STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235539	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Northwest	16181 Hubbell St Detroit, MI 48235

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 34901 Based on observation, interview, and record review, the facility failed to ensure that a call button was within reach for one resident (R178) reviewed for accommodation of needs, resulting in the resident not having a method to request assistance when needed. Findings include: On 1/6/25 at 3:25 PM, R178 was observed awake and lying in bed. R178's bed was positioned against the wall and R178's right arm appeared wedged between the bed and the wall. R178 indicated he was in pain and was unable to free his arm. R178's call light was clipped to his pillow case. R178's indicated he was unable to reach the call light with his left arm. On 1/6/25 at 3:30 PM, Licensed Practical Nurse (LPN) T joined the Surveyor in R178's room and confirmed R178's arm was wedged between the bed and wall and R178 was unable to reach the call light with his other arm. R178 winced in pain as LPN T moved the bed to free his arm. On 1/8/25 at 12:13 PM, the Director of Nursing (DON) said the call light should have been in place where the resident could reach it . On 1/8/25 at 5:30 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information regarding this concern when asked.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50634 Based on interview and record review the facility failed to ensure an Advance Directive was completed for one resident R14 of nine residents reviewed for advance directives resulting in the potential for inaccurate life sustaining measures or withholding medical treatment. Findings include: On 1/7/2025, record review of the Electronic Medical Record (EMR) revealed R14 was initially admitted into the facility on [DATE] with a diagnoses Candidiasis, Atherosclerotic Heart Disease, Benign Prostatic Hyperplasia Dysphagia and Myocardial Infarction. There was no signed Advanced Directive. According to admission Minimum Data Set (MDS) Quarterly assessment dated [DATE], R14 had Brief Interview for Mental Status (BIMS) of 4/15 impaired cognition. R14 required extensive one-person assistance with activities of daily living (ADLs). On 1/8/2025 at 12:35 PM, Social Worker (SW) L was interviewed regarding R14's Advance Directive and said they had emailed the guardian agency at the time of admission to have them complete the Advance Directive, but they have not gotten the signed copy returned. On 1/8/2025 at 1:45 PM, The Director of Nursing (DON) was interviewed and said SW L could have gotten a nurse as a wittiness and had the paper signed. The DON said Advanced Directives should be reviewed at R14 care conferences, which are held quarterly. The DON said since R14 was admitted in June they should have had two care conferences. Record Review review revealed R14 had care conferences on 9/12/2024 and 12/4/2024, but the Advance Directive was not signed at either care conference.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39465 Based on observation, interview and record review, the facility failed to notify the physician of a change in condition for one resident (R65) of six residents reviewed for bowel and bladder, resulting in the potential delay o care and treatment. Findings include: On 1/6/2025 at 11:11 a.m., R65's urinal was observed hanging on the foot of the bed with approximately five hundred and fifty milliliters (mls) of red-colored urine. R65 confirmed during an interview it was blood in the urinal that occurred while urinating the previous night before the start of day shift and the nurse was aware. R65 stated, I was scared to death when I saw the blood in my urinal, and no one has done anything about it Yet. According to the electronic health record (EHR), R65 was admitted to the facility on [DATE] with diagnoses of candidal sepsis (a life-threatening condition that occurs when the candida fungus enters the bloodstream . untreated candida infection carries the risk of leading to a systemic infection .), Enterocolitis due to clostridium difficile (C-Diff) (inflammation of the colon caused by the bacteria clostridium difficile), chronic kidney disease stage 5, and hypertension. R65's admission Minimum Data Set (MDS) assessment, with a reference date of 11/7/2024, indicated R65 had intact cognition with a BIMS (brief interview for mental status) score of 15/15. Review of the 12/5/2024 Activity Daily Living (ADLs) care plan documented, I need assistance with my ADL's due to generalized weakness related to recent hospital stay for candidemia, c-diff and hyperglycemia. Interventions as followed: -Toilet use: I need partial/moderate assistance by staff for toileting. -transfers: I need partial/moderate assistance by staff to move me between surfaces. Review of the 12/5/2024 Bowel and Bladder' care plan documented, I am incontinent of Bowel and Bladder due to decrease in functional mobility. Interventions: Observe and report any signs and symptom of an infection such as frequency, urgency, burning upon urination, mental status changes, fever, etc. Review of the EHR revealed no documentation of assessment, monitoring and information related to the physician being notified. On 1/8/2025 at 9:10 a.m., during a subsequent interview regarding the resident's bloody urine, R65 stated, no one did anything and my urine cleared up on its own. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/2025 at 9:20 a.m. R65's assigned Licensed Practical Nurse (LPN) B confirmed it was reported by the midnight nurse that R65 had blood in the urine. LPN B was asked what was the follow up results. LPN B stated, I think I documented, I would have to go see my documentation in my car. LPN B answered, No when asked was the physician called and No when asked was there follow up assessment and monitoring. On 1/8/2025 at 9:39 a.m., during an interview Unit Manager (UM) C denied knowledge of knowing R65 had blood in the urine and stated, I will call the physician and get some follow-up work done like a urine culture. On 1/8/2025 at 3:28 p.m., the Director of Nursing (DON) was informed of R65's change in condition with bloody urine with no follow up. The DON said the nurses should have notified the physician and interviewed the resident for any symptoms for further care and treatment. According to the facility's undated Acute Change in condition policy: An acute Change of condition is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. Clinically important Mean a deviation that, without intervention, may result in complications or death . Guidelines: . 5.Changes (symptoms) are communicated to the physician .