STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 Based on observation, interview, and record review the facility failed to ensure that accurate advance directive information was in place for two residents (Resident #88, Resident #182) of two residents reviewed for advance directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time) from a total sample of 24 residents, resulting in potential for a resident's preferences for medical care not to be followed by the facility. Findings Include: Resident #182 (R182): Review of the medical record revealed R182 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive, repeated falls, dementia, pain in right leg, peripheral vascular disease (PVD), heart failure, hyperlipidemia (high fat content in blood), hypothyroidism (low activity of thyroid gland), muscle weakness, and anemia (low red blood cells). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R182 had a Brief Interview for Mental Status (BIMS) of 00 (severe cognitive impairment) out of 15. During observation and interview on [DATE] at 10: 20 a.m. R182 was observed lying down in bed. Resident appeared to be well groomed. R182 did not answer questions during attempted interview. In an interview on [DATE] at 10:25 a.m. R182's family member J explained that her father was recently admitted to the facility and that she was his legal representative. During record review it was revealed that R182 had a physician order, dated [DATE], No CPR/DNR (no cardiopulmonary resuscitation/Do not resuscitate). Review of the R182's medical record demonstrated a document entitled Designation of Patient Advocate Form (Durable Power of Attorney for Health Care) which demonstrated R182's family member J was appointed his Patient Advocate and was signed [DATE]. R182's medical record did not demonstrate that he had been declared incompetent to make medical decisions. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 10:21 a.m. Social Worker (SW) Supervisor E explained that it was necessary for a Resident to be declared incompetent before a Durable Power of Attorney (DPOA) could be activated. She explained that incompetence had to be determined by two physicians or one physician and a psychologist. She explained that the facility typically uses the attending physician for one declaration of incompetence and a psychologist for the other declaration. SW Supervisor E also explained that a Residents Code Status (wishes for life saving measures) would then be determined once the DPOA was activated. She explained that the residents Code Status would then be entered into the medical record. SW Supervisor E confirmed that R182 had physicians order, dated [DATE], No CPR/DNR (no cardiopulmonary resuscitation/Do not resuscitate). She also confirmed that R182's medical record did not have any declaration of incompetence in the medical record. SW Supervisor E explained that R182's order for Code Status of Do not resuscitate was not correct because incompetence had not been determined and that R182 should have an order for Full Code (Cardiopulmonary resuscitation required). SW Supervisor E could not explain why an order No CPR/DNR (no cardiopulmonary resuscitation/Do not resuscitate) had been entered into R182's medical record without the proper declaration of incompetence. In an interview on [DATE] at 10:50 Social Worker (SW) K explained that prior to this interview she had already reviewed R182's Advance Directives, because she was told by her supervisor that the appropriate documentation was not present to determine his competency. She explained that she had been the person responsible to determine that the appropriate documentation should have been present and requested the appropriate orders for No CPR/DNR (no cardiopulmonary resuscitation/Do not resuscitate). SW K could not explain why she had not followed the appropriate process. Review of facility policy entitled Advance Directives-Michigan, with an effective date of [DATE], demonstrated Procedures Generally C-Determination Resident's Level of Cognition. All individuals are presumed to have the level of cognition to make informed health care decisions unless the Resident has been adjudicated as incompetent in a court of law or unless a determination is made by two physicians or a physician and licensed psychologist, that the individual is unable to participate in medical treatment decision. Further, if the initial facility cognitive evaluation (Nursing Comprehensive Evaluation and/or BIMS) indicate a level of cognition that questions the Resident's ability to participate in medical treatment decisions, the facility will initiate a capacity evaluation form. Two physicians or a physician and licensed psychologist will determine if the individual is able or unable to participate in medical treatment decisions. This determination is made on the Statement of Capacity. 45135 Resident #88 (R88): Review of the medical record revealed Resident #88 (R88) was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Syncope (fainting) and Collapse, Adjustment Disorder with mixed Anxiety and Depressed Mood, Dysphagia (difficulty swallowing), Muscle Wasting and Atrophy, Difficulty with walking, and Unsteady on Feet. According to Resident #88 (R88)'s Minimum Data Set (MDS) dated [DATE], revealed R88 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and had behaviors. R88 needs minimal to no assist with toileting, showering/bathing, getting dressed and personal hygiene. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Advanced Directive where R88 was listed as a Do Not Resuscitate (DNR), was not witnessed by two people and dated ,d+[DATE]. A new Advanced Directive had not been completed for , d+[DATE] yet as required by Michigan. During an interview on [DATE] at 09:01 AM, Social Worker (SW) K stated R88 Advanced Directives must not have been scanned in his medical records yet. Writer asked whose responsibility it was to see that this was done, she stated SW. Writer asked why ,d+[DATE] Advanced Directives for DNR did not have 2 witness signatures as required. SW K stated she would go look for it. During an interview on [DATE] at 10:50 AM, SW K stated the Advanced Directives were scanned in the medical record when she looked. Writer asked what date they were scanned in, and SW K stated she did not know, it was in the medical record when she looked in it. Record review revealed that the Advanced Directives for DNR was filled out on [DATE] during the survey and scanned into R88's medical record.

