STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235551	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree of Hubbell Rehab and Health	52225 B Avenue Hubbell, MI 49934

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 This deficiency pertains to Intake #MI00147055. Based on interview and record review, the facility failed to obtain consent for psychotropic medications prior to initiating them for one Resident (#8) of five residents reviewed for psychoactive medications. Findings include: Resident #8 (R8) Review of R8's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including Alzheimer's disease, vascular dementia, delusional disorders, anxiety disorder, and depression. Review of R8's most recent Minimum Data Set (MDS) assessment, dated 11/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicative of severe cognitive impairment. On 12/10/24 at 2:35 PM, a telephone interview was conducted with Complainant/Guardian L who stated the facility was not communicating with him regarding treatment decisions despite having guardianship. Review of R8's EMR revealed the following pharmacy orders: 1. Quetiapine fumarate Oral Tablet [an antipsychotic medication] 50 MG (milligrams), give 1 tablet by mouth two times a day related to depression. Date initiated: 11/10/23 - present day. 2. Sertraline HCl (hydrochloride) Oral Tablet 50 MG [an antidepressant medication], give 50 mg by mouth in the morning related to depression. Date initiated: 4/27/24. On 5/25/24, Sertraline HCl Oral Tablet was increased to 100 MG. On 12/11/24 at 12:22 PM, an interview was conducted with the Director of Nursing (DON) regarding written consents for mood altering medications. The DON replied, We found out they've [consents] been a problem and they've been getting missed . It's something we've been working on. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 12:40 PM, an interview was conducted with Social Services Designee (SSD) G who verified medication consents had been identified as a, problem area. SSD G stated she had recently started calling resident families for consents. Review of Consent for Use of Psychoactive Medications forms revealed Complainant L gave verbal consent for both quetiapine fumarate and sertraline use on 12/11/24, approximately 1 year and 8 months after initiation, respectively. Review of facility policy titled, Unnecessary Drugs-Without Adequate Indication for Use, reviewed 8/5/24, read, in part: .the attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents and/or representatives . Review of facility policy titled, Use of Psychotropic Medication, reviewed 7/15/24, read, in part: .Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions .

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 This deficiency pertains to Intake #MI00147055. Based on interview and record review, the facility failed to ensure care conferences were scheduled on a quarterly basis and the responsible party was notified for one Resident (#8) of 14 residents reviewed for resident rights. This deficient practice resulted in the failure to include the responsible party in the development of a person-centered plan of care. Findings include: Resident #8 (R8) Review of R8's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including Alzheimer's disease, vascular dementia, delusional disorders, anxiety disorder, and depression. Review of R8's most recent Minimum Data Set (MDS) assessment, dated 11/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicative of severe cognitive impairment. On 12/10/24 at 2:35 PM, a telephone interview was conducted with Complainant/Guardian L who stated he was not being afforded the opportunity to participate in regular care conferences for R8. Complainant/Guardian L estimated he had been involved in two care conferences since R8's admission on 8/24/23. Review of R8's EMR revealed the following dates of care conferences since 8/24/23: 5/23/24, 10/3/24, and 12/6/24. On 12/10/24 at 4:26 PM, an interview was conducted with Social Service Designee (SSD) G who stated, there used to be a problem with regular care conferences under previous administration. SSD G stated care conferences should be conducted for every resident at least quarterly (every 3 months). On 12/10/24 at 4:50 PM, an interview was conducted with the Nursing Home Administrator (NHA) who verified 9 and 5 months elapsed had occurred between R8's care conferences since admission, despite a quarterly requirement. The NHA stated a care conference process was not in place when new management took over. Review of facility policy titled, Comprehensive Care Plans, reviewed 10/11/23, read in part: .The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to .the resident and the resident representative . the comprehensive care plan will be reviewed and revised after each comprehensive and quarterly MDS assessment .

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735 Based on interview and record review, the facility failed to perform a resident assessment for one Resident (#36) of one resident reviewed for self-administration of medication resulting in a resident self-administering medication without appropriate assessments. Findings include: Resident #36 (R36) A review of R36's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with diagnoses that included: peripheral vascular disease (PVD) or peripheral arterial disease (PAD). R36 scored a 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. Review of facility document titled, Medication Self Administration Screening dated 7/23/24, read in part . Complete this assessment prior to resident initiation of self-administration of medication and with any medication order changes, change in function/condition that might affect the resident's ability to safely self-administer medications. Ongoing assessment should occur at a minimum of quarterly . Review of Electronic Medical Record (EMR) for R36 did not reveal any subsequent assessments following 7/23/24. During an interview on 12/10/24 at 3:09 p.m., the Assistant Director of Nursing (ADON) E stated, we complete quarterly assessments on residents who are able to self-administer medications. During an interview on 12/11/24 at 7:21 a.m., the Assistant Director of Nursing (ADON) E stated, If a resident requests to self-administer medications we add a new evaluation and fax the doctor to see if they agree with it .we assess the residents quarterly or if they have a change in cognition . we did miss the quarterly assessment for [R36]. During an interview on 12/11/24 at 7:37 a.m., Registered Nurse (RN) H stated, the assessments of residents to self-administer medications are completed quarterly . Review of facility policy titled, Resident Self-Administration of Medication date reviewed/revised 1/15/24, read in part . A licensed nurse will complete the Medical Self-Administration screening tool in the Electronic Medical Record (EMR) .a re-assessment for safety at a minimum should be considered by the interdisciplinary team for the following .quarterly.

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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. 35103 Based on observation, interview, and record review, the facility failed to provide incontinence briefs in an appropriate style and size to meet the needs and preferences of two Residents (#23 & #26) out of 14 sample residents. This deficient practice resulted in resident discomfort and dissatisfaction. Findings include: Resident #23 (R23) During an interview and observation on 12/10/24 at 9:07 a.m., R23 voiced dissatisfaction with wearing incontinence briefs that did not fit. R23 said the brief size had gone from a XXL (2 Extra Large) to a Large size which did not fit. R23 stated, They are supposed to go around your belly. It (incontinence brief) goes underneath my belly and lower back - it covers the crotch. I have been complaining . to Certified Nurse Aide (CNA)/Scheduler Q for at least a week. R23 lifted the gown they were wearing to show their incontinence brief was not positioned around the waist, with coverage only of R23's pubic area. Observation of the brief package in R23's closet, found only size Large incontinence briefs in the closet. Resident #26 (R26) During an observation and interview on 12/11/24 at 10:29 a.m., in the presence of Registered Nurse (RN) H and CNA Q, R26 was observed in an incontinence brief that appeared small. When asked about the incontinence brief, R26 stated, I don't like these (incontinence style briefs). It is uncomfortable. It gets all bunched up on the back end of your fanny. R26 said they were told they had to wear the incontinence style briefs because the pull-up style of brief did not hold enough urine (necessitating more frequent changes with a pull-up style brief). Observation of the incontinence briefs in R26's closet found size Large briefs stored for the Resident's use. No pull-up style incontinence briefs were observed in R26's closet. During an interview on 12/11/24 at 12:15 p.m., the Assistant Director of Nursing (ADON) E acknowledged the current incontinence briefs used by the facility required an accurate waist measurement to determine the size of the brief. ADON E said staff were told they should be doing an accurate waist measurement to determine the appropriate size brief for each resident and ask the resident if they are comfortable. ADON E said the size and type of brief worn should be the Resident's choice. ADON queried both R23 and R26, completed waist measurements and determined R23 fit in an XL or a 2XL. When R23 was asked by ADON E, which brief size was preferred, they said XL because they had lost some weight. ADON E confirmed R26 said they wanted to wear a pull-up style incontinence brief during the day and at night. ADON E stated, I passed that along to staff as well. I told the Nursing Home Administrator (NHA) that it was a deficiency concern. During an interview on 12/12/24 at 8:09 a.m., the NHA acknowledged that all team members had advised the NHA of potential deficiency concerns. The NHA expressed understanding of the Resident's right to wear an incontinence brief in the appropriate size and style. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Rights of Residents in [State Name] Nursing Facilities, Copyright 2022, revealed the following, in part: You have a right . to reside and receive services in the facility with reasonable accommodation of your needs and preferences except when to do so would endanger the health or safety of the resident or other residents .