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 This citation pertains to intake MI00147576. Based on interview and record review, the facility failed to ensure staff reported an injury of unknown source in a timely manner to the abuse coordinator for one resident (R125) out of two residents reviewed for abuse resulting in the untimely investigation of an injury of unknown origin. Findings include: The facility self-reported to the State Agency a resident injury of unknown source. A review of the facility's 5-Day submission dated 10/15/24 documented in part the following: - Investigation Summary: On 10/4/24 R125 complained of bilateral lower extremity pain. An order was entered for a stat x-ray for left knee, tibula, fibula and left foot and ankle. The stat X-ray result revealed no recent fracture or dislocation. The physician was notified of continued pain and swelling to left lower leg and foot. Additional orders given for x-rays for left leg and a venous doppler. The deep vein thrombosis was inconclusive, and R125 was transferred out to the local hospital for further evaluation and treatment. On 10/7/24, personnel from the local hospital reported to the Nursing Home Administrator (NHA) that R125 had a fracture. - Investigation Conclusion: The nature of the origin of the injury could not be identified. Residents and staff were interviewed with no viable results. Staff education was begun on transfers per Kardex specifications as well as continuing to report any abnormal findings such as pain, swelling, skin tears or abnormal looking extremities. A review of nursing staff interviews documented in part the following from Licensed Practical Nurse (LPN) U: The last day I worked (R125) was complaining of pain and we got an x-ray. The x-ray hadn't come when I left on Friday. When they were changing her, she complained of pain. I think it was her left leg. She was guarding the area. It wasn't swollen. She didn't want nobody to change her. It was a small bruise on her lower leg, below the knee. Gave resident Tylenol. A review of R125's clinical record documented an admitted [DATE] R125's diagnoses included vascular dementia, adult failure to thrive, and hypothyroidism. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment. A review of a medication administration note by LPN U was dated 10/4/24 at 12:30 PM but created 10/4/24 at 3:12 PM, revealed R125 was provided two tablets of acetaminophen tablet 325 MG. R125 complained of pain in left lower extremity. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review of the facility reported incident regarding R125 began on 1/8/25 at 10:30 AM with the Nursing Home Administrator (NHA). The NHA indicated they were responsible for the completion of the investigation. The NHA said she was notified of R125 injury by the hospital on 10/7/24 and that was when the investigation was initiated. The NHA confirmed that LPN U worked on 10/4/24 on the 7:00 AM to 7:00 PM shift. The NHA indicated that LPN U should have reported the observation of a bruise on R125's leg, especially if it is a possibility of a fracture. The NHA said it was expected that when there is a change in condition for a resident, that the NHA and/or DON (Director of Nursing) be notified. The NHA stated, They did not notify the DON, because she did not call me. During an interview on 1/8/25 at 12:18 PM, the DON said she was not notified about the presence of a bruise and pain regarding R125 on that Friday (10/4/24). The DON said she should have been notified about the observed bruise because that is not normal. The DON indicated that staff are to notify her of any abnormal findings or change of condition. A review of the facility document titled, Abuse and Neglect Prohibition Policy, dated 2/17/20, revealed in part the following: - The facility will monitor residents for changes in behavior, bruises/injuries of unknown origin or of a suspicious nature, or other types of patterns, occurrences and trends that may constitute potential abuse and investigate such situations. - The staff will report all allegations of abuse, neglect and misappropriation of property to the Administrator immediately. On 1/8/25 at 5:30 PM during the exit conference, the Nursing Home Administrator and Director of Nursing did not offer additional documentation or information when asked.

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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** 34901 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for a tracheostomy (a surgical opening in the neck to provide an airway to the lungs) for one resident (R175) reviewed for tracheostomy care. Findings include: On 1/6/25 at 1:00 PM, R175 was observed awake, lying in bed with a tracheostomy (trach) tube secured around his neck. Review of R175's clinical record documented an admitted [DATE]. R175's diagnoses included acute respiratory failure with hypoxia, laryngeal cancer, esophageal cancer, and tracheostomy status. On 1/8/25 at 12:10 PM, the Director of Nursing (DON) reviewed R175's care plans and confirmed that a comprehensive care plan for tracheostomy care had not been developed for R175. The DON said R175 should have a care plan that addressed tracheostomy care which would include how to care for it and what to look for. On 1/8/25 at 5:30 PM during the exit conference, the Nursing Home Administrator and Director of Nursing did not offer additional documentation or information when asked.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39465 Based on observation, interview, and record review, the facility failed to provide residents with nail care, oral care, shaves, hair care, and body hygiene for five residents (R2, R49, R51, R108, and R112) out of nine residents reviewed for Activities of Daily Living (ADLs), resulting in unmet ADL needs. R2 On 1/6/2025 at 10:38 a.m., R2 was observed lying in bed alert and unable to be interviewed. The surveyor observed R2 with long, dirty, untrimmed fingernails on both hands, with dry scaly skin on bilateral legs and feet. There was white-colored, crusty residue on lips and near both eyes. R2 had matted, unkempt hair. A hospital bracelet dated 12/15/2024 was noted on R2's right arm. On 1/8/2025 at 9:52 a.m., during an interview in R2's room, licensed Practical Nurse (LPN) B rubbed across R2's head and confirmed the resident's hair was not combed and matted on the top and on the back. LPN B was informed of R2's Tuesday's and Friday's afternoon showers days and was asked should the hospital bracelet have been removed. LPN B said, Yes, and it seems like the resident did not get a shower Tuesday because the residents' fingernails would not have been dirty and long. According to the electronic health record (EHR), R2 was readmitted into the facility on [DATE] with diagnoses of Multiple sclerosis, congestive heart failure, osteoarthritis, and vascular dementia. R2's annually Minimum Data Set (MDS) assessment dated [DATE] indicated R2 had severe cognitive impairment with a BIMS (brief interview for mental status) score of 00. Review of the Activity Daily Living (ADL) care plan with a review date of 10/1/2024 documented, I need total assist with my ADL's related to muscle weakness, impaired mobility, impaired balance, peripheral neuropathy and obesity. I need two persons assistance with transfers and mobility. Interventions: bathing/showering: Check my nail length-file and clean them on my bath day and as necessary. Report any changes to the nurse. Personal hygiene: I need total assistance from you with personal hygiene, hair washing and oral care. On 1/8/2025 at 3:28 p.m. during an interview the Director of Nursing (DON) was informed of R2's ADL concerns. The DON said combing residents' hair, nail care, oral care and hygiene is all part of ADL care and should be done with every a.m. care, shower days, and as needed. The DON was unaware of R2's matted hair. According to the facility policy Standard of Practice (undated) documented the following: Oral hygiene - Purpose: To cleanse the mouth, prevent odor, and to lessen the occurrence of mouth infections. Morning and Bedtime Care -Purpose: To facilitate residents' overall comfort, cleanliness, grooming, and well-being. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41423 R108 On 01/06/25 at 09:41 AM, Resident 108 (R108) was observed wearing a hospital style gown, thick hair on their chin and had an unkempt appearance. An odor was noted to emanate from the R108s mouth. An interview was completed. When R108 opened their mouth to speak, a significant, noticeable plaque buildup was observed on the R108's teeth. R108 said they needed more help with care. On 01/07/25 at 09:41 AM, Resident 108 (R108) was observed in bed, on their right side, wearing a hospital style gown. R108's hair was disheveled and appeared unkempt. R108's teeth had thick plaque buildup. On 01/08/25 at 08:31 AM, Certified Nurse Aide GG (CNA GG) was observed sitting at the nursing station on the first floor. CNA GG was interviewed at this time and asked if they assisted R108 with care on 1/7/25. CNA GG said I didn't brush (R108's) teeth yesterday .yesterday (R108) said (they) needed to have a bowel movement first and I did not go back .(R108) refuses care a lot. A review of R108's electronic medical record revealed an admitted to the facility on [DATE] with the diagnosis of Developmental Disorder, Osteoarthritis, Heart Failure, Paralysis of the Lower Extremities, and Sacral Wound. A review of R108's Brief Interview for Mental Health (BIMS) dated 11/22/24, revealed a scored 14/15 (cognition is intact). A review of R108's care plan noted the following: Focus-I need assistance with my ADL's (Activities of Daily Living) d/t (due to) generalized weakness .Bed Mobility: I require substantial/maximal assistance from staff to turn and reposition me frequently while in bed dated 1/22/24. R108's Care Plan did not include bathing or oral care assistance. A review of R108's Minimum Data Set (MDS) section GG revealed (specifically assesses a patient's functional abilities and goals related to self-care and mobility activities) dated 12/2/24, revealed that the resident required Supervision with oral care, substantial/maximal assistance with toileting, shower/bathe self, and lying to sitting on side of bed. A review of R108's Task Personal Hygiene dated 12/9/24-01/06/25 revealed the following: Dependent-Helper (staff) does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. There was no documentation on the Task-Personal Hygiene of R108 refusing care. On 01/08/25 at 2:08 PM, the Director of Nursing (DON) was interviewed and asked about R108 appearing disheveled and teeth with thick plaque buildup. The DON said, Every resident should have A.M. care. R112 On 01/06/25 at 10:01 AM, Resident 112 (R112) was observed in bed on their right side, with their eyes closed. R112 was observed wearing a hospital style gown, and had visible thick, and scruffy facial hair around their chin and jaw line. An attempt was made to interview the resident; however, the R112 did not provide meaningful responses when asked questions about their care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/07/25 at 09:55 AM, R112 was observed in bed, wearing a hospital style gown. R112 appeared disheveled. R112 continued to have thick, scruffy facial hair around their chin and jaw line. A review of R112's electronic medical record revealed and admitted to the facility on [DATE] with the diagnosis of Schizophrenia, Physical Debility, Cognitive Communication Deficit, and Rheumatoid Arthritis. A review of R112's Brief Interview for Mental Health (BIMS) dated 10/02/24, revealed a scored 06/15 (severe cognitive impairment). A review of R112's care plan noted the following: Focus-I need assistance with my ADL's (Activities of Daily Living) d/t (due to) chronic debility .Personal Hygiene: I require substantial/maximal assistance from staff with personal hygiene and oral care. dated 09/16/24. A review of R112's Task Personal Hygiene dated 12/9/24-01/07/25 revealed the following: Dependent-Helper (staff) does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. There was no documentation on the Task-Personal Hygiene of R112 refusing care. On 01/08/25 at 2:08 PM, the Director of Nursing (DON) was interviewed and asked about R112 appearing disheveled and the thick, facial hair around their chin and jaw line. The DON said, Every resident should have A.M. care .If the resident refuse care they (Certified Nurse Aides) should report this to the nurse. 50634 R49 On 1/6/2025 at 1:00 PM, observed R49 lying in bed. R49 had long nails which were discolored with dark matter underneath them. On 1/8/2025 at 10:25 AM, observed R49 laying in bed with nails that were long discolored and had dark matter underneath them. On 1/8/2025 at 10:28 AM, LPN B was interviewed and said R49 fingernails needed to be trimmed. LPN B said R49 fingernails should be clipped and filed on shower day or as needed. LPN B said the importance of clipping the fingernails is to decrease germs and skin tears. LPN B said she would educate the CNA's about clipping nails on shower day. On 1/8/2025 at 10:30 AM, Unit Supervisor LPN C was interviewed and said the importance of nail care is to prevent skin tears. LPN C added many residents eat with there hands so nails need to be cleaned for infection prevention. R49 was admitted on [DATE], with a diagnosis of Epilepsy, Alzheimer, Dementia, Dysphagia, Acute Respiratory Failure and Cerebral Infarction (stroke). According to admission Minimum Data Set (MDS) Annual assessment dated [DATE], R49 had Brief Interview for Mental Status (BIMS) of 3/15 impaired cognition. