, and supervised activities. A thorough review of the record (progress notes, medication administration records, treatment administration records, evaluations, certified nurse aide tasks) did not show evidence the restraint was released per the physician's orders, plan of care, or the Kardex instructions. On 1/29/25 at 10:15 AM, it was observed an activity was taking place in the activity room. At 10:19 AM and 10:36 AM, R67 was observed in their room asleep in their wheelchair with the seatbelt buckled across their lap. On 1/29/25 at 10:28 AM, the Director of Nursing was asked about R67's seatbelt and said it was only to be released during meals and at supervised activities. They were asked why it was not released every two hours and had no explanation. At that time, the observations of the seatbelt being buckled during the meals on 1/28/25 and 1/29/25 were shared with them and they said it should have been unbuckled. They were further asked about any documentation to show the release of the belt and had no explanation. Finally, they were made aware R67 was asleep in their room in their wheelchair at 10:19 AM while an activity was being provided in the activity room. They were asked if R67 could have either been assisted to bed if they were sleepy, or afforded the opportunity to attend the activity and have the seatbelt unbuckled; to which the Director of Nursing agreed. A review of a facility provided policy titled, Restraint Management revised 9/2022 was conducted and read, Restraints are not used unless the guest/resident has medical symptoms that warrant the use of the restraint .Physical Restraints are defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the guest's/resident's body that the individual cannot remove easily .Also included as a restraint are facility practices that meet the definition of a restraint, such as: .Placing a guest/resident in an enclosed framed wheeled walker, in which the guest/resident cannot open the front gate or if the device has been altered to prevent the guest/resident from exiting the device .5. Any guest/resident using a physical restraint or side rails must have a current, signed restraint consent .7. During the time a restraint is in place, the restraint is periodically removed and thee guest/resident assisted with change of position, range of motion, and/or stretching. Restraints should always be removed during supervised mealtimes and activities .

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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** 30675 Based on observation, interview and record review, the facility failed to develop a comprehensive care plan to address a resident's use of a midline intravenous (IV) line, use of antibiotics, and multiple infections for one (R111) of two residents reviewed for infection care planning. Findings include: On 1/30/25 at 8:34 AM, R111 was observed laying in bed asleep, with a blue wedge pillow under their right torso, and their left arm was observed swollen and propped on a pillow. There was a urinary catheter drainage bag secured to the side of the bed and an IV (Intravenous) pole with an empty bag of antibiotic medication placed next to their bed. Review of the clinical record revealed R111 was admitted into the facility on [DATE] with diagnoses that included: acute gastritis with bleeding, pneumonia, urinary tract infection, and cellulitis. According to the Minimum Data Set (MDS) assessment dated [DATE], R111 had intact cognition and had an indwelling urinary catheter. Review of R111's physician orders included multiple antibiotics (both oral and intravenous) for multiple infections which included cellulitis to the right upper extremity, urinary tract infections (UTI), and pneumonia since the end of December 2024. Further review of the care plans revealed there were none initiated for the resident's midline IV or use of antibiotics for the current UTI and pneumonia diagnoses. The only care plan that mentioned a UTI was an at risk for urinary tract infection initiated upon admission by the Director of Nursing (DON) that had not been revised since initiation on 12/20/24. On 1/30/25 at 8:16 AM, an interview was conducted with the Infection Preventionist (IP 'A'). When asked about R111's infections and antibiotics, IP 'A' reported they were recently started on an IV antibiotic to treat both a UTI and pneumonia. When asked who was responsible to initiate or revise care plans as infections were identified or midline IV's were implemented, IP 'A' reported they and the nurses were responsible. They were unable to explain why that had not occurred for R111. On 1/30/25 at 10:55 AM, an