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 This deficiency pertains to Intake #MI00147055. Based on interview and record review, the facility failed to obtain authorization prior to the withdrawal of personal funds for one Resident (#8) of 14 residents reviewed for resident rights. Findings include: Resident #8 (R8) Review of R8's electronic medical record (EMR) revealed initial admission to the facility on [DATE], with diagnoses including Alzheimer's disease, vascular dementia, delusional disorders, anxiety disorder, and depression. Review of R8's most recent Minimum Data Set (MDS) assessment, dated 11/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicative of severe cognitive impairment. On 12/10/24 at 2:35 PM, a telephone interview was conducted with Complainant/Guardian L who stated the facility withdrew five hundred dollars from R8's trust fund and applied the sum to the facility bill without authorization. Complainant/Guardian L stated, The money was in that account for her [R8] to get haircuts, go shopping, buy snacks .stuff like that. It wasn't supposed to go towards a bill. On 12/10/24 at 3:10 PM, an interview was conducted with Business Officer Manager (BOM) N who verified she was responsible for management of resident finances. BOM N verified she did not have a receipt for the five-hundred-dollar withdrawal because she stated the facility had received verbal consent from Complainant/Guardian L. On 12/11/24 at 10:07 AM, a follow-up interview was conducted with BOM N regarding the typical process for withdrawals from resident funds. BOM N stated the usual process for withdrawal is to have a receipt or written documentation of the transaction. BOM N recollected, I should have done that in this case .I'll know in the future. On 12/11/24 at 4:15 PM, an interview was conducted with the Nursing Home Administrator (NHA) who confirmed the need for written authorization prior to the withdrawal of money from resident accounts. Review of facility policy titled, Transactions Involving Resident Funds, undated, read in part: It is the practice of this facility that anytime there is a transaction involving resident funds, the resident must be provided with a receipt of such transaction. Copies of each transaction are filed in the business office . The Business Office Manager, or his/her designee, is responsible for providing residents with receipts for withdrawals and for requested or needed personal items when such funds are withdrawn from the resident's personal funds account managed by the facility.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 This deficiency pertains to Intake #MI00147055. Based on interview and record review, the facility failed to provide quarterly resident trust fund financial statements for one Resident (#8) of 14 residents reviewed for resident rights. Findings include: Resident #8 (R8) Review of R8's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including Alzheimer's disease, vascular dementia, delusional disorders, anxiety disorder, and depression. Review of R8's most recent Minimum Data Set (MDS) assessment, dated 11/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicative of severe cognitive impairment. On 12/10/24 at 2:35 PM, a telephone interview was conducted with Complainant/Guardian L who stated, The facility had not sent a quarterly resident trust fund statement despite several requests. On 12/11/24 at 10:07 AM, an interview was conducted with BOM N regarding the typical process for sending out quarterly statements. BOM N stated, The facility recently started using their own EMR system to manage resident fund accounts, and the next quarterly statement is [due up]. BOM N explained prior to this system, the facility used a management service which she did not have access to in order to verify quarterly statements were sent. On 12/11/24 at 4:15 PM, an interview was conducted with the Nursing Home Administrator (NHA) who stated, I will reach out to the management service to ascertain if quarterly statements were sent out. No quarterly statements were provided to this surveyor by the time of survey exit. Review of facility policy titled, Resident Personal Funds, undated, read, in part: .The individual financial record must be available to the resident through quarterly statements and upon request .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35103 Based on interview and record review, the facility failed to ensure advance directives related to code status were accurately and timely completed for four Residents (R6, R26, R46, and R50) out of a total sample of 14 residents reviewed for advance directives. This deficient practice resulted in absent or improperly documented resident's code status. Findings include: Resident #6 (R6) Review of R6's Minimum Data Set (MDS) assessment, dated 11/4/24, revealed admission to the facility on [DATE] with active diagnoses that included the following: dementia, anxiety, and respiratory failure. R6 scored 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. Review of R6's Electronic Medical Record on 12/10/24 at 11:47 a.m., found no documentation of an Advance Directive. On 12/10/24 at 4:25 p.m., R6's Code Status form was received from Social Services Designee (Staff) G. The document was signed by Staff G, as a witness on 5/2/24, with only one witness signature on the form. The Resident's Legal Guardian signed the form on 5/3/24. Of note, the Code Status form was witnessed by facility Staff G prior documentation of R6's Guardian on 5/3/24. Resident #26 (R26) Review of R26's MDS assessment, dated 11/19/24, revealed admission to the facility on [DATE], with active diagnoses that included the following: heart failure, end-stage renal disease (ESRD), pneumonia, and respiratory failure. R26 scored 15 of 15 on the BIMS, reflective of intact cognition. On 12/10/24 at 4:25 p.m., Staff G provided a Code Status form for R26, signed and dated by R26, and two witnesses on 12/10/24. During an interview on 12/10/24 at 4:25 p.m., Staff G was asked for the previous Code Status form for R26, showing the Residents DNR (do-not-resuscitate) status from admission until that day, 12/10/24. Staff G stated, I was unable to find that one. We re-did this whole form today.' The form provided on 12/10/24 at 4:25 p.m., was dated 12/10/24 and signed by R26 and two facility staff witnesses that same day. 49735 Resident #46 (R46) (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R46's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with diagnoses that included: diabetes mellitus, anxiety disorder, depression, and hypertension. R46 scored a 15 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of intact cognition. During an interview on 12/11/24 at 7:59 a.m., Social Services Designee G stated, We complete the advanced directives on admission .I am surprised I did not fill out a new advanced directive for R46 .I don't have one completed .I should have done one when R46 was admitted .we review advanced directives quarterly. Resident #50 (R50) Review of R50's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: dementia, diabetes, hypertension, and anemia. Further review of the MDS assessment revealed R50 rarely or is never understood and rarely or never makes decisions. Review of facility document provided by Social Services Designee G revealed only one witness instead of two witnesses. Review of facility policy titled Communication of Code Status date reviewed/revised 2/21/24, read in part . It is the policy of this facility to adhere to resident rights to formulate advance directives .the residents code status will be reviewed at least quarterly.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 This deficiency pertains to Intake #MI00147055. Based on interview and record review, the facility failed to provide a 48-hour notice of termination of Medicare benefits for three Residents (#8, #204, and #205) of 4 residents reviewed for beneficiary notifications. This deficient practice resulted in the inability for residents to appeal their non-coverage decision in a timely fashion. Findings include: Resident #8 (R8) Review of R8's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including Alzheimer's disease, vascular dementia, delusional disorders, anxiety disorder, and depression. Review of R8's most recent Minimum Data Set (MDS) assessment, dated 11/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicative of severe cognitive impairment. On 12/10/24 at 2:35 PM, a telephone interview was conducted with Complainant/Guardian L who stated he was not notified when R8's Medicare benefits were ending. Complainant/Guardian L stated he requested the notification several times from the facility without success. On 12/11/24 at 10:10 AM, an interview was conducted with Registered Nurse (RN) M who verified she was responsible for the issuance of beneficiary notifications. RN M was asked for all notifications issued to R8 since admission. On 12/11/24 at 10:14 AM, an interview was conducted with the Director of Rehabilitation (DOR) P who stated R8 received skilled physical and occupational therapy services under Medicare Part B from 7/10/24 - 9/5/24. DOR P stated R8 was discharged from therapy services when she reached maximum functional potential. On 12/11/24 at 10:30 AM, a follow-up interview was conducted with RN M who stated there was no record of a beneficiary notification issued to R8 or her representative since admission. 35103 Resident #204 (R204) On 12/12/24 at 12:43 p.m., a Notice of Medicare Non-Coverage (NOMNC) form for R204 was reviewed which revealed the effective date of coverage for R20 skilled services ended on 11/5/24. The formed was signed on 11/4/24. 49735 (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #205 (R205) A review of a Notice of Medicare Non-Coverage (NOMNC) form for R205 was reviewed and revealed the effective date of coverage for R205 skilled services ended on 10/15/24 and the formed was signed on 10/14/24. Review of facility policy titled, Advance Beneficiary Notices, reviewed 8/23/24, read, in part: .to ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending .the notice shall be written legibly in a language and /or format that the resient/reresentative understands .the notice shall be hand-delivered as possible to obtain beneficiary or representative signature .the notice shall be prepared with an original and at least two copies. The facility shall retain the original and give a copy to the resident/representative .a copy must be provided to the residnet/representative immediately after signing it