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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** 27446 Based on observation, interview, and record review the facility failed to ensure for one out of one residents (Resident #81) an assessment was completed for a half lap tray, and including the rational for the use of the lap tray. Findings Include: \Resident #81 (R81): Resident #81 (R81) was observed to have a half lap tray attached to his wheelchair on 5/30/2024 at 1:36 PM. In an observation on 6/04/2024 at 10:40 AM, R81 was observed to have a half lap tray attached to his wheelchair. Review of a Physician's order dated 9/7/2021, revealed R81 was ordered to have a half lap tray on his wheelchair at all times every day and evening shift for lap tray. The order did not specify what medical symptom the half lap tray was being used for R81. Record review of a Treatment Administration Record (TAR) dated 9/7/2021, revealed R81 was to have a half lap tray on his wheelchair at all times every day and evening shift for lap tray. The TAR did not specify why R81 required the use of the lap tray. No physical restraint assessment was found in R81's electronic medical record (EMR) in order to determine if the lap tray would have been a restraint or enabler. An assessment was completed on 6/3/2024 during the survey. The assessment further revealed R81 was to have a half lap tray for positioning/support, improve physical and emotional status, and comfort. The assessment revealed the word Yes was marked for Care Plan Updated. Review of R81's care plans revealed, (R81) has a functional ability deficit and requires assistance with self care/mobility R/T (related to): CVA (stroke), Rt (right) side flaccid (not able to move/paralyzed) . The care plan had one intervention that was dated 1/5/2024 which revealed, Right half lap tray in wheelchair at all times There was no indication as to why R81 required the use of the lap tray on the care plan. No other interventions were found upon review of R81's care plans. The care plan was not updated after the assessment dated [DATE]. Review of the facility's policy and procedure dated 5/1/2010 titled, Restraint Management revealed under, Guidelines, #3. A Physical Device Evaluation (assessment) will be completed prior to initiating a device by a licensed nurse or the interdisciplinary team., and #5. Any guest/resident using a physical restraint or side rails must have a current, signed restraint consent in the medical record. No consent was found in R81's EMR. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy under, #9 revealed, Any guest/resident using a restraint will have a current order with the following components: Type of restraint, When to use the restraint, Medical symptom for using the restraint, and A release/exercise statement. The policy further revealed under Documentation that a physical device evaluation, physical restraint reduction evaluation, restraint consent, and care plan/Kardex were to have documentation. In an interview on 6/04/2024 at 9:00 AM, Director of Nursing (DON) B stated that a physical device/restraint evaluation was expected to be performed prior to the use of the device. DON B said any nurse could perform the evaluation, and said then the nurse who performed the evaluation was expected to update the resident's care plan.

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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** 27446 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for two out of 24 residents (Resident #26, Resident #81). Findings Include: Resident #26 (R26): Review of Physician's orders revealed R26 was ordered to receive Seroquel (treats schizophrenia, bipolar disorder, and depression), 25 mg (milligrams) once a day for mood disorder. The orders also revealed R26 was ordered to receive Zoloft (treats depression, obsessive-compulsive disorder, posttraumatic stress disorder, anxiety, and panic disorders) 50 mg one time a day. Review of R26's diagnoses list revealed R26 had diagnoses of visual hallucinations and depression. Review of R26's care plans revealed a care plan with a Focus of (R26) is at risk for adverse reactions and side effects r/t (related to) receiving an Antidepressant and Antipsychotic. The care plan interventions list side effects to be observed for, but were not specific to Seroquel or Zoloft, and did not reveal R26 was receiving Seroquel and Zoloft, nor did the care plan list the specific side effects of the two medications for staff to observe for. Resident #81 (R81): Review of Physician's orders dated 9/26/2023, revealed R81 was ordered to receive Zoloft 100 mg one time a day for depression. Review of R81's care plans revealed R81 was at risk for adverse reactions and side effects related to receiving an antidepressant. There was no specific side effect intervention regarding the Zoloft, but rather generic side effects. The care plan was not updated on 9/26/2023 regarding the Zoloft order. Review of another care plan in place revealed R81 had the potential for mood/behaviors fluctuations related to major depression, but did not revealed R81 received Zoloft, and did not have any interventions related to the use of the Zoloft or side effects to observe for. The care plan was not updated on 9/26/2023 regarding the Zoloft order. In an interview on 6/04/2024 at 9:10 AM, Social Worker (SW) R stated that she was the one who was responsible for updating R81's care plan regarding Zoloft. Resident #81 was observed to have a half lap tray attached to his wheelchair on 5/30/2024 at 1:36 PM. In an observation on 6/04/2024 at 10:40 AM, R81 was observed to have a half lap tray attached to his wheelchair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Physician's order dated 9/7/2021, revealed R81 was ordered to have a half lap tray on his wheelchair at all times every day and evening shift for lap tray. The order did not specify what medical symptom the half lap tray was being used for R81. Record review of a Treatment Administration Record (TAR) dated 9/7/2021, revealed R81 was to have a half lap tray on his wheelchair at all times every day and evening shift for lap tray. The TAR did not specify why R81 required the use of the lap tray. No physical restraint assessment was found in R81's electronic medical record (EMR) in order to determine if the lap tray would have been a restraint or enabler. However, an assessment was completed on 6/3/2024 during the survey. The assessment further revealed R81 was to have a half lap tray for positioning/support, improve physical and emotional status, and comfort. The assessment revealed the word Yes was marked for Care Plan Updated. Review of R81's care plans revealed, (R81) has a functional ability deficit and requires assistance with self care/mobility R/T (related to): CVA (stroke), Rt (right) side flaccid (not able to move/paralyzed) . The care plan had one intervention that was dated 1/5/2024 which revealed, Right half lap tray in wheelchair at all times There was no indication as to why R81 required the use of the lap tray on the care plan. No other interventions were found upon review of R81's care plans. The care plan was not updated after the assessment dated [DATE]. In an interview on 6/04/2024 at 9:00 AM, Director of Nursing (DON) B stated that a physical device/restraint evaluation was expected to be performed prior to the use of the device. DON B said any nurse could perform the evaluation, and said then the nurse who performed the evaluation was expected to update the resident's care plan.