interview was conducted with the Director of Nursing (DON). When asked who was responsible for initiating care plans for infections, the DON reported that should've been IP 'A'. They were informed there was no care plan other than the one they initiated upon admission for being at risk for a UTI. They were also asked about a care plan for the use of a midline IV and the DON reported a care plan should've been initiated and that could've been done by any nurse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's policy titled, Care Planning dated 6/24/2021: .The care plan must be specific, resident centered, individualized and unique to each resident and may include .How to manage risk factors . Utilize current standards of practice .Treatment objectives should have measurable outcomes .Involve and communicate the needs of the resident with the direct care staff (i.e. CNA (Certified Nursing Assistant) Kardex) .The care plan and resident Kardex will be updated .with significant changes. This includes adding new focuses, goals, and interventions and resolving ones that are no longer applicable as needed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 34208 Based on observation, interview, and record review, the facility failed to ensure care was provided per professional nursing standards for one resident, (R75) of five residents reviewed during the medication administration observation. Findings include: On 1/29/25 at 9:23 AM, Nurse 'J' was observed preparing medications for administration to R75 at the medication cart in the hallway. The medications prepared were placed in a medication cup and it was not observed Tylenol had been removed from the cart and placed into the cup. Upon completing the preparation, Nurse 'J' entered R75's room and handed them the medication cup. R75 looked at the pills in the cup and asked Nurse 'J' if one of the large pills in the cup was Tylenol. Nurse 'J' told them no and said, the little pill is the Tylenol. R75 then proceeded to take the medications. On 1/29/25 at 9:39 AM, an interview was conducted with Nurse 'J'. They were asked why they told R75 one of the pills in the medication cup was Tylenol when no Tylenol had been prepared and taken into the room. In a defensive tone, Nurse 'J' said, I don't remember her (R75) asking me about Tylenol, so I won't confirm I said anything about that. On 1/30/25 at 10:34 AM, The Director of Nursing (DON) was made aware of the observation and conversation between Nurse 'J' and R75. They said Nurse 'J' should not have told R75 there was a medication in the cup that was not there. A review of a facility provided Charge Nurse Job description was reviewed and read, .2. Provides safe and accurate Medication Related interventions to residents. a. Administers and documents medications and treatments according to each resident's medication schedule using current standards of medication pass technique .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to ensure routine showers/baths and hygiene care were provided for two (R91 and R52) of five residents reviewed for activities of daily living (ADL's). Findings include: R91 On 1/28/25 at 11:55 AM, R91 was observed seated in a wheelchair just outside of their room. When asked about their care and whether they received baths or showers per their schedule, R91 reported they were supposed to get a shower last Friday, but they never did and they further reported it had been a while since they had one. When asked if staff informed them of the reason they might not be able to get a shower on their scheduled days, R91 reported they say they'll be too busy. Review of R91's shower/bath schedule in the task section of the Electronic Medical Record (EMR) documented and the resident was scheduled to have a shower/bath on Tuesdays and Fridays on the PM (evening) shift. Review of the clinical record revealed R91 was admitted into the facility on [DATE] with diagnoses that included: wedge compression fracture of T11-T12 vertebra, other chronic pain, and adjustment disorder with mixed anxiety and depressed mood. According to the Minimum Data Set (MDS) assessment dated [DATE], R91 had a Brief Interview for Mental Status (BIMS) exam score of 9/15 which indicated moderate cognitive impairment (however R91's recollections of discussions with staff were accurate during the resident interview), had no mood or behavior concerns, had impairment on both sides of lower extremities, and was dependent for shower/bathing. According to the profile information, R91 was currently their own responsible party. Review of the task section of the Electronic Medical Record (EMR) for R91's shower/bath