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to ensure a sanitary, clean, homelike environment for all 53 facility residents. This deficient practice resulted in unpleasant odors, rooms that were aesthetically unpleasing, and resident dissatisfaction with their environment. Findings include: During an observation and interview on 12/9/24 at 3:57 p.m., a strong odor of urine and feces was present surrounding the Hall B nurses' station, on both the resident room hall, and the hall outside of the kitchen and dining room. During an interview at this time, Certified Nurse Aide (CNA) Q was asked about the strong, pungent odor of urine and feces. CNA Q said they were unable to smell anything because of an issue with their sinuses, but indicated perhaps someone resident had recently received a brief change. During an observation on 12/10/24 at 9:46 a.m., the resident shower room on A Hall was emitting a strong odor of urine when the shower room door was opened by CNA Q, and an unidentified Resident wheeled into the room filled with a strong, pungent odor of urine and/or feces. During an interview at this time, CNA Q was asked why the shower room smelled so strongly or urine? CNA Q stated, I don't know I am just getting in here (with a Resident). CNA Q said they would look in the garbage, and then stated, Yeah, there is a dirty brief in here. During an observation of R26's room on 12/11/24 at 9:00 a.m., found the window draperies were fastened together with a metal, paper binder clip to provide closure of the bottom portion of the draperies. The upper top of the draperies was separated by approximately one to two feet, and it appeared that the drapes were unable to be moved along the drapery rod to close. When asked how R26 felt about the curtains not closing, R26 stated, I wish they would close. I don't know why they haven't been able to fix them (so they close). During an observation and interview on 12/11/24 at approximately 10:05 a.m., Maintenance Director (Staff) D was asked about the strong smell of urine near the B Hall nurses' station. Staff D said he initially could not smell the odor of urine, but upon standing in the same position as this Surveyor, was able to smell the odors and questioned if perhaps the urine odor was coming out of the air vents. During an observation and interview on 12/11/24 at 10:10 a.m., Staff D accompanied this Surveyor to R26's room, and acknowledged the paper-clipped draperies were not aesthetically pleasing in the room. Staff D said staff should have notified him about the condition of the drapes and he would have fixed them. During an observation and interview on 12/11/24 at approximately 10:13 a.m., Staff D accompanied this Surveyor into room [ROOM NUMBER], where the room draperies were found to be hanging awkwardly. Drapery pins, to secure the drapes to the drapery rod, were missing or unattached, and no pull-cord was found to open and close the draperies. Staff D acknowledged the draperies hanging awkwardly were not conducive to a homelike environment and said they would be corrected. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13791 On 12/9/24 at approximately 2:30 PM, during the initial tour, noxious odors were noted throughout the B side corridor, beginning near resident room [ROOM NUMBER] through resident room [ROOM NUMBER]. The odors were a combination of urine and bowel waste. The same odors were noted again at approximately 3:00 PM and 3:30 PM. An interview with Staff D was conducted at approximately 3:30 PM concerning the odors. Staff D stated he was unable to detect the odor. On 12/10/24 at approximately 7:42 AM noxious odors were noted again in the B side corridor. The odors were a combination of urine and bowel and permeated from resident room [ROOM NUMBER] to resident room [ROOM NUMBER]. An interview was conducted with Registered Nurse (RN) H concerning the odors, and stated he thought the odors were due to the garbage just being taken out. At approximately 7:52 AM an interview was conducted with ADON E who stated she thought the odors were emanating from the soiled utility room. The door to the soiled utility room was opened and a wave of increased intensity of odors rushed from the room into the corridor. ADON E stated that a number of residents were known to be incontinent and may be contributing to the pervasive odors. 49735 During an observation on 12/9/24 at 4:10 p.m., There was a strong odor of urine outside of room [ROOM NUMBER] down B hall. During an observation on 12/10/24 at 7:26 a.m., There was a strong odor of urine down B hall. During an observation on 12/11/24 at 9:08 a.m., there was a strong smell by R7's bed and R7 was up in their wheelchair. During an interview on 12/11/24 at 9:16 a.m., housekeeping aide O stated, The strongest odor in the facility is the smell of urine. 49302 On 12/9/24 at 3:19 PM, R20 was observed sleeping in bed. A cork bulletin board was observed hanging off a tack strip attached to the wall over the head of R20's bed. On 12/9/24 at 3:45 PM, a cork bulletin board was observed leaning against the wall near the head of R34's bed. R34 stated the cork board became unsecured when she was sitting in her room a couple week ago and was subsequently hanging from the wall with only one screw. R34 stated a staff member eventually took the bulletin board down and leaned it against the wall. On 12/11/24 at 10:02 AM, an interview was conducted with Staff D regarding the process for maintenance requests. Staff D stated maintenance concerns were recorded in a binder in the main facility hallway and were periodically reviewed by maintenance staff. Once the request was completed, maintenance staff then signed off in the binder, indicating its completion. Review of the maintenance binder did not list bulletin board repair requests in either R20 or R34's rooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 10:20 AM, R20's room was observed with Staff D. The cork bulletin board was again observed to be hanging off the tack strip which was adhered to the wall over the head of R20's bed. Staff D initially stated, That could fall on his [R20's] head. Staff D stated he was not notified of the state of R20's cork bulletin board and it was not to his standards. Staff D immediately removed the cork bulletin board from the wall. On 12/11/24 at 10:25 AM, R34's room was observed with Staff D. The cork bulletin board was again observed to be leaning against the wall below its previous hanging spot. Staff D stated he was not informed the bulletin board fell and was being stored in the room. Staff D agreed with this surveyor regarding lack of acceptable decorative aesthetic standards and stated he would try to find a replacement for the cork bulletin boards throughout the facility. On 12/11/24 at 4:15 PM, an interview was conducted with the Nursing Home Administrator (NHA) regarding resident room aesthetic expectations. After reviewing the state of the bulletin boards in both R20 and R34's rooms, the NHA agreed it did not meet expectations. The NHA stated the damaged bulletin boards should have been documented in the maintenance binder to ensure the appropriate staff was alerted to repair them in a timely manner. Review of facility policy titled, Resident Rights, reviewed 8/19/24, read, in part: .the resident has a right to a safe, clean, comfortable and homelike environment .