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of undated ADL policy supplied by facility documented when a bed bath is given nails should be trimmed. R51 R51 was admitted on [DATE] with a diagnosis of Traumatic Brain Injury, Manic Depression and Schizophrenia. According to admission Minimum Data Set (MDS) Assessment Quarterly review dated 9/18/2024, R51 had Brief Interview for Mental Status (BIMS) of 4/15 impaired cognition. On 1/6/2025 at 10:45 AM R51 was observed laying in the bed with no brief. R51 was also observed laying in urine. On 1/6/2025 at 12:14 PM R51 was up walking around their room with pants on. R51 smelled like urine even though R51 had clothes on. There was a brown urine stain on the mattress sheets. On 1/8/2025 at 12:50 PM R51 was observed sitting on his bed eating lunch. R51 was sitting in urine. The bed was saturated with urine. There were three brown rings around the saturated urine stain. On 1/8/2025 at 12:53 PM Certified Nurse Assistant, CNA D was interviewed and reported they did know R51 was wet (with urine.) CNA D said residents should be checked and changed at least every two hours. On 1/8/2025 at 12:55 PM Licensed Practical Nurse, (LPN) A said there was a CNA on the unit earlier that was supposed to check and change R51, but they went on break. LPN A said residents should be checked and changed every two hours. LPN A added that it looked like R51 had not been changed on midnight shift either. On 1/8/2025 at 1:45 PM, The Director of Nursing (DON) was interviewed they said resident should be checked and changed at least every two hours or as needed. The DON said every two hours is a standard of practice. Record Review of an undated ADL policy supplied by facility documented that when morning and bed time care is given perineal care should be performed.

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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** 39465 Based on observation, interview, and record review, the facility failed to remove broken and hazardous objects from one resident (R85) room to ensure safety of three residents reviewed for accident hazards, resulting in the potential for injuries. Findings include: On 1/6/2025 approximately at 9:57 a.m., R85 was observed lying in bed alert and able to be interviewed. Observed a long sharp metal screw protruding at the top of a detached closet door propped and leaning toward R85' s bed which was proximal to the closet. Observed a detached bed bumper with multiple protruding screws against the wall behind the resident's bed. R85 said during an interview that the closet door had been broken since admission (7/15/2024). R85 stated, I don't want that door with that screw in it to fall and hit me in my head. I am right here when it falls. It couldn't miss me. According to the electronic health record (EHR), R85 was admitted to the facility on [DATE] with diagnoses of anoxic brain damage, epilepsy, paroxysmal atrial fibrillation, generalized anxiety, history of repeated falls and encephalitis (inflammation of the brain .) encephalomyelitis (inflammation of the brain and spinal cord). R85's quarterly Minimum Data Set (MDS) assessment with a reference date of 10/28/2024 indicated R85 had severe cognition impairment with a BIMS (Brief Interview for Mental Status) score of 03/15. Review of the 11/24/2024 Activity Daily Living (ADL) care plan documented, I need assistance with my ADL's due to generalized weakness. Interventions: -Transfer: I need partial/moderate assistance from staff to move me between surfaces. -Bed mobility: I require partial/moderate assistance from staff to turn and reposition me frequently while in bed. On 1/8/2025 at 2:12 p.m., Maintenance Staff (MS) DD was interviewed while observing R85's room for repair needs. MS DD said R85's broken closet door was a safety hazard and removed the door out of the room. MS DD observed the protruding screws from the falling bed bumper behind R85's bed and said the staff is to document orders in the TELS system (a computer system to document when repairs are needed and to order for maintenance) and maintenance gets the orders to fix and replace. MS DD confirmed R85's needed repairs were not placed in TELS. On 1/8/2025 at 3:28 p.m. the Director of Nursing (DON) was informed and interviewed regarding R85's room repair needs. The DON said the broken door should not have been in the resident's room because of safety reason of having the potential to fall on the resident. The facility's undated Resident Room Maintenance policy documented the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: Resident rooms are inspected and maintained on a periodic basis to ensure proper function. Fundamental Information: In order to check each room at least once a week, it is necessary to schedule blocks of rooms to be checked each workday. This applies to both resident rooms and rooms for common use . 2. Check the condition of all doors (room, closet, and bath) to assure and that the hardware is damage-free and works properly . 3. Check that each room has appropriate furniture, and the furniture is not damaged . 6. Check for chipped paint on doors, woodwork, walls and ceilings, check walls and ceilings for damage, marks, or evidence of water stains. Check for torn, loose, or damaged wallpaper. Check for any loose wire mold. 14.Repair or replace faulty equipment and furnishings. Documentation: Record preventive maintenance and equipment repairs or replacement in the TELS system.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review, the facility failed to ensure proper weight monitoring occurred for one resident (R20) deemed to be at nutrition risk out of six residents reviewed for nutrition status, resulting in the potential for compromise in nutrition status to go undetected. On1/6/25 at approximately 10:00 AM R20 was observed in bed. The resident could not be meaningfully interviewed due to severe cognitive impairment. The resident had an intravenous (IV) pole with a tube feeding pump attached. No tube feeding was present on the IV pole. According to R20's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with most recent readmission on 11/29/24 with diagnoses that included fecal impaction, cerebral palsy acute and chronic respiratory failure, and anoxic brain damage. According to the Minimum Data Set (MDS) dated [DATE] R20 was classified as comatose and totally dependent on staff for all activities of daily living. R20 had a feeding tube (flexible tube inserted through the abdominal wall to administer liquid nourishment, fluids, and medications). On 12/6/24 a progress note written by Registered Dietitian (RD) E revealed Readmit Assessment: Resident returns remaining nothing by mouth (NPO). Significant weight fluctuations reordered -awaiting re-weight to clarify correct current body weight. Recommend clarify enteral feed orders to Jevity 1.5 @ 45cc/hr x 16 hrs with 20cc/hr water x 16 hrs autoflush and bolus flushes two times per day. R20's recorded weights were as follows: 9/11/24: 54.0 lbs. 11/29/24: 84.5 lbs. noted on 12/20/24 as error by RD E 11/30/24: 84.5 lbs noted on 12/20/24 as error by RD E 12/9/24 48 lbs (-11.11 % Loss) 12/20/24 54 lbs On 1/08/25 at 10:33 AM RD F was interviewed and said R20 was at high risk for weight loss and should have been reweighed weekly until her weight was stabilized. RD F agreed R20 did not have an accurate readmission weight nor weekly weights recorded for 12/1/24, 12/22/24 and 12/29/24. On 1/08/25 at 2:16 PM the Director of Nursing (DON) was interviewed and agreed R20 was at high risk for