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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** 45135 Based on observation, interview, and record review, the facility failed to provide appropriate care for Activities of Daily Living (ADL) for three of three residents reviewed for ADL care of dependent residents (R80, R91 and R32), from a total of 24 sampled residents, resulting in not achieving and/or maintaining their highest practicable well-being. Findings include: Resident #91 (R91): Review of the medical record revealed Resident #91 (R91) was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's, Gastrostomy, Psychotic Disorder with Delusion and Adjustment Disorder with Anxiety. According to Resident #91 (R91)'s Minimum Data Set (MDS) dated [DATE], revealed R91 scored 04 out of 15 (severely cognitively impaired) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and had behaviors. R91 is dependent of toileting, showering/bathing, getting dressed and personal hygiene. During an interview on 05/29/24 at 04:30 PM, R91's daughter V stated he had dirt under his nails and his nails were long. His feet were dirty and skin flaking from being dry. R91's daughter V also stated they were giving a bed bath, not a shower. R91's daughter V stated they were not scrubbing his feet. During an interview and observation on 05/30/24 at 10:19 AM, R91's daughter V was at bedside and stated that he was shaved this morning. R91's daughter V pulled up the blanket and sheet to look at his feet, then stated his toenails are still dark under the nails and long. Observation of flaking dry skin. During an interview on 06/04/24 at 09:23 AM, Certified Nursing Assistant (CNA) W stated they chart under their documentation if they provided the care or not. If not, they had to notify the nurse and chart that they refused and will attempt to provide care later. CNA W stated the same with foot care, they wash and dry feet. If they need their nails cut, then they notify the nurse who notifies the foot doctor. During an interview on 06/04/24 at 10:40 AM, Director of Nursing (DON) B stated the CNA's are trained to chart that they completed one or more of the tasks, listed under the Task: ADL Care Statement, Follow Up Question: Have you provided routine standard care which includes evaluating skin daily and reporting changes, shaving and nail care as needed, turning and repositioning, oral care, washing face and hands, hair care, clean clothes and linens, ROM, offering fluids, utilizing resident specific devices, dignity and respect, universal precautions, observing and reporting changes in behavior, keeping call light within reach, observing and notifying for pain, and encouraging and assisting to activities? Writer asked why there were 2 or 3 staff documenting daily stating that care was provided when the resident still had dirty nails, nor repositioned. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON B stated she would investigate this. Resident #80 (R80): Review of the medical record revealed Resident #80 (R80) was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Cerebral Aneurysm, Muscle Weakness, Major Depression, Vascular Dementia, Unspecified Osteoarthritis, Muscle Wasting and Atrophy, Hemiplegia and Hemiparesis following Cerebral Infarction affecting the right dominate side, Dysarthria, and Dysphagia. According to Resident #80 (R80)'s Minimum Data Set (MDS) dated [DATE], revealed R80 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and had behaviors. R80 is dependent of toileting, showering/bathing, getting dressed and personal hygiene. During an interview and observation on 05/29/24 at 03:11 PM, R80 appears scruffy/not shaven, and hair was greasy looking. R80 stated he did not get the showers he preferred. R80 stated the CNA's would ask him if he wanted a shower or bed bath, he reported a shower, but they gave him a spot clean bed bath. R80 also stated they would wash his armpits, but not the whole body. R80 added they would wash a portion of the top of his leg, but not the whole leg, not the front and back of his entire body. During an interview and observation on 05/31/24 at 10:29 AM, CNA X was providing personal care with the curtains pulled. When CNA X walked out of his room, she stated she just changed his brief. During an interview on 05/31/24 at 10:40 AM, CNA X stated there was a shower schedule in a binder at the nurse's station that tells staff which day and shift the residents are supposed to be showered. CNA X also stated they chart it in the electronic medical record under Activities of daily living (ADL care). Writer asked if the resident received a shower/or bed bath. CNA X stated documentation does not tell which one they received. Record review revealed R80 was scheduled for showers on Monday and Thursday evening on second shift. This writer requested the last 60 days of shower log from the NHA A. This log was provided but did not reflect if he was given a full bed bath or a shower of his preference. Nor did this log reflect if and when R80 had his hair washed or shaven. During an interview and observation on 06/04/24 at 09:11 AM, R80 stated he finally got a shower on Monday night and washed his hair. R80 stated he was shaved on and off, they do not do it with every shower or bed bath. Observation of chin hair longer in the middle of his chin, not shaved evenly. [NAME] hair on the left side is considerably longer than the right. During an interview on 06/04/24 at 10:40 AM, DON B stated the CNA's are trained to chart that they complete one or more of the ADL tasks. Writer asked why there was 2 or 3 shift documentations daily stating that care was provided when the resident still has greasy hair, not shaven and complained he had not had a shower. DON B stated she would investigate that. 46954 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32 (R32): Review of the Admission Record reflected that R32 readmitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus without complications, heart failure, cerebral infarction (stroke) without residual deficits, chronic kidney disease stage 2, contracture, weakness, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, attention deficit hyperactivity disorder, restlessness and agitation bipolar disorder, and major depressive disorder. R32 was cognitively intact and easily conversant. On 05/30/24 at 9:11 AM, R32 was observed in bed and watching television. R32's bedside table contained his remote and a cup of fluids. A strip of yellow tape that extended the length of the bedside table had honey thickened liquids written on it with black marker. R32 explained that he had recently switched from strictly tube feeding to a mechanical soft diet with honey thickened liquids. R32's left hand was contracted into a closed hand with the fingers extended. R32 allowed me to observe his left contracted hand. An odor was detected from his contracted hand. R32 stated that he is does not have use of his left arm and hand, however, could place his bed remote into his hand and utilize the bottoms to move his bed. R32 reported full use of his right arm. R32's fingernails were long and caked with brown debris underneath of him. When queried if he preferred to have his fingernails clean and cut shorter, R32 stated that he would but staff reported to him that they would not assists him with cutting his fingernails because he is a diabetic. R32 reported that he had not had a shower in quite some time and enjoyed showers. R32 stated that his shower days were Wednesday and Saturday. R32 stated that he refused his shower on 5/29/24 due to his room being too cold but had not refused any other bed baths or showers. R32 reported that he had not received oral care and desired to have his teeth brushed. R32 stated that he was currently on an antibiotic for an infection in his mouth and hadn't been offered set up assistance to complete oral care on himself in over two weeks. Review of R32's Shower Task reflected that R32 had received a shower or bed bath on every scheduled day since 5/8/24. Review of a Psychology Note dated 2/22/24 revealed R32 stated that he would like reminders of his shower days and does not feel that he receives his scheduled showers. On 5/31/24 at 2:04 PM, R32 was observed in bed in the same condition as the previous observation on 5/30/24. A quick peak at the Shower Task revealed R32 was marked as receiving a bed bath or shower on 5/31/24 from Certified Nursing Assistant (CNA) CC. When questioned if R32 had received the bed bath or shower, R32 responded that he had received neither. In a telephone interview on 05/31/24 at 3:53 PM, although R32 was marked as receiving a bed bath or shower just a few hours prior, CNA CC stated that R32 did not receive a bed bath or shower either that day and that R32 refused. CNA CC stated that she did not document that he had refused.