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to notify the resident and/or resident representative in writing with the reason for a transfer out of the facility for one Resident (#49) of four residents reviewed for transfer and/or discharge. Findings include: Resident #49 (R49) Review of R49's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including right ankle fracture, congestive heart failure, and chronic obstructive pulmonary disease (COPD). Review of R49's most recent Minimum Data Set (MDS) assessment, dated 10/24/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. On 12/11/24 at 10:12 AM, an interview was conducted with R49 who stated she had been hospitalized three times since initial admission to the facility. R49 did not recall signing a transfer notification document prior to any hospitalization . Review of the facility census verified R49 was sent to an acute care hospital three times since admission from 7/25/24 - 8/5/24, 8/10/24 - 9/6/24, and 9/21/24 - 9/27/24. Review of R49's progress notes revealed the following: 1. 7/25/24 at 1:44 PM: .resident will be transported to [hospital] .after surgical dressing was removed .and dehiscence of surgical incision was noted . 2. 8/10/24 at 6:00 PM: .resident was observed shaking uncontrollably with cyanosis [bluish-purple discoloration] noted upper & lower lips, and bilateral fingertips. Resident short of breath, reported she felt cold Emergency services contacted, and resident transported by ambulance to [local emergency room] for evaluation . 3. 9/21/24 at 9:29 AM: Received order .to send resident to the ER [emergency room] for evaluation and treatment . On 12/11/24 at 10:16 AM, an interview was conducted with Social Services Designee (SSD) G regarding transfer and discharge requirements. SSD G stated she was unfamiliar with the transfer notification process. Review of the EMR for R49 revealed no written transfer notice prior to any hospitalization . Review of facility policy titled, Transfer and Discharge, reviewed 8/7/24, read in part: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Emergency Transfers/Discharges .provide a notice of transfer .to the resident and representative .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735 Based on interview and record review, the facility failed to update or revise care plans after multiple falls for one Residents (#50) of fourteen residents reviewed for care planning. This deficient practice resulted in the potential for further falls, and the potential for injury. Findings include: Resident #50 (R50) Review of R50's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: dementia, diabetes, hypertension, and anemia. Further review of the MDS assessment revealed R50 rarely or is never understood and rarely or never makes decisions. Review of facility incident reports revealed R50 had one fall in August on 8/28/24, two falls in October on 10/10/24 and 10/18/24, and two falls in November on 11/18/24 and 11/19/24. The care plan for R50 was not revised after any of the falls. Review of R50's care plan revealed baseline care plan initiated on 8/7/24, revised on 9/12/24 after R50 fell on [DATE], and revision on 11/11/24 after R50 fell on [DATE] During an interview on 12/11/24 at 12:35 p.m., the Director of Nursing (DON) stated, we look at the fall and find out what happened .we meet as a team and discuss the fall and we implement interventions in their care plan. Review of facility policy titled Incidents and Accidents date reviewed/revised 2/7/24, read in part . The purpose of incident reporting .include assuring that appropriate and immediate interventions are implemented, and corrective actions are taken to prevent recurrences and improve the management of resident care.

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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** 35103 Based on observation, interview, and record review, the facility failed to maintain infection control per standards of practice and failed to implement interventions for the prevention and treatment of pressure injuries for three Residents (R11, R26, and R54) out of three Residents reviewed for pressure injuries. This deficient practice resulted in the development of facility acquired pressure injuries, and the potential for delayed wound healing. Findings include: Resident #11 (R11) During a pressure injury wound observation on 12/10/24 at 3:16 p.m., R11's chronic ,Stage III wound treatment was completed by Licensed Practical Nurse (LPN) J. LPN J, donned in a gown and gloves, retrieved her personal cell phone from inside her scrubs, underneath the donned isolation gown. The cell phone was used to call a nurse for an item necessary for the dressing change. LPN J donned clean gloves, and then made a second call on the personal cell phone , using her clean gloves. LPN J requested a little cup (small, plastic medication cup) for their wound solution. LPN J used the same, now dirty gloves from handling the cell phone to reach into the plastic storage bag with all the wound supplies and retrieved additional 4 x 4 gauze pads. LPN J opened the sterile gauze pads with her dirty gloves and continued to cleanse the wound with wound cleanser using the same dirty gloves. LPN J removed their dirty gloves, reached into their scrub pockets to retrieve a black permanent marker, and then place the marker back into their scrub top with bare hands. LPN J touched R11's bed linens with their bare hands and stated, I am going to cover you until she gets back here. LPN J used the cell phone again with bare hands that were in scrub pockets and touched the Residents' linens. On 12/10/24 at 3:24 p.m., a small bottle of hand sanitizer was delivered to R11's room by Assistant Director of Nursing (ADON) E. LPN J disinfected their hands with the hand sanitizer, and donned clean gloves prior to placing one sterile 4 x 4 into the wound solution in the medication cup and inserted the 4 x 4 into R11's Stage III pressure injury with her gloved fingers. LPN J picked up the sterile foam dressing package with her dirty gloves, opened the package and dropped the foam dressing on R11's bed linens. After drying the area surrounding the wound, and application of skin prep, LPN J picked up the foam dressing from R11's bed linens and place the dressing on R11's sacrum. During an interview on 12/11/24 at 11:36 a.m., the Director of Nursing (DON) said nurses were able to use their cell phones if it was work related, however the nurse should remove their dirty gloves, disinfect [their] hands, and don clean gloves (after contact with the phone). The DON also agreed the products in the wound supply bag would be contaminated if the nurse placed their dirty gloved hands in the bag, and the wound gauze would have been contaminated by using dirty gloves that had contacted the personal cell phone. The DON agreed R11's foam wound dressing should have been placed on a barrier not on the bed linens. Review of the Hand Hygiene policy, reviewed/revised 8/5/2024, revealed the following, in part: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice .The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #26 (R26) During an interview on 12/10/24 at 11:25 a.m., when asked about any skin concerns, R26 stated, I have an area on my tailbone that is sore. During a wound care observation on 12/11/24 at 10:29 a.m., Registered Nurse (RN) H performed wound care on a Stage II pressure injury on R26's coccyx. When the bed linens were removed to begin wound care, R11's bilateral heels were observed in contact with the bed mattress, with the right heel, red, spongy, and fairly blanchable as described by RN H. On 12/11/24 at 10:50 a.m., Review of the [Facility Name] Standing Orders, provided by ADON E on 12/11/24 at 10:50 a.m., revealed the following, in part: Pressure Ulcer Treatment - Document on Wound/Skin Healing Record when identified and weekly thereafter . Stage I and SDTI:(Suspected Deep Tissue Injury): Protect area from shear, moisture, friction and pressure; may apply moisture barrier cream PRN or use a foam dressing, check daily . On 12/11/24 at 11:26 a.m., review of the Pressure Injury Prevention and Management policy , dated 11/12/2023, revealed the following, in part: .Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i. Re-distribute pressure (such as repositioning, protecting and/or offloading heels, etc.). ii. Minimize exposure to moisture and keep skin clean . iii. Provide appropriate, pressure-redistributing, support surfaces . During an interview on 12/11/24 at 11:28 a.m., when asked about prevention and treatment of pressure injuries for R26, the DON. stated, I am fairly confident that [R26] has an air mattress. I am going to go and check right now, to verify that. Upon the DON's return it was confirmed that [R26]did not have an air mattress. The DON stated, I went into the dining room and asked [R26] if they would be accepting of an air mattress, and they agreed. I spoke with [Maintenance Director D] and we are going to get [R26] an air mattress. I think she needs one - especially with the foot. (heel redness and sponginess). I don't know if she was offered an air mattress, and I can't guarantee that there is a progress note detailing any previous refusal. The DON agreed R26's heels should have been elevated without an air mattress on the bed. 49735 Resident #54 (R54) Review of Minimum Data Set (MDS) assessment for R54, dated 8/13/24, revealed admission to the facility on [DATE] with active diagnoses that included: hypertension, heart failure, fracture, and coronary artery disease. R54 scored a 14 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. Review of facility document titled Nursing Evaluation- admission assessment dated [DATE] revealed R54 did not have a pressure ulcer. (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 facility document titled Skin Evaluation on 8/14/24, 8/15/24, and 8/22/24 revealed R54 did not have a pressure ulcer. Review of Progress notes dated 8/23/24, revealed, resident has a wound on coccyx. Review of facility document titled Skin and Wound Evaluation dated 8/30/24, revealed a Stage 2 pressure ulcer to the coccyx that measured 4.7 cm long and 1.1 cm wide. During an interview on 12/12/24 at 10:31 a.m., the Director of Nursing (DON) stated, R54 did not have any pressure ulcers on admission and then developed one while at the facility .she was a frail lady and had very bony prominences, we should have had an air mattress in place for R54 earlier or upon admission and we did not .the air mattress wasn't in place until after the pressure ulcer developed .we did not educate the Resident regarding the risk of pressure ulcers developing if Resident did not turn in bed .I can't explain how R54 did not have one and then it became a stage 2 so fast. Review of facility policy titled Pressure Injury Prevention and Management date reviewed/revised 11/12/23, read in part . The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment .basic interventions could include .redistributing pressure .provide appropriate pressure re-distributing support surfaces.