weight loss and should have been reweighted accurately upon readmission and weekly for a month and then as needed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Unintended Weight Loss not dated revealed in part . The Dietary Manager/RD and DON are responsible for coordination of an interdisciplinary approach to managing the process for prediction, prevention, treatment, monitoring, and calculation or unintended weight loss/gain. Process weigh all new residents upon admission, and weekly x 4. Re-weights are initiated for a five-pound variance if the resident is > 100 pounds and for a three-pound variance if <than 100 pounds. Re-weights will be done within 24 hrs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on observation, interview, and record review, the facility failed to (1) have emergency tracheostomy (a surgical opening in the neck to provide an airway to the lungs) supplies readily available for one resident (R175) and (2) failed to consistently follow the physician's medical orders for tracheostomy care (R74) out of three residents reviewed for tracheostomy care. Findings include: R175 On 1/6/25 at 1:00 PM, R175 was observed awake and lying in bed. R175 was observed with a tracheostomy (trach) tube secured around his neck. An emergency trach bag/box was not visible in R175's room. On 1/6/24 at 1:04 PM, Licensed Practical Nurse (LPN) W was queried if R175 had emergency trach equipment. LPN W and LPN X entered R175's room. Both LPN W and LPN X searched R175's room and were unable to locate emergency trach equipment. LPN X said the equipment was usually tacked on the board. LPN X pointed to a empty bulletin board at the head of R175's bed. LPN X said it was an issue that the trach emergency equipment was not in R175's room and that they need to correct that now. Review of R175's clinical record documented an admitted [DATE]. R175's diagnoses included acute respiratory failure with hypoxia, laryngeal cancer, esophageal cancer, and tracheostomy status. On 1/8/25 at 11:59 AM, the Director of Nursing (DON) said that emergency trach equipment should have been in R175's room. The trach tube can be replaced immediately just in case the trach becomes dislodged. On 1/8/25 at 5:30 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked. 41423 R74 On 1/6725 at 09:48 AM, R74 was observed sitting on the side of their bed, watching TV. R74 was observed with a tracheostomy (trach) tube that was capped (block air from going through the trach tube, person will breathe in and out of their noise) and trach ties secured around their neck. The dressing appeared stained with dried sputum. R74 was asked how often the nurses provide trach care (a set of procedures that keep a tracheostomy tube clean and clear to prevent infection and breathing problems). R74 said they (staff) change it once a week. A review of R74's electronic medical records revealed an admission to the facility on [DATE] with the diagnosis of Asthma, Vocal Cords Paralysis, Tracheostomy, and Chronic Respiratory .Failure. A review of R74's Care Plan noted revealed the following: Focus-I have potential for an alteration in respiratory status r/t (related to) Asthma, Tracheostomy, and h/o (history of) respiratory failure .Date initiated 6/4/2020 .Provide tracheostomy care and suctioning as ordered and as necessary. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician medical order noted the following: Change inner cannula, trach tie, and collar as ordered daily Every Shift and PRN (as needed). Dated 11/15/24 at 3:07 PM by Physician II. A review of R74's treatment record revealed the following missing inner cannula, trach tie, and collar changes per order: November 2024: 11/16 AM, 11/22 AM, 11/23 PM, 11/25 PM, December 2024: 12/2 PM, 12/6 PM, 12/13 PM, 12/16 PM, 12/19 PM, 12/22 AM, 12/27AM, 12/27 PM, 12/30 PM January 2025: 1/4 On 1/8/25 at 2:15 PM, the Director of Nursing (DON) was interviewed and asked about staff not consistently following Physician II trach care orders. The DON stated, The nurses should have carried out the physician's order. A review of the facility's policy Tracheostomy Tube (undated) revealed the following: It is the policy of this facility to provide tracheostomy care according to standards of practice.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was on duty for eight consecutive hours a day, seven days a week; resulting in the potential for inadequate coordination of emergent or routine care that could cause negative outcomes. This deficient practice had the potential to affect all 120 residents in the facility. Findings include: On 1/08/25 at 12:13 PM review of the nurses' schedule for the months of October, November and December 2024 with staffing coordinator G, revealed there was no Registered Nurse (RN) coverage on the following dates: -[DATE] -[DATE] -[DATE] -[DATE] -[DATE] -[DATE] -[DATE] -[DATE] -[DATE] -[DATE] -[DATE] -[DATE] -[DATE] -[DATE] Staffing coordnitaor G acknowlwdged the facility has not been able to get RN coverage for weekends. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	O1/08/25 at 2:20PM the Director of Nursing (DON) agreed there hasn't been consistent RN weekend coverage and the expectation is that there is 8-hour RN coverage 7 days per week. Review of the facility policy titled Staff Schedule Review (undated) revealed in part: .The purpose of reviewing the staff schedule is to assure the facility has adequate staffing each day and to anticipate the following day (weekend) staffing that may need to be addressed to avoid staff shortfalls. The DON should review the daily staffing sheet to assure: appropriate staffing levels have been achieved, RN coverage (8 hours per day).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on observation, interview, and record review, the facility failed to ensure medical supplies for one resident (R10) reviewed for tracheostomy (a surgical opening in the neck to provide an airway to the lungs) care were not expired. On [DATE] at 1:20 PM, R10 was observed in bed eating lunch. Licensed Practical Nurse (LPN) X entered the room with the State Surveyor to check for tracheostomy (trach) supplies. LPN X stated that R10 did not have a trach but R10 had a stoma. On [DATE] at 12:30 PM, R10 provided permission for a nurse and the Surveyor to look through the supplies in his room. On [DATE] at 12:34 PM, the contents of a multi-drawer storage cabinet located in R10's room were observed with the Director of Nursing (DON) and revealed the following: - One box of (Brand XX) HME expired [DATE]. (HME is a heat and moisture exchanger designed to replicate the functions of the nose and upper airways to improve respiratory function following laryngectomy.) The box contained approximately 30 devices. - Three full boxes of (Brand XX) all expired [DATE]. The DON indicated the contents of these boxes contain caps to cover a stoma. A review of R10's clinical record documented an initial admitted [DATE] and readmitted [DATE]. R10's diagnoses included cancer of the larynx and supraglottis and presence of artificial larynx. A Minimum Data Set assessment dated [DATE] documented intact cognition. The DON said these expired medical supplies should not have been stored with unexpired medical supplies. They should have been removed so they would not be utilized. On [DATE] at 5:30 PM during the exit conference, the Nursing Home Administrator and Director of Nursing did not offer additional documentation or information when asked.