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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** 46954 Based on observation, interview, and record review, the facility 1) Failed to perform dressing changes as ordered and 2) Failed to follow physician's orders for removal of a peripherally inserted central catheter (PICC) for one resident (Resident #74) of 24 residents reviewed for quality of care, resulting in the potential for an infection and feelings of frustration and worthlessness. Findings include: Resident #74 (R74): Review of the Admission Record reflected that Resident #74 (R74) was admitted to the facility on [DATE], with diagnoses that included neurogenic bladder and sepsis. R74 was cognitively intact. On 05/30/24 at 11:33 AM, R74 was observed in his room and resting in his bed. R74 was playing on a gaming console. A peripherally inserted central catheter (PICC line- a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart) was observed on his left upper arm. R74 stated that the PICC line was being used for antibiotic infusions. R74 had stated that it had been over a week since the PICC line dressing was changed. The PICC line dressing was observed to be dirty, stained a darker color. The Tegaderm covering the PICC line was peeling up. The dressing did not contain a date on the dressing of when it was last changed. In conversation, it was apparent that R74 was very knowledgeable about PICC lines, and the maintenance required. R74 reported that he had mentioned the lack of care for the PICC line however, staff dismissed his concerns. Review of a Skin/Wound Note dated 4/18/2024 at 3:10 PM reflected Resident [R74] has a PICC line in place to the left upper arm . On 6/04/24 at 11:55 AM, R74 was in his room resting in bed. The PICC line was observed in his left upper arm. The dressing had no been changed and was in the same condition as the initial observation. R74 stated that he had completed his antibiotics days ago. An old antibiotic bag remained hanging on an IV pole adjacent to R74's bed. The IV tubing was not in use and was dated for 5/31. Review of the treatment administration record revealed a Physician Order initiated on 4/20/24 which stated, change transparent dressing to PICC every day shift every 7 days . The order was marked as last completed on 5/25/24. Further review of the Treatment Administration Record revealed an order initiated on 5/31/24 for Remove PICC per Dr {Doctor] [name redacted]. The order for PICC line removable was marked as completed. In an interview on 6/04/24 at 12:22 PM, Licensed Practical Nurse (LPN) AA stated that she was the assigned nurse for R74 that day. LPN AA reported that she was unsure of R74 still had the PICC line, however, did state that R74 finished his IV antibiotics prior to the weekend. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/04/24 at 1:38 PM, Assistant Director of Nursing (ADON) C that she had very recently took over the Infection Control Nurse role until a replacement could be selected. Regarding PICC line dressing changed, ADON C stated that it is policy flush PICC lines every shift and to change PICC line dressings every 7 days or as needed. When PICC line dressings are changed, it is expected to label the dressing with the date and initials of the staff member who performed the dressing change. ADON C confirmed the order for PICC line removal for R74 and stated that she was told that the PICC line had been removed on 5/31/24 at 4:00 PM. ADON C stated that since the order was completed, all corresponding PICC line orders had also been completed which meant, R74 had not gotten the required dressing changes and PICC line flushes. ADON C stated that this concern required immediate education.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review, the facility 1) Failed to implement interventions to promote pressure ulcer healing and prevent the worsening of pressure ulcers for one resident (Resident #37) and 2) Failed to prevent a pressure ulcer for two residents (Resident #37, Resident #91) of three residents reviewed for pressure ulcers, resulting in facility-acquired pressure ulcers and the potential for delayed wound healing and/or the worsening of wounds. Findings include: Resident #37 (R37):: Review of the Admission Record reflected that R37 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included gout, alcoholic liver disease, type two diabetes without complications, and degeneration of nervous system due to alcohol The Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/8/24, reflected that R37 scored a 14 out of 15 on the Brief Interview for Mental Status (cognitively intact). R37 required partial assistance of one person for bed mobility and assistance from one person for transfers. The Quarterly MDS reflected that R37 did not have pressure ulcers. On 5/29/24 at 4:02 PM, R37 was observed in his bed. R37 was conversant and answered questions appropriately. R37's pad of his right foot and the toe of his left foot were pressed up against the footboard of his bed onto a smooth, square plastic case with the word Medi-[NAME] on the surface. The Medi-[NAME] stuck out toward R37 approximately 3 inches and covered a large portion of his footboard, leaving no room for R37's feet to be positioned off the Medi-[NAME]. R37 had a dressing on his left foot wrapped around the base of his foot. A red, open area was observed on his 3rd left toe. R37's lower extremities were not floated. When asked about the dressing to left foot, R37 stated that he was too long for his bed which caused his feet to press against the Medi-[NAME] case on his footboard. When asked what the purpose of the Medi-[NAME] was, R37 stated that the Medi-[NAME] case covers up the mechanics of the bed. R37 stated that he had been in the bed with the Medi-[NAME] pressing up against his feet for months. R37 also stated that a staff member had come into his room earlier in the day to mention the possibility of removing the Medi-[NAME] from his footboard. A soft, green boot for offloading heels was observed on a wheelchair in R37's room. Review of R37's Care Plan revealed a Focus Area for risk of impaired skin/pressure injury which was created on 6/7/21. An intervention reflected encourage to float heels while in bed and assist as needed was implemented on 6/11/21. Review of the same Care Plan revealed a Focus Area initiated on 5/6/23 which stated [R37] has actual impairment to skin integrity r/t [related to] left ankle, right ankle, and right foot third digit. An intervention included elevate the extremities and float the hells to avoid pressure on bony areas. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note dated 4/17/2024 revealed .Pressure - Stage 2 Left Lateral Malleolus - This wound measures 1.0 x 0.8 cm [centimeters] with a depth of <0.1 cm. This wound is partial thickness. There is a scant amount of drainage from this area. Wound bed consists of 100% pink/white moist epithelial tissue loss. Edges are attached and there is no slough, eschar, tunneling, undermining, or odor. The surrounding tissue is fragile but without redness, warmth, swelling, pain, induration, or sign of infection . [R37] should be turned frequently. Patient should be supported with pillows or wedges to prevent pressure on wound. Continue preventative measures and pressure relief. Elevate bilateral lower extremities, float heels, apply soft heel lift boots . Review of a Progress Note dated 5/1/2024 revealed .Pressure - Stage 2 Left Lateral Malleolus - Stalled. This wound measures 8.1 x 1.4 cm with a depth of <0.1 cm. This wound is partial thickness. There is a scant amount of drainage from this area. Wound bed consists of 2 areas - proximal area is 100% scab and distal area 10% pink moist epithelial tissue loss and 90% scab. Edges are attached and there is no slough, eschar, tunneling, undermining, or odor Pressure - Stage 2 Right Lateral Malleolus - This wound measures 1.6 x 1.1 cm with a depth of <0.1 cm. This wound is partial thickness. There is a scant amount of drainage from this area. Wound bed consists of 100% pink/white moist epithelial tissue loss .Continue supportive care. Patient should be turned frequently. Patient should be supported with pillows or wedges to prevent pressure on wound. Continue preventative measures and pressure relief. Elevate bilateral lower extremities, float heels, apply soft heel lift boots . Review of a Progress Note dated 5/15/2024 revealed .Pressure - Stage 3 Left Lateral Malleolus - Improving. This wound measures 1.4 x 7. cm with a depth of <0.1 cm. This wound is partial thickness. There is a scant amount of drainage from this area. Wound bed consists of 2 areas - proximal area is 100% scab and distal area 10% pink moist epithelial tissue loss and 90% slough . Edges are attached and there is no slough, eschar, tunneling, undermining, or odor. The surrounding tissue is fragile but without redness, warmth, swelling, pain, induration, or sign of infection . Pressure - Stage 2 Right Lateral Malleolus - Improving. This wound measures 0.6 x 0.4 cm with a depth of <0.1 cm. This wound is partial thickness. There is a scant amount of drainage from this area. Wound bed consists of 100% scab .AbrasionLeft [sic] Dorsum - 3rd Digit (Toe) - This wound measures 0.7 x 0.5 cm with a depth of <0.1 cm. This wound is partial thickness. There is a scant amount of drainage from this area . Review of a Progress Note dated 5/29/2024 revealed .Pressure - Stage 3 Left Lateral Malleolus - Stable. This wound measures 1.2 x 6.3 cm with a depth of <0.1 cm. There is a scant amount of drainage from this area. Wound bed consists of 10% pink moist epithelial tissue loss and 90% slough . Edges are attached and there is no slough, eschar, tunneling, undermining, or odor .Pressure - Stage 2 Right Lateral Malleolus - Resolved .Abrasion Left Dorsum - 3rd Digit (Toe) - Stable. This wound measures 1.2 x 0.6 cm with a depth of <0.1 cm. This wound is partial thickness. There is a scant amount of drainage from this area. Wound bed consists of 100% scab . In a Wound Care observation and interview on 05/31/24 at 9:23 AM, Registered Nurse (RN) D reported that she does the wound care for the facility. RN D stated that the Nurse Practitioner comes into the facility on Wednesdays and performs the wound assessments on required residents and implements wound care orders. RN D stated that R37 was hitting his toe on the Medi-[NAME] which caused the injury on R37's left tie. RN D stated that she was not sure what the purpose of the Medi-[NAME] was and she had let maintenance know that R37 required a new bed frame on Wednesday (6/5/24). RN D stated that R37's bilateral heels should be elevated to protect his pressure ulcers from worsening and to prevent new pressure ulcers. RN D stated that R37's right lateral pressure ulcer had resolved. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 at 9:26 AM, R37 was observed in bed with his heels not floated. The green foam boot was observed in the wheelchair. R37 stated that he did not care for the green foam boot, however, did not have a problem offloading his heels with the use of a pillow. On 5/31/24 at 2:29 PM, R37 was observed in his room seated on his wheelchair. The Medi-[NAME] was no longer attached to R37's footboard. R37 stated that it was removed earlier that day. Upon observation of R37's feet, blood was noted on the right lateral ankle. RN D entered the room to do an assessment of R37's right ankle. RN D stated that R37's right ankle pressure ulcer had previously resolved but had appeared to have reopened. Review of a Total Body Skin Assessment note dated 5/31/2024 at 2:50 PM revealed Number of new skin conditions:1 Comments: Resident had a resolved wound to the right lateral ankle that had a small scab over it and was resolved 05/29/24. Scab came off and the wound reopened. Orders in place . In an interview on 5/31/24 at 3:02 PM, Assistant Director of Maintenance (ADM) S stated that a member of the clinical team had noticed that R37 slides down in his bed and hits the feet of his bed on the Medi-[NAME] which caused pressure sores to his feet. ADM M stated that she was notified of the issue on 5/30/24 so she changed the bed frame for R37 on 5/31/24. ADM S denied having to order a bed frame. Review of the Maintenance Work History Report dated 3/31/24-6/1/24 revealed no work order for R37's bed frame. On 06/04/24 at 9:01 AM, R37 was observed in his bed. R37's heels were not floated. On 06/04/24 at 11:28 AM, R37 was observed in his bed. R37's heels were not floated. Review of the Progress Note's revealed no documented refusals for offloading pressure interventions. In an interview on 06/04/24 at 1:25 PM, RN D stated that staff should be floating R37's heels and documenting refusals. When asked about the Medi-[NAME] obstruction on R37's bed frame, RN D stated that she watched to see how he moved in bed and when she identified it as an issue, she had maintenance order a new bed frame sometime around Mid-May. 45135 Resident #91 (R91): Review of the medical record revealed Resident #91 (R91) was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's, Gastrostomy, Psychotic Disorder with Delusion and Adjustment Disorder with Anxiety. According to Resident #91 (R91)'s Minimum Data Set (MDS) dated [DATE], revealed R91 scored 04 out of 15 (severely cognitively impaired) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and had behaviors. R91 is dependent of toileting, showering/bathing, getting dressed and personal hygiene. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 06/04/24 at 09:35 AM, Certified Nursing Assistant (CNA) W stated they chart in the resident's medical record if they provided the personal care or not. If not, they had to notify the nurse and chart that the resident refused and will attempt to provide care later. CNA W stated the same with foot care, they wash and dry feet. If they need their nails cut, then they notify the nurse who notifies the foot doctor. During this observation of R91's feet, the left foot/heel was wrapped with a Kerlix/gauze dressing dated 05/29/24. R91's heels were laying against the mattress with no support under his feet or heels to prevent further skin breakdown. No low air loss mattress was observed on the bed. Record review revealed that R91 was care planned to float heels while in bed and encourage to reposition. R91 was care planned to have a pressure reduction mattress to the bed. Record review revealed an active order for dressing changes to the left heel as follows. Left Heel: Cleanse with wound cleanser and allow to dry. Apply skin prep to the wound bed, cover with an ABD Pad and wrap with Kerlix. Monday, Wednesday and Friday and PRN every evening shift every Mon, Wed, Fri for Wound Care and as needed for Wound care. Active order dated 5/22/2024 15:00. R91 did not reflect dressing change last Friday 05/31/24 or Monday 06/03/24 by the date still on the left heel dressing. Record review also revealed R91 had an active order for dressing change/wound care to sacral area as follows. Sacrum: Cleanse the area with wound cleanser and allow to dry. Apply triad to the open area and leave open to air. Daily and PRN every evening shift and as needed. Active order dated 4/9/2024 14:15. During an interview