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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** 49735 Based on observation, interview, and record review, the facility failed to investigate an accident for one Resident (#46) of four residents reviewed for accidents/hazards which resulted in the potential for further burns, pain, and disfigurement. Findings include: Resident #46 (R46) Review of R46's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: diabetes mellitus, anxiety disorder, depression, and hypertension. R46 scored a 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. During an observation on 12/10/24 at 8:32 a.m., R46 had a scab on his right middle finger. This Surveyor queried R46 regarding the scab on his middle finger. R46 stated, I burned myself when I was smoking .I smoked the cigarettes down to the filter and the staff didn't notice what I was doing .I was told that if I do it again, they will take my smoking privilege away from me. Review of R46's Electronic Medical Record (EMR) dated 10/29/24, read in part .Certified Nurses Aide (CNA) reported findings, this nurse assessed the following: blister on right medial second finger and scabs on right third finger. Resident reported the cause is ash from his cigarettes falling onto his fingers. This nurse will pass this on to administration .blister wound acquired in house; it is unknown how long the wound has been present. During an interview on 12/11/24 at 7:40 a.m., Registered Nurse (RN) H stated, [R46] was outside and was burned on the cigarette [R46] was holding .we have to watch [R46] more closely .we did a re-evaluation for safe smoking and talked with [R46] about being more careful. During an interview on 12/11/24 at 7:47 a.m., Assistant Director of Nursing (ADON) E stated, I do not have any incident or accident reports for R46 .I did hear about a blister but not why [R46] had one .I did a re-evaluation assessment for smoking and told R46 to pay attention to how much cigarette is left and to be more careful. Review of facility policy titled Incidents and Accidents date reviewed/revised 2/7/24, read in part .It is the policy of this facility for staff to .report, investigate, and review any accidents or incidents that occur and . involve a resident .the following incidents/accidents require an incident/accident report .for unobserved injuries .documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notification, and orders obtained or follow-up interventions.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to obtain consent, document the use of non-pharmacological approaches, and routinely monitor the response and/or effects of psychotropic medications for three Residents (#8, #33, and #38) of five residents reviewed for unnecessary medications. Findings include: Resident #8 (R8) Review of R8's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including Alzheimer's disease, vascular dementia, delusional disorders, anxiety disorder, and depression. Review of R8's most recent Minimum Data Set (MDS) assessment, dated 11/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicative of severe cognitive impairment. Review of R8's EMR revealed the following pharmacy orders: 1. Quetiapine fumarate Oral Tablet [an antipsychotic medication] 50 MG (milligrams), give 1 tablet by mouth two times a day related to depression. Date initiated: 11/10/23 - present day. 2. Sertraline HCl (hydrochloride) Oral Tablet 50 MG [an antidepressant medication], give 50 mg by mouth in the morning related to depression. Date initiated: 4/27/24. On 5/25/24, sertraline HCl Oral Tablet was increased to 100 MG. Review of R8's EMR revealed the following Abnormal Involuntary Movement Scale (AIM) assessment dates: 9/2/23, 2/25/24, 5/23/24, and 8/23/24. Review of R8's plan of care revealed the following focus initiated 6/12/24: I use psychotropic medications r/t [related to] anxiety, depression, dementia. The following interventions were listed: 1. Administer medications as ordered. Monitor for side effects and effectiveness. 2. Consult with pharmacy, MD [medical doctor] to consider dosage reduction when clinically appropriate. 3. Education the family about risk, benefits, and the side effects and/or toxic symptoms of psychoactive medication drugs being given. R8's plan of care did not list specific medication side-effects for which to monitor, non-pharmacological interventions, nor targeted behaviors. (continued on next page)

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Greentree of Hubbell Rehab and Health	52225 B Avenue Hubbell, MI 49934