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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. 34901 Based on observation, interview, and record review, the facility failed to: 1. Clean surfaces in the kitchen that were visibly soiled; 2. Maintain easily cleanable floors in various areas of the kitchen; 3. Ensure properly working garbage disposal and sink faucet; 4. Ensure chemical solution (quaternary) was an effective sanitizer; 5. Ensure pans were clean and air dried before stacking. This deficient practice would affect any resident that consumed food from the kitchen. Findings include: On 1/6/25 at 10:38 AM, during the initial tour of the kitchen with Dietary Manager (DM) N the following was observed: - caked up dust covered a white opaque circular disk above the handwashing sink - the trash can lid near the handwashing sink appeared dirty and uncleaned. - several floor tiles in the dish tank machine were chipped or missing rendering a floor surface not easily cleanable. - a splattering of grits was on the backsplash of the drain board on the clean side of the commercial dishmachine On 1/6/25 at 12:00 PM, during a return visit to the kitchen, the splattering of grits remained on the backsplash on the clean side of the dishmachine. DM N said it should be cleaned. On 1/8/25 at 2:15 PM, during a return visit to the kitchen with DM N the following was observed: - a pan on the floor underneath the garbage disposal contained a watery appearing fluid. The DM N said the garbage disposal was leaking. - a bucket of sanitizing solution was located under the counter in the cook's prep area. DM N said the solution contained a quaternary solution and should test near 200 parts per million (ppm). The solution tested less than 100 ppm. The DM N said the solution should have been disposed of. - in a clean pot/pan storage area, the surfaces of two full-size pans nestled together were soiled with food debris. Additionally, two 4-inch loaf pans were nestled together wet and soiled with food debris. The DM N said pan are supposed to be washed, sanitized, and put up dry. - the drip pan on the stove was very soiled with burnt food debris. The DM N said the drip pan should be cleaned after each meal. - the sink faucet in the cook's prep area did not shut off completely (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- several floor tiles were missing in the dry food storage room which exposed surfaces that were not easily cleanable. According to the 2013 FDA Food Code: -Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. - Section 4-602.11, Equipment Food-Contact Surfaces and Utensils. Equipment food-contact surfaces and utensils shall be cleaned at any time during the operation when contamination may have occurred. - Section 4-602.13, Nonfood-Contact Surfaces: Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. - Section 4-703.11, Hot Water and Chemical. After being cleaned, equipment food-contact surfaces and utensils shall be sanitized. - Section 6-201.11 Floors, Walls, and Ceilings. Except as specified under S 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable On 1/8/25 at 5:30 PM during the exit conference, the Nursing Home Administrator and Director of Nursing did not offer additional documentation or information when asked.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34901 Based on interview and record review, the facility failed to implement an effective Quality Assurance and Performance Improvement (QAPI) program. Findings include: On 1/8/25 at 3:12 PM, the Nursing Home Administrator (NHA) was interviewed about the facility's QAPI program and process and identified customer service and adherence to the resident smoking policy as areas of concern and opportunities for improvement. The NHA said they were trying to get staff to speak with residents in a professional manner and that resident needs were being met. The NHA indicated that residents were keeping smoking paraphernalia on their persons and were going out to smoke when they got ready and there was no supervision. The NHA was unable to provide objective data gathered regarding these areas of concern. Therefore there was no analysis performed to identify trends and measure the effectiveness of the performance improvement plan. The NHA said the best practice would have been after the problem was identified to count the actual defective items and analyze the data monthly for improvement. The facility policy titled, Quality Assurance Performance Improvement, dated January 2019, was reviewed and the following was documented: - QAPI committee responsibilities include identifying and responding to quality deficiencies throughout the facility, and oversight of the facility's QAPI program. The committee must develop and implement corrective action and monitor those actions to ensure performance goals or benchmarks are achieve. It also determines what performance measures will be monitored, the schedule or frequency for monitoring this data, identifies opportunities for improvement and prioritizes issues by their size of impact. - Conducting the study: Measure the situation - utilizing objective criteria that outline the expected process to achieve desire outcome. The data tools can be customized to address the area being studies. Over a preplanned period of time, collect the data. On 1/8/25 at 5:30 PM during the exit conference, the Nursing Home Administrator and Director of Nursing did not offer additional documentation or information when asked.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41423 Based on observation, interview and record review, the facility failed to continuously implement and operationalize a comprehensive infection control program, encompassing outcome and process surveillance, accurate data collection/documentation/analysis, resulting in a lack of accurate and comprehensive infection control tracking, surveillance and data monitoring/analysis and the potential for the spread of microorganisms, illness and other harmful pathogens among other residents that reside in the facility. Findings include: On 1/8/25 at 9:29 AM, a review of the facility's infection control program was conducted with the Director of Nursing (DON) who has performed as the facility's designated infection control leader since August 2024. Review of the infection control books provided by the facility revealed no documentation of an infection control program from August 10, 2024, through September 30, 2024. The DON confirmed prior to her running the infection control program, it was overseen by the Infection Preventionist (IP) who resigned in early August of 2024. The DON said, I hired another IP in September, but it did not work out. We did not have anyone to do the work . It just wasn't done. A review of the facility's policy, Infection Prevention and SOP, Infection Prevention and Control Program Overview Reveled the following: The infection prevention and control program is designed to identify and reduce the risk of acquiring and transmitting infection among residents, staff, volunteers students, and visitors Surveillance based on systematic data collection to identify to identify nosocomial infections .A system for the detection, investigation, analysis, and planning to prevent and control institutional outbreak of infectious diseases. 