and observation on 06/04/24 at 09:40 AM, 2 CNA's repositioning R91 and observed the sacral pressure ulcer. CNA W stated she asked the wound care nurse what the order was for his sacral pressure ulcer. CNA W then added she would provide peri care and apply the barrier cream to his sacral area. R91's heels were laying against the mattress with no support under his feet or heels to prevent further skin breakdown. No low air loss mattress was observed on the bed. During an interview on 06/04/24 at 09:55 AM, LPN Z stated it was documented the nurse changed the dressing on R91's left heel yesterday (06/03/24) on afternoon shift. Record review revealed the left heel wound care was provided and was signed out on 05.31.24 and on 06.03.24 by the same nurse. During an interview on 06/04/24 at 10:47 AM, DON B stated she knew about the wound care orders but was not involved with the details of the wounds. During an interview on 06/04/24 at 10:51 AM, wound care Registered Nurse (RN) D stated current wound care treatment was to cleanse the heel with a wound cleanser, allow to dry, apply a skin prep, cover with an ABD dressing, and wrap with Kerlix dressing on Monday, Wednesday, Friday and as needed. Writer reported the dressing on R91's heel was dated 05/29/24. Wound care RN D stated she will assess it and re-educate on that.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review the facility failed to ensure that necessary behavioral health care interventions were implemented for one resident (Resident #32) of 1 resident reviewed for behavioral and emotional needs, resulting in the potential for worsening signs and symptoms of depression, ongoing mental distress, isolation, and the potential for a decline in physical functioning. Findings include: Resident #32 (R32): Review of the Admission Record reflected that R32 admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus without complications, heart failure, cerebral infarction (stroke) without residual deficits, chronic kidney disease stage 2, contracture, weakness, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, attention deficit hyperactivity disorder, restlessness and agitation bipolar disorder, and major depressive disorder. R32 was cognitively intact and easily conversant. On 05/30/24 at 9:11 AM, R32 was observed in bed and watching television. R32's reported that he often feels lonely and depressed. R32 stated that he had made remarks of feeling suicidal in the past, however, does not have any act to desire on it. R32 stated that he misses his father and would like to be able to regain strength in order to utilize his power wheelchair. An observation of the room was made. R32's blinds were closed. There were no reading materials nearby. The May activities calendar was not displayed in R32's room. Review of a Psychology Note dated 7/31/23 revealed R32 had self-reported depressive symptoms. Psychology recommended to encourage socialization and participation in meaningful activities. Review of a Psychology Note dated 2/22/24 revealed R32 experiences depression and anxiety frequently and is often bored. Review of a Psychology Note dated 5/13/24 revealed a plan to encourage socialization and participation in meaningful activities. Offer reassurance, support, redirection, and diversionary activities as needed. Review of the 1:1 Visit tasks revealed R32 had no 1:1 visits in the past 30 days. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan revealed a Focus Area initiated on 6/15/2023 which stated R32 had a potential for activity deficit related to decreased mobility. R32 enjoys music sports TV movies news and fishing . current restrictions in place inhibit ability to interact and leisure activities. Interventions included offer materials for individual activities as desired, [R32] prefers the following independent activities sports, religious activities, TV/movies, fishing and news. Provide an activities calendar, invite and encourage [R32] to attend activities of interest. [R32] stated an interest in the following types of group activity programs per assessment such as sports, religious activities, TV viewing, fishing the news . promote activities out of this comfort zone as well . In an interview on 6/04/24 at 12:27 PM, Activities Director (AD) DD stated that R32 does not typically come out of room to participate in group activities. AD DD stated that when resident prefer to decline group activities, they are added to a list to ensure 1:1 socialization is provided to the resident. AD DD checked the 1:1 list and verified that R32 was not on the 1:1 visit list. AD DD stated that he would benefit from 1:1 activities and added R32 to the 1:1 list.

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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. 45038 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was less than 5% when six medication errors were observed form a total of 29 opportunities for two residents (Resident #64, Resident #186) of five residents reviewed for medication administration, resulting in a mediation error rate of 20.69% Findings Included: Resident #186 (R186): Review of R186 Medication Administration Record (MAR) demonstrated Insulin Lispro 100 unit/ml (milliliter) VL (vial) 10 ml. Inject as per sliding scale: if 100-150=0 units; 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units if blood sugar is less than 70 or greater than 400 contact physician. Subcutaneously before meals and at bedtime for DM II (Diabetes Mellitus). R186 (MAR) also demonstrated Fenofibrate Oral Tablet 145 MG (milligrams) Give 1 tablet by mouth one time a day for hyperlipidemia was to be given at 09:00 a.m. During observation of medication administration on 05/31/2024 at 08:54 a.m. Registered Nurse (RN) U was observed to enter R186's room and conduct a blood glucometer reading. R186 was observed sitting up in bed with his breakfast tray on the over bed table. His breakfast tray was to be totally empty of food at that time. RN U obtained a blood glucometer reading of 164mg/dl (milligrams/deciliter). RN U returned to medication cart and prepared Lispro Insulin 100 unit/ml 2 units. She then returned to R186's room and administered the insulin injection. RN U explained that the Fenofibrate Oral Tablet 145 MG (milligrams) was not available in the medication care or in the back up medication dispenser and that she would have to contact pharmacy to obtain the medication. In an interview on 06/04/2024 at 08:03 a.m. Director of Nursing (DON) B explained that it is the expectation that nurses follow the physician orders for medication administration. If the medication is ordered at a specific time, it is the professional practice that medication be given one hour before or one hour after the scheduled time. She also explained that if the medication was not available to be given at within that time, the physician would be notified, and a nursing progress note would be written. She explained that some insulin orders required a blood glucometer reading be obtained prior to the administration of insulin that is to be given based on the blood glucometer reading. She explained that it is professional practice to obtain the blood glucometer reading prior to the consumption of a meal when it is ordered before meals. DON B explained that the amount of insulin administered would be based upon that blood glucometer reading. DON B confirmed that R186's blood glucometer reading was to be completed before meals and that insulin should have been given prior to breakfast. DON B confirmed that Fenofibrate Oral Tablet 145 MG (milligrams) give 1 tablet by mouth one time a day