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 12:22 PM, an interview was conducted with the Director of Nursing (DON) regarding written consents and adverse consequence monitoring for psychotropic medications. The DON replied, We found out they've [consents] been a problem and they've been getting missed . It's something we've been working on. The DON stated AIM assessments should be completed quarterly and verified R8 was missing an assessment in December of 2023 as well as November of 2024. The DON verified only non-pharmacological interventions that targeted R8's dementia diagnosis rather than the psychotropic medications were listed in the plan of care. On 12/11/24 at 12:40 PM, an interview was conducted with Social Services Designee (SSD) G who verified medication consents had been identified as a, problem area. SSD G stated she had recently started calling resident families for consents. Review of Consent for Use of Psychoactive Medications forms revealed Complainant/Guardian L gave verbal consent for both quetiapine fumarate and sertraline use on 12/11/24, approximately 1 year and 8 months after initiation, respectively. Review of facility policy titled, Use of Psychotropic Medication, reviewed 7/15/24, read, in part: 35103 Resident #33 (R33) Review of R33's EMR revealed initial admission to the facility on [DATE], with diagnoses including anxiety disorder, Parkinson's disease, dementia with mood disturbance, dementia with anxiety, metabolic encephalopathy, vascular dementia, bipolar disorder, depression, and adjustment disorder. Review of R33's most recent MDS assessment, dated 10/28/24, revealed a BIMS was not able to be completed due to severely impaired cognition. Review of R33's Physician Order Recap, retrieved 12/10/24 at 4:04 p.m., revealed the following pharmacy orders for psychoactive medications without justification for continued use without 14-day PRN (as needed) stop dates: 1. Lorazepam (Ativan) Oral Tablet 0.5 mg (Lorazepam). Give 1 tablet by mouth every 4 hours as needed for agitation. Date Initiated: 4/4/23. No End Date. 2. Lorazepam Oral Tablet 0.5 mg. Give 1 tablet by mouth every 4 hours as needed for anxiety until 5/7/2024 23:59 (11:59 p.m.). Give one 0.5 mg tablet every 4 hours as needed for anxiety. Date Initiated: 11/20/2023, End Date 5/7/2024. 3. Haloperidol Oral Tablet 0.5 mg (Haloperidol). Give 1 tablet by mouth every 6 hours as needed for agitation or nausea until 11/8/2024 23:59. Give one 0/5 mg tablet every 6 hours as needed for agitation or nausea. Date initiated: 11/20/23 - 11/8/2024. 4. Quetiapine fumarate Oral Tablet 25 mg. Give 1 tablet by mouth in the morning for mood disorder. Start Date 12/9/23. No End Date. The following medication dose changes were ordered: a. Start Date 10/1/24 - quetiapine fumarate 25 mg by mouth one time a day for wandering, restlessness, and anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Start Date 9/30/24 - quetiapine fumarate 50 mg by mouth at bedtime for insomnia. c. Start Date 12/6/24 - quetiapine fumarate 50 mg. Give 50 mg by mouth two times a day for agitation re-eval (re-evaluate) agitation in 4 weeks (1/3/25). 5. Trazodone HCL Oral Tablet 150 mg. Give 75 mg by mouth at bedtime related to bipolar disorder. Start Date 5/29/24. The following medication dose changes were ordered: a. Trazodone HCl Oral Tablet 50 mg. Give 1.5 tablet by mouth at bedtime related to unspecified dementia, unspecified severity with other behavioral disturbance. Start Date: 4/26/24. 6. Duloxetine HCl Oral Capsule Delayed Release Particles 40 mg. Give 1 capsule by mouth for depression. Start Date 1/27/24. Review of R33's Informed Consent for Psychoactive Medications, provided by the facility on 12/11/24, found the following consents for psychoactive medications including: 1. Trazodone, dated 12/4/24, Specific Condition to be treated: Depression . Antidepressant . Telephone authorization of Resident noted. 2. Seroquel (quetiapine fumarate), dated 12/4/24, Specific Condition to be treated: Dementia with Behavioral Features Antipsychotic . Telephone authorization of Resident Representative noted. 3. Cymbalta (duloxetine HCL) Oral Capsule Delayed Release, dated 12/4/24, Specific Condition to be treated: Depression Antidepressant Telephone authorization of Resident Representative noted. 4. Lorazepam, dated 12/4/24, Specific condition to be treated: Generalized Anxiety Disorder . Anti-Anxiety . Telephone authorization of Resident Representative noted. During an interview on 12/11/24 at 1:06 p.m., when asked for all of R33's active, signed Consents for Use of Psychoactive Medication Therapy for the previous year, SSD G said that no previous consents had been found prior to the newly signed documents of 12/4/24. No signed consent was available for review regarding R33's use of Haloperidol (antipsychotic medication) while in the facility. 49735 Resident #38 (R38) Review of R38's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: Alzheimer's disease, dementia, depression, anxiety disorder, and schizophrenia. R38 scored 11 of 15 on the BIMS reflective of moderate cognitive impairment. Review of Physician order for R38 to receive olanzapine (antipsychotic) 5 mg (milligram) tablet in the evening. During an interview on 12/11/24 at approximately 11:54 a.m., Social Services Designee G stated, I do not have a consent signed for Olanzapine from the Legal Guardian of R38. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/24 at 1:32 p.m., the Director of Nursing (DON) stated, R38 has not had an Abnormal Involuntary Movement Scale (AIMS) assessment since 3/10/22. .Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions . Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs .Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, PRN or as per facility policy The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record .The resident's symptoms and therapeutic goals shall be clearly and specifically identified and documented .