for the past 30 days (max look-back period available for review) documented the resident only received four showers on 12/31/24, 1/3/25, 1/7/25, 1/10/25 (most recent). The documentation on 1/14/25 and 1/28/25 had a check marked next to No for the prompt if the resident received a shower/bath, and the documentation on 1/17/25 had a check marked next to Not Applicable. There were no documented refusals on the task documentation or in the progress notes. According to the care plan initiated on 11/25/24, revised on 11/27/24, interventions included: BATH/SHOWER: Resident (SPECIFY: is .Dependent .Substantial/maximal assistance with two helper(s). On 1/29/25 at 11:47 AM, the facility was requested via email to clarify where the bathing/shower documentation was kept and the facility reported that would be under the TASK section for bathing (same documentation that was reviewed above). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 1:06 PM, an interview was conducted with the Director of Nursing (DON). When asked to confirm the process of where showers/baths were documented, the DON reported only in the TASK section. At that time, the DON reviewed the available documentation for R91 and confirmed the lack of showers documented. The DON was asked if there was any refusal if offered where would that be documented and the DON reported that should be indicated on the TASK documentation and if refused, it would send an alert. The DON reported they did not recall receiving any alerts like that for R91. R52 On 1/28/25 at 10:32 AM, R52 was observed lying in their bed. Their face and hair had a shiny, greasy appearance and their teeth appeared with yellow/brown discoloration and debris caked on them. On 1/29/25 at 11:55 AM, R52 was observed lying in their bed. Their hair and face remained with a shiny, greasy appearance. A green/yellow crusty material was observed in their nostrils and their teeth appeared with yellow/brown discoloration and debris. They were asked the last time anyone had cleaned them up such as washed their face or assisted them with oral care and they said they had a bed bath two days ago. On 1/29/25 at 12:03 PM, a review of R52's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: acute renal failure, bipolar disorder, and psychotic disorder with delusions. Their most recently completed Minimum Data Set assessment dated [DATE] indicated moderately impaired cognition and required moderate to total assist for hygiene and bathing. A review of a Certified Nursing Aide (CNA) task for showering/bed bathing was reviewed and documented the task done on 1/2/25, 1/6/25, 1/13/25, and 1/16/25. On 1/29/25 at 3:45 PM, a review of a CNA task for hygiene indicated hygiene care was provided on 1/29/25 at 12:34 PM, despite R52's appearances after that time with debris in their nostrils, greasy hair and face, and discolored teeth with debris. On 1/29/25 at 3:49 PM, R52 remained in bed with yellow/green debris in their nostrils, a shiny, greasy face and hair and discolored teeth with debris. On 1/30/25 at 10:34 AM, R52's appearance was brought to the DON's attention and they indicated they would look into it. 34208

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure wound care treatments were provided per physician's orders for one resident (R46) of one resident reviewed for non-pressure ulcer wound care, resulting in verbalized complaints and the potential for the worsening of wounds. Findings include: On 1/30/25 at 9:24 AM, R46 was observed lying in their bed. They had soft heel boots on both of their feet and bulky bandages were wrapped around their feet and ankles. The tape securing the bandaging was observed to be dated 1/28/25. At that time R46 was asked if staff provided them wound care per physician's orders and said they did not. They indicated the dressings on their feet were to be changed daily, however; it was not being done daily. A review of R46's clinical record was conducted and revealed they admitted to the facility on [DATE] with diagnoses that included: chronic kidney disease, deep vein thrombosis (blood clots), diabetes, and high blood pressure. A review of a wound care consultation dated 1/24/25 revealed they had diabetic ulcers to both their left and right foot that was to be treated daily with Medi-honey (wound treatment) and wrapped with bulky dressings. A review of R46's treatment administration record for January 2025 was conducted and the treatment scheduled for 1/29/25 had been signed off as completed, despite the dressings being dated 1/28/25. On 1/30/25 at 10:34 AM, an interview was conducted with the facility's Director of Nursing (DON) and they said wound care treatments should be performed per physician's orders and only signed off on the treatment administration record if they had been completed. A review of a facility provided policy titled, Skin Management revised 8/2024 was conducted and read, . Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated, and provided the appropriate treatment to promote prevention and healing .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to implement interventions and provide care to prevent accidents for two residents, (R#'s 67 and 74) of three residents reviewed for accidents, resulting in a fall and the potential for injuries. Findings include: On 1/28/25 at 11:30 AM, R67 was observed in their room. They were seated in their wheelchair equipped with a seatbelt fastened around their waist. The wheelchair was not equipped with anti-tipping devices. An interview was attempted with R67, however; they did not respond. On 1/28/25 at approximately 4:00 PM, R67 was observed sleeping in their bed. Their wheelchair was placed in the hallway and the cushion was not observed with Dycem (a non-slip material used to stabilize surfaces) in place. A review of R67's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included; falls, femur fracture, cataracts, anxiety, and dementia. Their most recent Minimum Data Set (MDS) assessment dated [DATE] indicated R67 had severely impaired cognition and was maximal assist to dependent on staff for transferring and ambulation. The MDS assessment further indicated R67 had a restraint device in place. Continued review of R67's record revealed a physician's order originating July 2024 for the use of a seatbelt restraint. A progress note dated 12/13/24 at 4:55 PM was reviewed and read, Writer was told by nurse aide, Resident was observed sitting on the floor with seat belt on chest and head on wheelchair facing forward . On 1/29/25 at approximately 11:00 AM, a review of R67's incident/accident reports was conducted and revealed documentation on 12/13/24 that read, .Nursing Description: Writer was told by nurse aide, Resident was observed sitting on the floor with seat belt on chest and head on wheelchair facing forward .Immediate Action Taken Description: Education with the cna (Certified Nurse Aide) to check seatbelt & Keep <sic> within staff Vision <sic> while awake. education <sic>provided to the cna to ensure seatbelt is secured correctly . The Post Fall Evaluation form provided with incident/accident report read, .Factors observed at time of fall: Guest/resident slipped .What was the guest/resident doing during or just prior to the fall? Sliding out from wheelchair .New Interventions after IDT (interdisciplinary team) review: Education provided to CNA to ensure seatbelt is secured correctly . A review of R67's care plans for falls was conducted and revealed the following, .Interventions . Non-releasing seatbelt (7/18/24) .Anti roll back on wheelchair (1/23/23) .Dycem to wheelchair (1/11/23) . On 1/30/25 at 10:34 AM, an interview was conducted with the facility's Director of Nursing (DON) regarding the fall on 12/13/24 and they indicated the CNA did not have the seatbelt pulled tight enough around R67's waist so they were able to slide underneath and was found on the floor with the belt around their chest. R74 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 9:48 AM, Certified Nurse Aide (CNA) 'I' was observed transporting R74 from the shower room to their room in the shower chair. CNA 'I' had R74 facing rearward and was pulling the chair in forward motion with their back to R74. When they arrived to the room they were asked if pulling a resident facing rearward was the appropriate way to transport someone in a wheeled chair. They said, It's not safe for me to push them in the chair. They were asked what was unsafe about having the resident face forward with them behind the chair pushing it in a forward motion and they pointed to the wheels and said it was, unsafe for me. They were asked if the chair needed maintenance or repair and said no. They further declined to give any additional explanation on why they transported the resident in the chair in the manner they did. On 1/30/25 at 10:34 AM, an interview with the facility's Director of Nursing (DON) was conducted regarding the observation of CNA 'I'. They said CNA 'I' should not have transported R74 in the chair facing rearward pulling the chair, or have their back to the resident as it was a safety concern. A review of a facility provided policy titled, Resident Dignity & Personal Privacy revised 3/2024 was conducted and read, .d. Roll wheelchairs/geri-chairs in a forward direction .