was given at 05/31/2024 at 11:23 a.m. DON B confirmed that the Fenofibrate Oral Tablet 145 MG was to be given at 09:00 a.m. She could not demonstrate a nurse progress note that the physician had been notified for the delay in administration of the Fenofibrate Oral Tablet 145 MG. 45135 Resident #64 (R64): (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/30/24 at 10:22 AM, a medication cup with 4 pills in the medication cup was sitting on the over the bed table of R64 unattended while she was sleeping. The medication cup contained two blue rounds tablets, an oblong light green tablet broke in half and a rectangular light peach colored tablet. This writer tried waking up R64, which she raised her head, stated a couple of words that were not understood and closed her eyes again. During an interview on 05/30/24 at 10:30 AM, Writer asked LPN Y if that was a regular practice of setting the medication cups on the residents over the bed table. (LPN) Y stated That's on me, I know I am not supposed to do that. LPN Y asked writer if R64 had taken the medications yet or not. Writer stated the medications were still in the cup sitting on the over the bed table unattended. LPN Y stated she would go get them, as she walked away from the medication cart to retrieve the medication cup with the pills still in it.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on interview and record review, the facility failed to prevent a significant medication error for one resident (Resident #33) of 1 resident reviewed for medication errors resulting in Resident #33 not receiving a prescribed medication and the potential for a worsening infection. Findings include: Resident #33 (R33): Review of the Admission Record reflected that R33 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included cerebral infarction (stroke), gastrostomy status, and heart failure. The Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/8/24, reflected that R33 scored a 1 out of 15 on the Brief Interview for Mental Status (cognitive impairment). On 5/31/24 at 2:36 PM, R33 was observed in bed. R33 had a tube feeding infusing. Adjacent to R33's bed was an intravenous line (IV) pole and IV infusion pump. Review of a Progress Note dated 4/12/2024 revealed R33 was being seen by her medical provider for a follow up of a right heel X-ray result. The Wound Care Nurse Practitioner ordered IV Vancomycin and Cefepime (antibiotics) due to osteomyelitis (infection in the bone) to the right heel. Review of a Nurses Note dated 4/12/2024 at 6:16 PM revealed verbal order from Nurse Practitioner [name redacted] to start Cefepime IV pharmacy to dose X 6 weeks and Vancomycin IV pharmacy to dose X 6 weeks .related to wound infection . Review of R33's Physician Orders revealed an order for Vancomycin HCl intravenous solution reconstituted 750 milligram use 750 milligram intravenously 2 times a day for osteomyelitis until 5/26/2024. Review of a Physician Order revealed an order for Vancomycin HCl intravenous solution 1000 milligrams/200 milliliters .intravenously 2 times a day for osteomyelitis until 5/26/2024. Review of an Encounter Note dated 5/28/2004 revealed notified by nursing the patients Vanco IV will be extended x 10 doses due to missed doses. Rounding notified. Review of a Nurses Note dated 5/28/2004 at 2:55 PM revealed Vancomycin IV for osteomyelitis extended x 10 doses due to missed doses. Provider and unit manager aware. Review of the Medication Administration Summary for the months of April and May revealed several dates where the Vancomycin was held with no explanation provided and/or the Vancomycin medication was not given with no explanation provided in the medical record. (continued on next page)

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	235550	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/04/24 at 1:38 PM, Assistant Director of Nursing (ADON) C that she had very recently took over the Infection Control Nurse role until a replacement could be selected. When asked about the missing Vancomycin doses, ADON C stated that the nursing staff was educated regarding the use of the appropriate code when charting in the Medication Administration Record. ADON C some of the missed doses could have been due to a delay in receiving the results from the Vancomycin trough which pharmacy requires prior to sending additional doses of Vancomycin IV infusion. ADON C stated that the medical provider was notified immediately of the missed doses and increased monitoring for infection was implemented. Failure to take antibiotic as prescribed can result in reduced therapeutic levels of the antibiotic and therefore, increases the opportunity for worsening of the current infection.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 Based on observation, interview, and record review the facility failed to serve food at the preferred temperature for one resident (Resident #57) of two residents reviewed for food palpability, resulting in dissatisfaction during meals. Findings Include: Resident #57 (R57): Review of the medical record revealed R57 was admitted to the facility on [DATE] with diagnoses that included insomnia, depression, heart failure, arthritis, peripheral vascular disease (PVD), chronic pain syndrome, history of falling, weakness, hypertension, hyperlipemia (high fat content in blood), and anxiety. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/15/2024, revealed R57 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 05/29/2024 at 01:45 p.m. R57 was observed sitting up in her wheelchair at the side of her bed. She explained that the food, at the facility was poor and that the food is frequently cold. During observation on 05/31/2024 at 01:28 p.m. it was observed that the food cart arrived on the 500 hall (the unit R57 resides). R57's food tray was delivered to her room at 01:30 p.m. It was observed at that time that R57 had received fish, cauliflower, potatoes, and apple pie. The Certified Dietary Manager (CDM) L was present with this surveyor at that time and was asked to perform temperatures for the items R57 had received on her food tray. The temperatures observed, conducted by CDM L was observed to be the following: Fish 136 degrees F (Fahrenheit), cauliflower 110 degrees F, potatoes 118 F and apple pie 68 degrees F. CDM L explained that the fish, cauliflower, and potatoes should be at 140 degrees F and that the apple pie temperature was appropriate. CDM L explained that she was going to go back to the kitchen and re-heat R57's food tray. When CDM L' returned with the tray R57 was observed tasting the food and acknowledge that now the food was warm to her satisfaction.