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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. 35103 Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than 5 percent for one Resident (#27) of four residents reviewed for medication administration. This deficient practice resulted in two medication errors observed, out of 26 opportunities for error and a medication error rate of 7.69 percent, and had the potential for inaccurate dosing and administration of insulin. Findings include: Resident #27 (R27) Observation of medication administration performed by Registered Nurse (RN) I for R27, found the following medication errors: On 12/12/24 at 8:35 a.m., RN I failed to disinfect the humalog [short acting insulin] qwikpen [brand name pen injection device]) hub prior to placement of the insulin needle onto the pen. The pen was primed with two units of insulin, by placing the pen downward over the medication cart garbage can. When asked if the insulin pen hub and been disinfected prior to application of the insulin needle, RN I acknowledged they had not cleaned the hub. RN I re-started the process preparing the humalog insulin pen for administration of 14 units of fast-acting insulin to R27 on 12/12/24 at 8:37 a.m. RN I removed the insulin pen needle, disinfected the hub, placed a new insulin needle on the pen, but then failed to prime the insulin pen. RN I dialed the pen up to 14 units and was ready to administer the insulin to R27. On 12/12/24 at approximately 8:40 a.m., RN I prepared R27's lantus [long-acting insulin] solostar [brand name pen injection device] by priming the insulin pen with 2 units of insulin, with the pen facing again downward over the medication cart garbage can. RN I removed the primed needle, re-cleansed the pen hub, replaced the insulin pen needle, and dialed the pen up to 10 units. When asked why insulin pens were primed prior to administration of insulin to a resident, RN I stated, You don't want to be shooting air (with no insulin primed into the needle). You want to give the proper dose. On 12/12/24 at 8:48 a.m., RN I requested assistance/advice from Assistant Director of Nursing (ADON) E regarding the insulin pens. ADON E recommended dialing down to two units, priming the pens and re-dialing up to the accurate doses to be administered. While priming the 14 units on the humalog qwikpen, RN I stated, I had the wrong needle on the (insulin) pen. It popped off when I primed. During an interview at this same time, ADON E acknowledged the errors in administration completed by RN I during preparation of the insulin pens prior to administration of insulin to R27. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the humalog qwikpen Instructions for Use, Copyright 2012, received from the facility on 12/12/24 at 9:55 a.m., revealed the following, in part: Wipe the Rubber Seal (hub) with an alcohol swab . Push the capped needle straight onto the pen and turn the needle forward until it is tight . Prime before each injection. Priming ensure the Pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin. Turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Hold your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window . Select your dose . The dose can be corrected by turning the Dose Knob in either direction until the correct dose lines up with the Dose Indicator . Inject your [insulin] . Review of the lantus solostar Instructions for Use, revised July 2015, and received from the facility on 12/12/24 at 9:55 a.m., revealed the following, in part: . Wipe the Rubber Seal (hub) with alcohol . Line up the needle with the pen, and keep it straight as you attach it (screw or push on, depending on the needle type). Perform a Safety Test. Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring the pen and needle work properly (and) removing air bubbles. Select a dose of 2 units by turning the dosage selector . Hold the pen with the needle pointing upwards. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way in. Check if insulin comes out of the needles tip . Select the dose . if you turn past your dose, you can turn back down . Insert the needle into the skin .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 13791 Based on observation, interview and record review, the facility failed to ensure staff had the appropriate competencies and skills to carry out the functions of the food and nutrition services. This deficient practice has the potential to result in unsafe practices occurring in the kitchen and dietary services and could affect all 53 residents. Findings include: On 12/9/24 at approximately 4:20 PM, the three compartment sink was observed being used to wash, rinse and sanitize food contact surfaces. An interview with Kitchen Manager (KM) A was conducted at this time. KM A acknowledged she did not know the proper testing procedure to ensure the proper concentration of sanitizing chemical was present to sanitize food contact surfaces. On 12/10/24 at approximately 9:30 AM, [NAME] C was observed conducted dish washing activities at the three compartment sink. When asked to demonstrate the testing procedure to ensure proper concentration of sanitizing chemicals in the sink, [NAME] C was unable to demonstrate the procedure properly. When asked if KM A had provided any training related to this procedure, [NAME] C stated No. On 12/10/24 at approximately 10:10 AM, during an interview, KM A indicated she had not yet completed the Certified Dietary Manager (CDM) program. KM A stated she had been enrolled in the program for approximately two years and had only completed one of the ten modules required for completion. All ten modules are required pre-requisites to write the certification exam. It was further learned KM A had been in the position of manager of dietary services for almost three years. A review of KM A's produced credentials revealed she had completed a Certified Food Manager (CFM) course. The FDA Food Code identifies an acceptable level of education for a person in charge of a food service operation as: 2-102.11 Demonstration. Based on the RISKS inherent to the FOOD operation, during inspections and upon request the PERSON IN CHARGE shall demonstrate to the REGULATORY AUTHORITY knowledge of foodborne disease prevention, application of the HAZARD Analysis and CRITICAL CONTROL POINT principles, and the requirements of this Code. The PERSON IN CHARGE shall demonstrate this knowledge by: (A) Complying with this Code by having no violations of PRIORITY ITEMS during the current inspection; Pf (B) Being a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735 Based on observation, interview, and record review the facility failed to provide food in a manner that was a palatable (preferable) in temperature and/or form for 10 Residents (#2, #5, #6, #9, #14, #23, #26, #27, #38, & #46) of 14 sample residents in the facility reviewed for food. This deficient practice resulted in frustration with meals and the potential for weight loss and diminished nutrition. Findings include: Resident #2 (R2), Resident #5 (R5), Resident #14 (R14), Resident #26 (R26), Resident #27 (R27), Resident #38 (R38), Resident #46 (R46) During a group interview on 12/10/24 at 1:30 p.m., seven R2, R5, R14, R26, R27, R38 and R46 all agreed the food was not palatable due to cold temperatures of food. R26 stated, the food is cold, and we have told them about the food and nothing has changed. R2 stated, the other day we had pizza, and it was cold. R46 stated, the food here sucks, the noodles we had today were undercooked and cold .the food is very bland. R5 stated, the food is cold and there is no flavor .today I received a hard boiled egg with the shell on it and I can't peel the egg, but no one helped me. 35103 Resident #6 (R6) On 12/10/24 at 8:30 a.m., R6's meal tray delivery was observed. R6 was heard, as they sighed while looking at the breakfast meal plate that included two cold, hard-boiled eggs with the shell intact. When asked why they sighed, R6 stated, They gave me hard-boiled eggs with the shells on. R6 pressed their call light and Assistant Director of Nursing (ADON) E arrived to assist. R6 asked ADON E to remove the shells from the eggs because R6 had arthritis in their hands. R6 raised their hands to show the disfigured, arthritic fingers on both hands. This Surveyor observed ADON E don gloves and watched her struggle to remove all the egg fragments from R6's two hard-boiled eggs. The egg surfaces remained scattered with visible egg shells when ADON E was finished with the shell removal. ADON E left the room, and R6 was asked about the presence of egg shells on the hard-boiled eggs. R6 stated, There are always going to be shells on the egg when peeled, because with gloves to peel the egg you are not going to get all the shells off. Resident #9 (R9) On 12/10/24 at 12:06 p.m., R9 walked out into the Hall with their meal tray and stated, This is the worst meal I have eaten in my life. There is pasta as a side with no sauce, cheese, or anything. The cauliflower has [NAME] parts and I have to cut it with a fork and it was too hard. The zucchini was mush and awful. The chicken was ok. I ate it but I hope that I don't get diarrhea or something. It was so awful . Observation of the tray at that same time found what appeared to be plain, white elbow macaroni without sauce, mushy appearing zucchini, and cauliflower with [NAME] stems. Resident #23 (R23) (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/24 at 1:13 p.m., when asked about food in the facility, R23 said they had lost a significant amount of weight while in the facility because the food was so bad. On 12/11/24 at 11:59 a.m., Kitchen Manager (KM) A was asked about the breakfast service on 12/10/24 when unpeeled, cold, hard-boiled eggs were served to residents. KM A stated, I have never even eaten a hard-boiled egg warm. The staff were supposed to peel the eggs for the residents that couldn't (peel it themselves). When asked about what facility residents or staff were supposed to do if the eggs were hard to peel and shells remained on the eggs, KM A said she had not thought about that. Review of the Week 5 Menus, received from KM A on 12/11/24 at 12:05 p.m., revealed Hot Cereal, Hard Boiled Egg, Sausage Link, and Toast on the 12/10/24 breakfast menu. The menu listed hard-boiled egg, but did not say with shell on (unpeeled). Lunch on 12/10/24 listed Lemon Pepper Chicken, Buttered Noodles, Chateau Veg (vegetable blend), and Bread Pudding. 13791 On 12/10/24 at approximately 11:50 AM, lunch meal trays were observed being delivered to residents' in their rooms. Staff were observed removing trays from an un-insulated, metal wheeled cabinet, containing plates with insulated lids but no insulated bases. The cart contained 14 prepared meal trays. Staff M was requested to remove the lid covering the plate she had removed from the cart. With the lid removed from the plate the temperature of chicken, pasta and vegetables was measured using an infrared thermometer. The surface temperature of the food was read to be 102 F to 104 F. A second tray, removed by another staff was measured in the same way and found to have temperatures of 104 F to 106 F. At approximately 12:30 PM, lunch trays were observed being delivered to residents sitting at tables in the dining room. The trays were being removed from an un-insulated metal wheeled cart containing 27 trays. As food was delivered and the insulated covers removed from the plates, temperatures were measured using an infrared thermometer. Temperatures were found to range between 102 F and 109 F. An interview with a resident in the dining room was conducted and asked how her food was. The resident responded It's edible.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among any and all 53 residents of the facility. Findings include: On 12/9/24 at approximately 3:25 PM, a snack cart was observed in the hallway near resident room [ROOM NUMBER]. No staff were observed near or around, tending to the cart. The cart had an uncovered Lexan container, sitting on the top shelf with ice cubes and tongs. At approximately 3:40 PM, during an interview, Activity Aide (AA) F confirmed he was passing snacks to residents and the container of ice cubes was used to fill resident drinking water cups. When asked if he had been instructed to ensure the ice cubes were protected from contamination by covering or other means, AA F stated he had not been instructed to cover the ice cubes. The FDA Food Code 2017 states: 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 -3-306. On 12/10/24 at approximately 11:30 AM observations of the noon meal service were completed in the kitchen. Two hamburger patties were observed in a stainless steel pan, sitting in the well of the steam table. The temperature of the patties was measured with a metal stem digital probe thermometer and found to be 120 F. An interview with [NAME] C was conducted at this time. [NAME] C indicated he had taken the cooked patties from the refrigerator and placed them directly into the steam table well. [NAME] C confirmed he had not properly re-heated the product to 165 F for 15 seconds prior to placing into the steam table. [NAME] C indicated he was not aware of the requirement to reheat food to 165 F for 15 seconds before the food could be served, and was not aware the steam table was not to be used for the heating of food. [NAME] C was unaware the steam table was only for the maintenance of food temperature once initial required heating temperatures had been reached. The FDA Food Code 2017 states: 3-403.11 Reheating for Hot Holding. (A) Except as specified under (B) and (C) and in (E) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the FOOD reach a temperature of at least 74 C (165 F) for 15 seconds (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/9/24 at approximately 4:20 PM, the three compartment sink in the kitchen was observed being used to wash, rinse and sanitize food preparation utensils, including spoons, whips, and pans. Kitchen Manager (KM) A was requested to demonstrate the process used to ensure adequate concentration of sanitizer was present in the solution. Prior to testing, [NAME] D stated she had just tested it and it should be fine. KM A proceeded to remove a strip of QT 40 (Quaternary Test Paper) test strip, and dipped it in the sink for approximately seven seconds while swishing it back and forth. KM A removed the strip, compared it to the color guide and reported a concentration of about 400 parts per million (ppm). [NAME] D was then asked to demonstrate her procedure for testing the sink solution. [NAME] D removed a section of QT 40 test strip, placed in the water and swished through the solution for approximately 4 seconds, and reported a concentration of about 150. Neither staff member measured the temperature of the water. Both staff were requested to read the directions for using the strips to test the solution. Both staff admitted they were not aware the strip was to be held in the solution without agitation, or that the solution being tested was to be between 65 and 75 F to have an accurate test. The water temperature was measured using a probe thermometer and found to be 94 F. The sink solution was then measured with a non-temperature dependent QAC (Quaternary Ammonium Compounds) strip and found to have a concentration of Quat (Quaternary Ammonium) (Quaternary Ammonium) (Quaternary Ammonium) (Quaternary Ammonium) (Quaternary Ammonium) (Quaternary Ammonium) between 50-100 ppm. A review of the container of quaternary sanitizer revealed the concentration for proper sanitizing was 200-300 ppm. On 12/10/24 at approximately 10:20 AM the three compartment sink in the kitchen was observed being used for cleaning cooking utensils. An interview was conducted with [NAME] C which revealed he was conducting the dish washing in the sink. [NAME] C was then requested to demonstrate the procedure used to show the sanitizing solution was at the proper concentration. [NAME] C removed a section of test strip from the QT 40 strip dispenser. [NAME] C placed the strip in the sink, held it for 10 seconds, removed it and read it at 400 ppm. This surveyor measured the temperature of the water and found it to be 114 F. The interview with [NAME] C revealed he had not been instructed on the proper procedure for testing the sanitizing solution, and was not aware the test strips were accurate only between the range of temperatures 65-75 F. The FDA Food Code 2017 states: 4-302.14 Sanitizing Solutions, Testing Devices. A test kit or other device that accurately measures the concentration in MG/L of SANITIZING solutions shall be provided. and 2-102.11 Demonstration. Based on the RISKS inherent to the FOOD operation, during inspections and upon request the PERSON IN CHARGE shall demonstrate to the REGULATORY AUTHORITY knowledge of foodborne disease prevention, application of the HAZARD Analysis and CRITICAL CONTROL POINT principles, and the requirements of this Code. The PERSON IN CHARGE shall demonstrate this knowledge by: (A) Complying with this Code by having no violations of PRIORITY ITEMS during the current inspection; Pf (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(B) Being a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM;Pf or (C) Responding correctly to the inspector's questions as they relate to the specific FOOD operation. The areas of knowledge include: (1) Describing the relationship between the prevention of foodborne disease and the personal hygiene of a FOOD EMPLOYEE; Pf (2) Explaining the responsibility of the PERSON IN CHARGE for preventing the transmission of foodborne disease by a FOOD EMPLOYEE who has a disease or medical condition that may cause foodborne disease; (3) Describing the symptoms associated with the diseases that are transmissible through FOOD; Pf (4) Explaining the significance of the relationship between maintaining the time and temperature of TIME/TEMPERATURE CONTROL FOR SAFETY FOOD and the prevention of foodborne illness; Pf (5) Explaining the HAZARDS involved in the consumption of raw or undercooked MEAT, POULTRY, EGGS, and FISH; Pf (6) Stating the required FOOD temperatures and times for safe cooking of TIME/TEMPERATURE CONTROL FOR SAFETY FOOD including MEAT, POULTRY, EGGS, and FISH; Pf (7) Stating the required temperatures and times for the safe refrigerated storage, hot holding, cooling, and reheating of TIME/TEMPERATURE CONTROL FOR SAFETY FOOD; Pf (8) Describing the relationship between the prevention of foodborne illness and the management and control of the following: (a) Cross contamination, Pf (b) Hand contact with READY-TO-EAT FOODS, Pf (c) Handwashing, Pf and (d) Maintaining the FOOD ESTABLISHMENT in a clean condition and in good repair; Pf (9) Describing FOODS identified as MAJOR FOOD ALLERGENS and the symptoms that a MAJOR FOOD ALLERGEN could cause in a sensitive individual who has an allergic reaction. Pf (10) Explaining the relationship between FOOD safety and providing EQUIPMENT that is: (a) Sufficient in number and capacity, Pf and (b) Properly designed, constructed, located, installed, operated, maintained, and cleaned; Pf (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235551	A. Building B. Wing	12/12/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(11) Explaining correct procedures for cleaning and SANITIZING UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT; Pf (12) Identifying the source of water used and measures taken to ensure that it remains protected from contamination such as providing protection from backflow and precluding the creation of cross connections