28214 Based on observation, interview, and record review the facility failed to properly store environmental services equipment. Findings include: On 1/7/25 at 11:30 AM, observation with Laundry Aid (LA) EE, revealed newly cleaned environmental services equipment (rags, mop heads, and towels) were stored in the soiled laundry area where items were placed into the washing machines. When asked, LA EE reported the items were clean and the facility did not any place to store them. On 1/8/25 at 2 pm with Head of Laundry (HL) FF the clean items were observed in the soiled laundry area. When queried HL FF acknowledged the environmental service equipment was not properly stored and explained that clean items should not be stored in an area where soiled articles are sorted and washed.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 41423 Based on interview, and record review the facility failed to maintain a continuous Antibiotic Stewardship Program that included monitoring antibiotic usage and following protocols for antibiotic use resulting in the potential for unnecessary medications and antibiotic resistance. Findings include: On 1/8/25 at 9:29 AM, a review of the facility's infection control program was conducted with the Director of Nursing (DON) who has performed as the facility's designated infection control leader since August 2024. Review of the infection control books provided by the facility revealed no documentation of an infection control program from August 10, 2024, through September 30, 2024. The DON confirmed prior to her running the infection control program, it was overseen by the Infection Preventionist (IP) who resigned in early August of 2024. The DON said, I hired another IP in September, but it did not work out. The DON was asked how they were able to identify residents on antibiotics during the months of August and September 2024. The DON said that they talked about residents on antibiotics during morning meetings, however, there was no documented evidence of resident use of antibiotices, indication of use, dosage, duration of antibiotic treatment, or the monitoring of symptoms In addition, the DON added, I just started working at this facility August 2024. A review of the Centers for Medicare and Medicaid Services (CMS) Form #20054 noted the following: Antibiotic Stewardship Program: o Written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage, and duration of use of antibiotics; o Protocols to review clinical signs and symptoms and laboratory reports to determine if the antibiotic is indicated or if adjustments to therapy should be made and identify what infection assessment tools or management algorithms are used for one or more infections (e.g., SBAR tool for urinary tract infection (UTI) assessment, Loeb minimum criteria for initiation of antibiotics); o A process for a periodic review of antibiotic use by prescribing practitioners: for example, review of laboratory and medication orders, progress notes and medication administration records to determine whether or not an infection or communicable disease has been documented and whether an appropriate antibiotic has been prescribed for the recommended length of time. Determine whether the antibiotic use monitoring system is reviewed when the resident is new to the facility, when a prior resident returns or is transferred from a hospital or other facility, during each monthly drug regimen review when the resident has been prescribed or is taking an antibiotic, or any antibiotic drug regimen review as requested by the QAA committee; o Protocols to optimize the treatment of infections by ensuring that residents who require antibiotics are prescribed the appropriate antibiotic; and o A system for the provision of feedback reports on antibiotic use, antibiotic resistance patterns based on laboratory data, and prescribing practices for the prescribing practitioner. (continued on next page)

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	235539	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Northwest	16181 Hubbell St Detroit, MI 48235

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy, Infection Prevention and SOP, Antibiotic Stewardship revealed the following: The purpose of the program is to reduce inappropriate use of antibiotics, improve resident outcomes and lessen adverse events . The IP will critically evaluate each antibiotic ordered to determine the necessity of the antibiotic .Antibiotic use will be calculated on a monthly basis for QAQPI (Quality Assurance and Performance Improvement) purposes.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 41423 Based on interview and record review the facility failed to ensure continuity of care for the role of an Infection Control Preventionist (ICP) and ensure the ICP completed specialized training in infection prevention and control, resulting in the potential for knowledge deficits pertaining to current infection prevention and control standards, outbreaks going undetected because of inadequate infection control surveillance, and a delay in infection control data collection and summary. Findings include: On 1/8/25 at 9:29 AM, a review of the facility's infection control program was with the Director of Nursing (DON) who has performed as the facility's designated infection control leader since August 2024. Review of the infection control books provided by the facility revealed no documentation of an infection control program from August 10, 2024, through September 30, 2024. The DON confirmed prior to her running the infection control program, it was overseen by the Infection Preventionist (IP) who resigned in early August of 2024. The DON was asked when they completed the Nursing Home Infection Preventionist Training Course training. The DON provided their certificate for IP that was dated November 18, 2024. The DON was then asked if there was anyone else in the facility that completed the required Nursing Home Infection Preventionist Training Course from August 2024 - November 17, 2024. The DON said, No. The course was over 19 hours. I did not have the time to complete the training until November (2024).