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39083 Based on observation, interview, and record review, the facility failed to maintain a sanitary kitchen, and maintain equipment and plumbing in good repair, resulting in an increased risk of food borne illness, affecting all residents that consume food from the kitchen. Findings include: On 5/29/24 at 1:43 PM, two wire racks, located in the walk-in cooler, were observed to have white mold-like accumulation. According to the 2017 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. Pf (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. On 5/29/24 at 1:54 PM, the steamer, located on the cookline, was observed to be leaking water out of the front door on to multiple clean pitchers stored below. At this time, Chef EE confirmed the finding and stored the pitchers in another location. Chef EE continued to say they were unaware the steamer shouldn't be leaking water from the door. According to the 2017 FDA Food Code Section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened. On 5/29/24 at 2:07 PM, the atmospheric vacuum breaker (AVB) (a backflow device commonly used in plumbing arrangements to prevent backflow/backsiphonage of contaminated water into the potable water supply), located at the dish machine, was observed to be covered with a cloth. Chef EE was queried on the cloth and was unaware of the reason for the cloth placement, then proceeded to remove it. The AVB was then observed to leak water out of the air inlet port when the dish machine was running a cycle. The AVB was observed to have scale build-up from hard water. According to the 2017 FDA Food Code Section 5-202.14 Backflow Prevention Device, Design Standard. A backflow or backsiphonage prevention device installed on a water supply system shall meet American Society of Sanitary Engineering (A.S.S.E.) standards for construction, installation, maintenance, inspection, and testing for that specific application and type of device. On 5/29/24 at 2:12 PM, an opened jug of soy sauce was observed on the shelf in the dry storage room. The manufacturer's label on the soy sauce jug states, Refrigerate after opening. Chef EE stated that they were unaware the soy sauce required refrigeration after opening. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 2017 FDA Food Code Section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or (2) At 5 C (41 F) or less. P . On 5/29/24 at 2:15 PM, the walk-in freezer door gasket was observed to be damaged with excessive ice build-up around the door opening. At this time, Chef EE stated that staff attempt to remove the ice by tapping it off the door, in turn, damaging the gasket. On 5/29/24 at 2:17 PM, a working spray bottle, located near the entrance of the kitchen, was observed to not be labeled to identify the contents. At this time, Chef EE instructed staff to label the [NAME] bottle. According to the 2017 FDA Food Code Section 7-102.11 Common Name. Working containers used for storing POISONOUS OR TOXIC MATERIALS such as cleaners and SANITIZERS taken from bulk supplies shall be clearly and individually identified with the common name of the material. Pf

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 Based on observation, interview, and record review the facility failed to coordinate hospice services for one resident (Resident #59) of one resident reviewed for Hospice Services, resulting in the potential of care not being provided to a resident receiving hospice services and the potential for residents not to be fully informed of hospice services provided. Findings Included Resident #59 (R59): Review of the medical record revealed R59 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), dysphagia (difficulty swallowing), weakness, gastro-esophageal reflux, seizures, hypotension (low blood pressure), anxiety, traumatic brain injury, and malignant neoplasm of prostate (cancer of the prostate). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/12/2024, revealed R59 had a Brief Interview for Mental Status (BIMS) of 10 (moderately impaired) out of 15. Section O-Special Treatments, Procedures, and Programs (with the same ARD) revealed R59 was receiving Hospice Services. During observation and interview on 05/29/2024 at 01:07 p.m. R59 was observed lying down in bed. He explained that he was receiving Hospice Services but could not explain when the services were provided each week, and he would not explain what disciplines were providing Hospice Services. R59 denied every receiving a Hospice Calendar which list the days or disciplines that would be providing care. No Hospice Colander was observed in R59's room. Review of R59's medical record demonstrated a physician order Admit to . Hospice which was active on 05/07/2024. Review of R59's plan of care demonstrated that he was receiving Hospice Services. R59's plan of care did not reveal what hospice disciplines were providing care or the frequency of that care. Review of R59's Kardex (document used by certified nursing aides to provide Resident care) did not demonstrate that he was on Hospice Services. In an interview on 06/04/2024 at 09:11 a.m. Certified Nursing Aide (CNA) P explained that Residents that received Hospice Services had a Notebook which was located at the Nurses station. She demonstrated R59's Notebook. She explained that she would refer to his Notebook to know what disciplines provided services and when they where to provide those services. Review of the book demonstrated two different weekly calendars but did not specify which weeks the calendars where for. Review of first calendar demonstrated that RN (Registered Nurse) Case Manager provided services Tuesday and Friday. CNA personal care Monday and Thursday, Social Work as needed and Clergy Spiritual Care two times monthly. The second calendar demonstrated RN (Registered Nurse) Case Manager provided services Tuesday and Friday. CNA personal care Monday and Thursday, Social Work no services provided Clergy Spiritual Care no dates of services provided. CNA P could not explain which calendar was accurate and current. CNA P' was also unable to explain what personal care R59 was to be provided by the Hospice CNA. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/04/24 at 09:15 a.m. Certified Nursing Aide (CNA) M explained that she was providing care for R59. When asked how she knew that he was being provided Hospice Services she explained that she would refer to the medical record. CNA M proceeded to look in R59's Kardex (document used by certified nursing aides to provide Resident care) but was unable to determine that he was receiving hospice services. CNA M' was also unable to explain what personal care R59 was to be provided by the Hospice CNA. In an interview on 06/04/2024 at 09:34 a.m. Director of Nursing (DON) B was asked to review which Hospice Calendar was correct, which was found in R59's Hospice notebook. DON B confirmed that no date was present on either Hospice Calendar and could not speak to which one was the most current. In an interview on 06/04/2024 at 09:42 a.m. Social Work (SW) Technician R explained that she coordinated Hospice Services for the hall that R59 resided. She explained that staff would know what Hospice Services were provided by reviewing the Hospice Colander located in his hospice notebook. SW Technician R reviewed R59's Hospice Colander and could not explain which calendar was correct. SW Technician was asked if R59 had received a copy of the Hospice Calendar and she responded that he had not. She could not explain why R59 was not given a calendar showing which Hospice Disciplines were providing services or when those services were provided. When asked how Certified Nursing Aides (CNA's) would know if a Resident was on Hospice Services, she explained that they would know by the Kardex. SW Technician R was unable to demonstrate that Hospice services were listed on the Kardex and explained that she must have forgot to place that information on R59's Kardex. Review of the Facility Policy entitled Hospice Care, effective date of 08/04/2023, demonstrated Guidelines which stated: 3) Develop a plan of care that reflects the participation of the hospice agency, the facility, and the resident and family 4). Ensure that the plan of care identifies the care and services which the facility and hospice agency will provide in order to be responsive to the unique needs of the resident and their expressed desire for hospice care. 8). Ensure the facility staff is aware of their responsibilities in implementing the plan of care, as well as the responsibilities of the hospice staff.