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235551	A. Building B. Wing	12/12/2024

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Greentree of Hubbell Rehab and Health	52225 B Avenue Hubbell, MI 49934

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observation and interview, the facility failed to ensure the environment was safe, sanitary and functional for residents, staff and the public, potentially affecting all 53 residents. Findings include: On 12/9/24 at approximately 3:00 PM, exit door, identified as Exit #4 was observed with a gap between the threshold and the bottom of the door. This gap allowed cold air and potentially insects and other vermin entrance into the building. On 12/10/24 at approximately 10:15 AM, an interview with Maintenance Director (Staff) D was conducted who confirmed the door was in disrepair and needed to be replaced. On 12/9/24 at approximately 3:30 PM a community shower room located near resident room [ROOM NUMBER] was observed with a vertical wall, separating the toilet and shower enclosure. The wall was missing eight 6 x 6 ceramic tiles, exposing sharp edges which could potentially result in lacerations or other injury to residents or staff. On 12/10/24 at approximately 10:30 AM an interview with Staff D confirmed the missing tiles and stated replacements were not able to be found and the remaining tiles would be removed. On 12/11/24 at approximately 8:30 AM, an observation of the shower room confirmed the remaining ceramic tiles had been removed which left the underlying drywall board exposed. MD D stated he was looking for other materials to cover the unsealed backing board. On 12/10/24 at approximately 8:30 AM, an observation of the dish washing area in the kitchen revealed an atmospheric vacuum breaker connected to the submerged inlet of the garbage disposal. The vacuum breaker was not intact with the top bell housing missing, potentially contributing to a failure in the device in a negative pressure event in the potable water supply system. This would result in the back flow of contaminated liquids from the disposal into the drinking water supply for the entire building.