STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Canterbury on the Lake	5601 Hatchery Rd Waterford, MI 48329

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to ensure accurate advance directive information, including social service assessment and a physician order for a Do-Not-Resuscitate (DNR) was in place for one (R83) of five residents reviewed for advance directives. Findings include: Review of the facility's advance directive form signed and dated by R28 and Physician 'G' on 2/13/24 documented R83's code status was to be a DNR. Review of the current advance directive (AD) order that was active since 8/19/23 read, AD: Full Code. On 7/15/24 at 11:00 AM, R83 was asked about their code status and reported they wanted to be a DNR and had completed that paperwork. Further review of the clinical record revealed R83 was admitted into the facility on [DATE] with diagnoses that included: congestive heart failure, permanent atrial fibrillation, adjustment disorder with depressed mood, and chronic respiratory failure with hypoxia. According to the Minimum Data Set (MDS) assessment dated [DATE], R83 had intact cognition and had no communication concerns. Review of social service assessments revealed conflicting documentation in regard to the resident's code status. Documentation included: An entry by Social Worker (SW 'F') dated 6/27/24 at 9:10 AM read, SW completed quarterly assessment and chart review .[R83] is his own legal guardian. His code status is Full Code . An entry by SW 'F' on 6/7/24 read, SW completed quarterly assessment and review .He is Full Code . An entry by the Social Services Coordinator (SSC 'D') on 2/27/24 at 3:08 PM read, QUARTERLY ASSESSMENT: SW completed quarterly assessment and chart review Resident is his own responsible party. There is no DPOA paperwork current on file for resident. Resident wishes to remain a full code . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 10:45 AM, an interview was conducted with SSC 'D'. They reported SW 'F' was not available (called-in) to speak. When asked about the facility's process for completing advance directives, SSC 'D' reported usually nursing signs the forms with the resident, but if it's not done, then Social Work will follow up to complete. They further reported, once signed, the form was placed in the Physician book, then when the Physician signed the form, it was returned to social work, then went to the person who does the filing, then the nurse is notified to change the code status. SSC 'D' reported they were able to see that the medical record clerk entered the form in the resident's record on 2/16/24, so they weren't sure what happened. Upon review of the advance directive form signed by R83 and Physician 'G' on 2/13/24, and the conflicting social service assessments that indicated R83 was to be a full code, SSC 'D' reported they had similar concerns and reported SW 'F' was new. When asked about their own documentation from 2/27/24 that also indicated R83 desired full code when they had just completed a DNR a few weeks earlier, and how that could be if that information was actually discussed, SSC 'D' acknowledged the concern and was not able to provide any further explanation. According to the facility's policy titled, Advance Directives dated 11/21/2016: .If the resident is a DNR, a red heart will be placed on their armband and their Electronic Health Record (EHR) will read DNR .The form will then be signed by the patient's attending physician and two witnesses Once the Do-Not-Resuscitate order is completed, signed and order entered into the EHR, the order form will be uploaded into the EHR under the advance directive section of document management by medical records .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00145365. Based on observation, interview, and record review the facility failed to protect the rights of one resident (R26) to be free from resident-to-resident verbal and physical abuse by R67 resulting in continued abuse to have occurred. Findings include: Review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) documented in part . On May 31, 2024, (nurse name) observed (R67 name) and (R26 name) in the hallway. While approaching them (nurse) observed (R26) call (R67) a derogatory term. (R67) then proceed to hit (R26) with his walker. He hit her in her left shin. (R26) grabbed her leg and yelled out in pain. (nurse) immediately intervened and separated and redirected both residents back to their room. Review of the medical records for R's 26 & 67 documented this event to have occurred on 5/27/24, not 5/31/24 as submitted to the SA. On 7/15/24 at 9:30 AM, R26 was observed sitting in their wheelchair outside the nurses station. When asked about the incident with R67 the resident did not respond. The medical record for R26 revealed R26 was initially admitted to the facility in 2015, with a readmitted [DATE]. R26 was admitted with a diagnosis that included dementia and required staff assistance for all ADLs. On 7/15/24 at 10:11 AM, R67 was observed sitting in a recliner in their room. When asked about the incident with R26, the resident did not respond. The medical record for R67 revealed R67 was admitted to the facility on [DATE] with diagnoses that included dementia. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 3 (which indicated severely impaired cognition). R67 required staff assistance for most Activities of Daily Living (ADLs). A review of R67's progress notes documented the following: On 5/17/24 at 7:04 PM, a Nursing note documented in part . (R67 name) walked out of this room and was informed by resident (R26) that he needed to return to his room. In response, (R67 name) threatened to wrap his walker around (R26) head and hit her in the face. However, the situation was de-escalated by nurse who re-directed (R67) back to his room . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/18/24 at 10:56 PM, a Nursing note documented in part . (R67) observed this evening coming out of room with brief on threatening to hit (R26) . in the mouth stating to staff she will learn. After being redirected back into room by AM (morning) nursing he again came out threatening to attack her lifting up his walker. Writer phone Np (nurse practitioner) asked for something to help calm him down, she ordered Haldol 1mg (milligram) . After resident was medicated with his scheduled medications and went to sleep about an hour later in <sic> came out into hall naked. He was walking toward room . (R26's room number) staff redirected him back to room IM (intramuscular) injection given . On 5/27/24 at 6:32 PM, a Nursing note documented in part . I observed (R26) call (R67) a derogatory term. R67 then proceed to attack R26 with his walker. Hitting (R26) in her left shin. R26 immediately grabbed her leg and screamed in pain. The writer quickly intervened and redirected (R26) and (R67) back to their room <sic>. On 5/30/24 R67 was seen by the facility's behavioral group. A review of the consult documented in part . Hospice requests medication evaluation due to aggressive behavior. Pt (patient) struck a frail female pt on the unit with his walker earlier in the week . is intolerant of what he deems disrespectful or challenging actions/behaviors. He also tends to have an exacerbation of aggressive behavior when he is in a stimulating environment and often interprets the stimulation as threatening. A behavioral approach in addition to medication alterations will best address his aggressive behavior to keep him and other residents of the unit safe and comfortable . Behavioral Modifications: 1. Limit time out of room, time out of room should be spent in quite low stimulus environment no more than 2 other residents that are quiet in demeanor 2. Pt to take meals in room staff approach should be soft with quiet voice and non-threatening movement . 3. Routine schedule that is predictable to the pt . Medication Adjustments: 1. D/C (discontinue) Ativan 2. Initiate klonopin at 0.25 mg (milligram) Q AM (every morning), may increase as he adjusts to dose. He may at onset be more sleepy but should adjust with time. This medication has a longer half life of 30/40 hours providing broader coverage of anxiety and eliminating distressing peaks and troughs of a short acting benzodiazepine. 3. d/c Seroquel, start 75 mg Trazodone and 10mg of Melatonin at HS (hour of sleep). Pt has a long hx of insomnia which may be unresponsive to pharmacological intervention. This is a conservative and appropriate approach. 4. Treatment of pain, that pt is unable to verbalize. Provide scheduled Tylenol 1000mg po (by mouth) TID (three times a day). This is well below recommended limits, but quite effective in pain management for dementia patients. By day 5 of scheduled administration pt's have noted a significant reduction in pain. Provider will follow up with assessment and consultation regarding pt response and management in 2 weeks . Reviewed PCP notes, nursing notes, behavior tracking notes. Discussed case with nursing staff . Collaborated with nursing staff . A review of R67's medical record revealed the behavioral management plan was not implemented and/or documented as discussed with the interdisciplinary team. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 2:11 PM, the Administrator (who also serves as the facility's Abuse Coordinator) and Director of Nursing (DON) was interviewed and asked to confirm the correct date of the incident, May 31, 2024, as submitted to the SA or May 27, 2024. The Administrator confirmed the incident to have occurred on 5/27/24. The Administrator stated they completed the investigation in consultation with their team. The Administrator and DON was then asked about the incidents that occurred between R26 & R67 on 5/17/24 and 5/18/24, days before the actual incident and was asked why additional interventions were not implemented to protect R26 from R67. The Administrator and DON stated they were both unaware of the prior incidents that occurred with R's 26 & 67. The Administrator and DON was asked if the interdisciplinary team conducted meetings to discuss the behavior of R67 and interventions to put in place to prevent further resident to resident abuse, the Administrator and DON stated meetings are held, but was unsure on why further interventions were not put in place. The DON and Administrator were then asked about the behavioral consultation for R67 that was conducted in response to the incident and why the behavioral management plan and medication changed were never implemented. The DON stated the behavioral NP usually makes those changes into their system themselves. The DON stated they were not sure on what happened but would look into it and follow back up. No further explanation or documentation was provided by the end of the survey. Review of a facility policy titled Abuse & Elder Justice Act Policy documented in part, . It is our policy to maintain an environment free of abuse, neglect, exploitation, mistreatment . The resident has the right to be free from verbal, sexual, physical and mental abuse . Residents will not be subjected to abuse by anyone including, but not limited to . other residents . If the accused is a resident, the facility shall take measures to prevent recurrence and the alleged perpetrator will be immediately separated and the rights of the other residents at large will be protected .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on interview and record review, the facility failed to complete an annual OBRA (Omnibus Budget Reconciliation Act) Level I evaluation to determine if a Level II Evaluation was needed, or if exemption was identified for one (R31) of one resident reviewed for PASARR (Preadmission Screen and Resident Review). Findings include: A review of R31's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: psychotic disorder, Lewy Body Dementia and Parkinsonism. A review of the Minimum Data Set (MDS) noted a Brief Interview for Mental Status (BIMS) score of 4/15 (severely cognitively impaired). Continued review of R31's clinical record revealed a document titled PASRR Level 1 (DCH-3877). Section 1 was completed documenting the resident's personal information and information about their legal representative. Section II documented Yes to four questions that noted the resident had diagnoses of both mental illness and dementia and listed the antipsychotic medications the resident was taking. Section III was signed by a past Social Worker and dated 7/14/23. The bottom portion of Section III noted: .If any answer to items 1-6 in Section II is Yes send one copy to the local Community Mental Health Service Program (CMHSP) with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative. *It should be noted that there was no documentation that a DCH-3878 had been sent to CMHSP. On 7/16/24 at approximately 1:27 PM, an interview was conducted with Social Service Tech (SST) D. SST D reported that they were not a licensed social worker and not familiar or able to complete PASARR documents. They noted that the facility had recently hired a licensed social worker but that person was not in the building and most likely would not be familiar with R31. SST D stated that they would try to contact CMHSP to obtain further information. On 7/16/24 at approximately 2:35 PM, SST D asked the Surveyor to be present as they were going to contact CMHSP to obtain information as to the failure to have information as to DCH-3878 form. While on the phone with the department, SST D was told that the facility did not submit the required document. A request for the facility policy was made. No policy was provided by the end of the Survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to develop and implement a care plan for oxygen use and specific transmission-based precautions for one (R18) of 25 residents reviewed for comprehensive care plans. Findings include: On 7/15/24 at 11:18 AM, R18's call light was observed activated (lit up in hallway outside of the room). There was signage posted outside the door that identified R18 was on transmission-based precautions, specifically contact precautions. Upon entry into the resident's room, oxygen was observed in use via nasal cannula. R18 was unable to respond to simple questions asked. Review of the clinical record revealed R18 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy, cognitive communication deficit, other pericardial effusion, and epilepsy. According to the Minimum Data Set (MDS) assessment dated [DATE], R18 had severely impaired cognition, and did not receive oxygen. Further review of the clinical record included physician orders for: Ordered 7/11/24 every shift until 7/17/24 01:00: Utilize Contact Precautions r/t (related to) MDRO (Multi-Drug Resistant Organism) in urine. Practice hand hygiene. Put on gown and gloves prior to entering resident's room. Where goggles/Shield for splash potential care. Remove/dispose of used PPE (Personal Protective Equipment) prior to exiting Resident's room. Practice hand hygiene. Ordered 7/6/24, Administer oxygen at 2L (Liters) NC (Nasal Cannula) PRN (As Needed). Review of R18's care plans revealed there were none implemented for the resident's use of oxygen. Although there was a care plan initiated on 7/10/24 for R18's MDRO which read, [R18's name redacted] has K. pneumo michgenensis. The interventions did not specify any details of the type of transmission-based precautions to implement. On 7/17/24 at 10:54 AM, the Director of Nursing (DON) was asked who was responsible for initiating care plans for things such as oxygen, and transmission-based precautions. The DON reported normally the MDS nurses do the comprehensive care plans and for transmission-based precautions or infection care plans, the unit nurse or unit manager should be doing those. The DON was informed of concerns with the lack of care plans for resident's oxygen use, and TBP. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 11:05 AM, the DON reported the care plan for the TBP was included in intervention but that was now discontinued. Upon further review of the electronic clinical record which included details of the care plan such as initiation and revision dates now revealed an intervention on the UTI care plan for utilize contact precautions as ordered. This intervention was documented as Date Initiated: 07/16/2024; Revision on: 07/16/2024; Resolved Date: 07/16/2024. This information was not available to the staff during the time R18 was on precautions through 7/16/24. According to the facility's policy titled, Care Plans, Comprehensive Person-Centered dated Revised December 2016: .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .The interdisciplinary team must review and update the 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** 48680 Based on observation, interview and record review, the facility failed to provide a shower for one (R349) of three residents reviewed for activities of daily living. Findings include: On 7/15/24 at 10:27AM, R349 was observed in their room visiting with family. When asked how was the care that they received, R349 and a family member both stated that the facility was fine but they did not know any schedules and would like to receive a shower. The family member was then asked how many showers have they received and they stated one on Saturday (7/13/24). They further stated the only reason they (facility staff) gave R349 one was because they came up to the facility ready to give them a bath themselves. R349 then stated, I ask for a shower all the time but I just don't know when I should get one and I was supposed to get one on this passed Wednesday, but something happened and I didn't get it. A review of the record revealed that R349 was readmitted to the facility on [DATE] with diagnoses that included: effusion right knee, unspecified osteoarthritis and fall. Their cognition was intact (scored 13/15 on the Brief Interview for Mental Status exam). Review of the shower/bathing documentation revealed R349 had only received a shower on 7/13/24 as was stated. On 7/16/24 an interview was held with the Director of Nursing (DON). When asked how often were showers/baths given, and if a person requested a shower outside of their scheduled days, should they be able to receive one, and why didn't R349 received any showers? the DON replied Yes. Residents can get showers whenever they want to, or upon request, but they are usually scheduled for three showers a week. The DON further reported they would have to check on why R349 did not receive showers. There was no additional information provided by the exit of survey.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation has two deficient practices (DPS). DPS #1 Based on observation, interview and record review the facility failed to implement Physician treatment orders in a timely manner for one resident (R28) of three residents reviewed for pressure ulcers. Findings include: On 7/15/24 at approximately 10:11 a.m., R28 was observed in their room, laying in their bed. R28 indicated they were in pain and had wounds on their backside. R28 was queried if the staff were completing their wound dressings and they reported that sometimes dressings do not get changed. On 7/16/24 the medical record for R28 was reviewed and revealed the following: R28 was initially admitted to the facility on [DATE] and had diagnoses including Bipolar disorder and Cerebral Infarction. A review of R28's MDS (minimum data set) with an ARD (assessment reference date) of 4/20/24 revealed R28 needed assistance from facility staff with most of their activities of daily living. R28's BIMS (brief interview for mental status) score was 13 indicating intact cognition. A review of R28's comprehensive plan of care revealed the following: Focus-[R28] has Stage 4 coccyx ulcer (sores that extend below the subcutaneous fat into deep tissues, including muscle, tendons, and ligaments.) and adjoining buttocks, . Lt (left) Great Toe, 2, 3, 4th Digit. Hx (history) of ulcers, Immobility. Date Initiated: 07/09/2024 .Interventions-Administer treatments as ordered and monitor for effectiveness. Date Initiated: 04/09/2024 . A Physician skin/wound note dated 6/3/24 revealed the following: .Stage 4 ulcer to coccyx and adjoining buttocks. 