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 41423 Based on interview and record review the facility failed to screen residents for eligibility to receive the COVID 19 vaccine and/or booster, provide education regarding the COVID 19 vaccine and/or booster, and offer the COVID 19 vaccine and/or booster, resulting in residents not receiving the Covid-19 immunization, and the potential for decreased protection from SARs-CoV-2 virus and serious illness and complications among residents that reside in the facility. Findings include: On 1/8/25 at 9:29 AM, a review of the facility's infection control program was conducted with the Director of Nursing (DON) who has performed as the facility's designated infection control leader since August 2024. Review of the infection control books provided by the facility revealed no documentation of an infection control program related to COVID 19 vaccines and/or boosters. The DON was asked about their COVID 19 vaccines. The DON stated, We do not have any COVID 19 vaccines. No one has received the vaccine. The DON also stated that they previously had an outside company that would come into the facility, provide the education, and administer COVID vaccines and/or boosters for staff and residents. However, the company was no longer available in Michigan. The DON was asked if residents would be offered COVID vaccines and/or booster. The DON said, We can call the pharmacy for COVID Vaccines. However, the DON was unable to explain why residents had not been offered and administered COVID 19 vaccines prior to the recertification survey. The facility policy for COVID 19 immunization for residents was requested but not provided.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 47964 Based on observations, interviews, and record review the facility failed to effectively clean and maintain the physical plant effecting all residents residing on the second floor and all residents who use the elevator, resulting in an unsafe, poorly functional environment with the potential for cross-contamination and bacterial harborage. Findings include: On 1/8/25 at 8:05 AM the Director of Maintenance (DOM) M was interviewed and said maintenance completed ongoing monthly checklists for environmental and maintenance concerns. On 1/8/25 at 8:20 AM a second-floor environmental tour was conducted with the DOM M. The following items were noted: -The elevator had a soiled exhaust fan. -The second-floor pantry door paint was scuffed. DOM M agreed the door needed to be painted. -The second-floor hallways paint appeared dingy with multiple scratches. DOM M agreed the entire second floor was in need new paint. - Two nails were exposed on the handrail between the soiled and clean linen rooms. DOM M stated I will remove the exposed nails and fix the handrail today. -Resident rooms 227, 228, 236 had scuffed paint on entry doors. -The Two east day room had missing flooring near the East and [NAME] windows. -The two west day room had missing and peeled paint for the entire room at the baseboard. -The entire second floor had scuffed and peeled paint on the handrails. On 1/8/25 at 2:00 PM the Nursing Home Administrator (NHA) was interviewed and agreed cleaning and maintenance is an ongoing process and the above listed items should be repaired and or cleaned. On 1/8/25 at 2:52 PM a maintenance checklist was requested and not provided by survey exit.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47964 Based on interview and record review the facility failed to ensure annual Dementia Management and Abuse training were performed for three Certified Nurse Assistant (CNA) H, I and J out of five CNAs reviewed for in-service training resulting in the potential for unmet resident care needs. Findings include: On 1/6/24 at 2:28 PM, review of five CNAs in-service training education content revealed the following: CNA H Date of hire (DOH)- 5/28/2004. Review of a facility provided transcript dated 5/28/24 through 6/28/24 for CNA H, failed to identify abuse and dementia management training. CNA I DOH 5/17/2016. Review of a facility provided transcript dated 5/17/23 through 5/17/24for CNA I, failed to identify abuse and dementia management training. CNA J DOH 6/21/2010. Review of a facility provided transcript dated 6/21/23 through 6/21/24 for CNA J, failed to identify abuse and dementia management training. On 1/08/25 at 8:51 AM Staff Educator K was interviewed and said that she recently started the position in September of 2024 and that there were limited records for staff education. Staff educator K agreed there were no record of abuse and dementia annual training for CNA H, I, and J. On 1/08/25 at 2:20 PM the Director of Nursing (DON) was interviewed and agreed that CNAs are expected to have yearly training that includes abuse and dementia management in order to provide adequate care for residents. The DON agreed that there were no records of CNA's H, I, and/or J having abuse and dementia training. Review of the facility policy titled 12 Hour Nurse Aid Training revised 2/17/20 revealed, to assure nursing assistants receive at least 12 hours of training annually. During the year, the Staff development coordinator should monitor the 12-hour training records to assure CNAs are on track with training programs. CNAs who do not meet the 12-hour annual training requirements will be removed from the schedule on their hire anniversary date and will not ve put back on the schedule until 12 training has been achieved.