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	235529	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Novi	24500 Meadowbrook Rd Novi, MI 48375

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34208 Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than 5% when two medication errors were made for two residents (R#'s 57 and 75) of five residents reviewed during the medication pass observation, resulting in a medication error rate of 7.69%. Findings include: On 1/28/25 at 9:12 AM, Nurse 'K' was observed preparing medications for administration to R57. Nurse 'K' prepared multiple medications including a 600 mg (milligram) calcium supplement. Nurse 'K' entered the room, administered the medications to R57, exited the room and signed the medications out as given on the medication administration record. On 1/30/25 at 11:22 AM, a review of R57's medication orders was conducted and revealed R57 did not have an order for a 600 mg calcium supplement, rather they had an active order for Calcium Carbonate-Vitamin D 500 mg-200 mg combination supplement. On 1/29/25 at 9:23 AM, Nurse 'I' was observed preparing medications for administration to R75. The medications prepared included Dorzolamide eye-drop 2% (glaucoma treatment) with instructions on the pharmacy label attached to the box that indicated one drop was to be instilled in the left eye. After preparing the medications Nurse 'I' entered R75's room and when they administered the Dorzolamide eye drop they were observed to place one drop in R75's right and left eye. On 1/29/25 at 9:39 AM, Nurse 'I' was asked how they administered the Dorzolamide and said they put one drop in each eye because that was, what the box said. They were asked to remove the box and confirm the pharmacy label instructions and when they did so, they said they should have only put a drop in R75's left eye. On 1/30/25 at 11:38 AM, a review of 75's medication orders was conducted and revealed an active order for Dorzolamide eye drop 2% with instructions that indicated one drop was to be placed in the left eye. On 1/30/25 at 1:42 PM, the Director of Nursing was interviewed regarding the medication errors and said the nurses must administer medications per the physician's orders using the, Five rights of medication administration (right patient, right medication, right dose, right route, right time). A review of a facility provided document titled, Medication Administration revised 10/2023 was conducted and read, Resident medications are administered in an accurate, safe, timely, and sanitary manner .2. Verify the medication label against the medication administration record for resident name, time, drug, dose, and route .

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 Based on interview, and record review, the facility failed to obtain physician ordered x-rays for one resident, (R69) of one resident reviewed for radiology/diagnostic services. Findings include: Review of R69's physician orders included an order dated 12/28/24 for an x-ray of the right shoulder and hips related to pain. Review of the record did not reveal documentation that the x-rays had been obtained. Further review of the record revealed that R69 was admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes, insomnia, and end-stage renal disease. On 1/29/25 at 8:44 AM, an interview was conducted with the Director of Nursing (DON). When asked about the timeframe for a diagnostic order (x-ray) to be completed, the DON reported if it was a STAT order, usually within 4 to 6 hours but if it was a general order the nurse practitioner would put it in for three days so it would not get missed. The DON was then asked if they could locate the results of R69's x-ray ordered on 12/28/24 of the right shoulder and hips but was not able to provide evidence the x-ray had been completed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 Based on observation, interview, and record review, the facility failed to maintain the kitchen in a sanitary manner, and failed to maintain the C hall medication cart water pitcher in a sanitary manner. This deficient practice had the potential to affect all residents that consume food and water orally. Findings include: On 1/28/25 between 8:40 AM-9:15 AM, during an initial observation of the kitchen, the following items were observed: In the walk-in cooler, there was pooled milk underneath the crates of milk cartons. There was a tray of raw chicken with blood pooled in the bottom of the tray and blood spilled on the floor underneath the rack. There was raw ground beef and raw pork stored directly next to the tray of raw chicken. When queried, Certified Food Manager (CFM) D stated the spills would be cleaned up right away. When queried about the storage of the raw meats, CFM D stated, they should have been separated. According to the 2017 FDA Food Code section 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation, (A) Food shall be protected from cross contamination by: .(2) Except when combined as ingredients, separating types of raw animal foods from each other such as beef, fish, lamb, pork, and poultry during storage, preparation, holding, and display by: .(b) Arranging each type of food in equipment so that cross contamination of one type with another is prevented,. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean. Next to the toaster, there was an uncovered, unlabeled 4 quart container of a white powder, and an unlabeled 4 quart container of a light tan powder. CFM D confirmed the containers should be covered and labeled with the contents. According to the 2017 FDA Food Code section 3-302.12 Food Storage Containers, Identified with Common Name of Food, Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD. On the lower shelf of a food preparation table, there were 3 uncovered bins of clean ladles, scoops, whisks, and various utensils. According to the 2017 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, (A) Except as specified in (D) of this section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean equipment and utensils shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	30675 Water Pitcher: On 1/30/25 9:20 AM observation of the C-hall medication cart had a clear plastic pitcher filled with water and ice stored on top of the cart. There was a sticker that had a handwritten date of 1/28. On 1/30/25 at 9:26 AM, Nurse 'E' was observed to return to the medication cart and confirmed they were assigned to the entire unit. When asked about the process for changing the water, ice, and plastic pitchers stored on the medication cart, Nurse 'E' reported they forgot to change the pitcher. When asked how often that gets changed, Nurse 'E' reported they would get a fresh pitcher every two to three days and further stated We don't have a standard of when we change our pitchers. Nurse 'E' was then observed to remove the existing sticker dated 1/28 and placed a new sticker dated 1/30. On 1/30/25 at 9:55 AM, an interview was conducted with Unit Manager (UM 'F') who reported had been in their role since Friday 1/24/25. When asked about the changing of the water pitchers on the medication carts, UM 'F' reported those should be changed out at the end of each night shift and the water and ice should be changed out every shift. They were informed of the observation and interview with Nurse 'E' and reported that should not have occurred. According to the facility's policy titled, Cleaning Water Pitcher & Drinking Utensils dated 4/20/2023: .Nursing is responsible for collecting and delivering soiled water pitchers and drinking utensils to the dietary department .Send water pitchers and trays to the dietary department for cleaning and sanitizing daily and when soiled .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 30675 Based on observation, interview and record review, the facility failed to ensure a doorway frame was maintained in a safe manner for two (R36 and R54) of two residents reviewed for safe environment, resulting in the potential for injury (laceration). Findings include: On 1/28/25 at 11:35 AM, 1/29/25 at 2:15 PM, and 1/30/25 9:30 AM, observations of the C-Hall revealed the room occupied by R36 and R54 was observed to have a doorway frame that had a sharp metal strip around the bottom portion that was pulled away and exposed sharp metal edges (at about the ankle height of anyone that entered the room). On 1/30/25 at 9:55 AM, an interview was conducted with Unit Manager (UM 'F') who reported they were in their role since Friday 1/24/25. When asked about the process if staff identified concerns with the environment such as broken door frames, UM 'F' reported they used the TELS (an electronic reporting system). UM 'F' was asked about the state of R36 and R54's doorframe and confirmed the sharp metal and stated they would have to be covered right away. They denied being aware of this before this discussion. On 1/30/25 at 10:34 AM, the facility was requested to provide TELS documentation for the past 3 months. Review of the TELS documentation provided from 11/30/24 - 1/29/25 revealed no identification of the doorway frame for the room occupied by R36 and R54. On 1/30/25 at 11:40 AM, an interview was conducted with the Maintenance Director (Staff 'C'). When asked if they were aware of any concerns with doorframes, they reported (Name of Staff 'B' who was their Maintenance Assistant) was informed by a nurse (UM 'F') when they were making rounds with the fire inspector. (After this concern was identified during the survey.) When asked if they conducted any environmental rounds to identify concerns such as unsafe items, they reported they did and had not seen anything like that before. Staff 'C' was informed the concern was identified during the past three days of the survey and concerns remained since no staff had identified a concern until it was identified by this surveyor. Staff 'C' was requested to provide their environmental audits for the past month. Review of the documentation provided by Staff 'C' for their Facility Audit Tool from 1/2/25 - 1/29/25 revealed no identification of what specific areas of the facility were observed/audited. There was no documentation the facility had identified any concerns with the sharp metal doorframe. According to the facility's policy titled, Environmental Rounds Policy and Procedure dated 4/29/2022: .The purpose of environmental rounds is to ensure facility standards reflect federal, state, and local regulations .When issues are found they will be corrected and addressed by the appropriate department head .