9 x 14.9 x 0.3 cm (centimeters). Clean based. With surrounding cicatrix. Mild serosanguinous drainage. Continue Rx (prescription) with Aquacell Ag over open area and cover with hydrocolloid. Change q (every) Monday and Thursday and PRN (as needed). Continue to apply triad paste q shift and PRN around the Hydrocolloid A Physician skin/wound note dated 6/10/24 revealed the following: .Stage 4 ulcer to coccyx and adjoining buttocks larger. 11 x 14.8 x 0.9 cm. With surrounding cicatrix. Base with yellow slough(40%). Mild serosanguinous drainage. Change Rx to medihoney on 4 x 4 gauze and cover with bordered gauze. Change daily and PRN. Apply triad paste to area surrounding dressing q shift and PRN A Physician skin/wound note dated 6/17/24 revealed the following: .Stage 4 ulcer to coccyx and adjoining buttocks larger. 11 x 14.6 x 0.8 cm. With surrounding cicatrix. Base with yellow slough(40%). Mild serosanguinous drainage. Continue Rx with medihoney on 4 x 4 gauze and cover with bordered gauze. Change daily and PRN. Apply triad paste to area surrounding dressing q shift and PRN (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician skin/wound note dated 7/1/24 revealed the following: .Stage 4 ulcer to coccyx and adjoining buttocks. 11 x 14.5 x 0.7 cm. With surrounding cicatrix. Base with yellow slough coming loose (35%). Mild serosanguinous drainage. Peri wound with surrounding maceration. Continue Rx with medihoney on 4 x 4 gauze to the open area and cover with bordered gauze. Change daily and PRN. Apply triad paste to area surrounding dressing q shift and PRN A review of R28's Physician order summary in the EMR (electronic medical record) revealed the following: Cleanse buttock with soap and water then pat dry. Apply Aqua AG to open areas cover with Hydrocolloid drsg. Apply triad paste to surrounding areas. every day shift every Mon (Monday), Thu (Thursday) for Promote Wound Healing .-Start date 5/2/24. Cleanse buttock with soap and water then pat dry. Apply Medi Honey to open areas cover with Hydrocolloid drsg. Apply triad paste to surrounding areas. every night shift every Mon, Thu for Promote Wound Healing . -Start date 6/20/24. Further review of the transcribed Physician's order for the Medi Honey revealed the incorrect frequency (every night shift every Mon, Thur) was transcribed into the order. Cleanse buttock with soap and water then pat dry. Apply Medi Honey to open areas cover with Hydrocolloid drsg (dressing). Apply triad paste to surrounding areas. every night shift for Promote Wound Healing .-Start date 7/11/24. A review of R28's June 2024 Treatment Administration Record (TAR) revealed the treatment change ordered by the Nurse Practitioner on 6/10/24 for the coccyx and adjoining buttocks to Medi Honey was not completed until 6/18/24 with a start date of 6/20/24 and only had three documented treatments completed in June (6/20, 6/24 and 6/27). Further review of the TAR revealed the Aqua AG treatment was administered twice past the change date of 6/10 on 6/13 and 6/17. On 7/17/24 at approximately 12:39 p.m., a review of R28's wound orders was conducted with the facility wound care Nurse B (WCN B). WCN B was queried why R28's order for the medi honey was not started until 6/20/24 when the Wound Nurse Practitioner ordered the treatment to be changed on 6/10/24 and they indicated that they were not the wound care Nurse at that time and that another Nurse did not transcribe the order. WCN B was queried regarding the medi honey order that had a start date of 6/20/24 and they indicated that an error was made in transcribing the frequency and that it should have been administered every day as indicated in the note on 6/10/24. 48680 DPS #2 Based on observation, interview and record review, the facility failed to assess, implement, and prevent a pressure ulcer from developing for one resident (R355) of three reviewed for pressure ulcers resulting in the development of pressure ulcers. Findings include: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/15/24 at 10:00 AM, R355 was observed in their room with the head of bed elevated, oxygen in place, and the resident was coughing. R355 was asked how they were doing and if they were okay and R355 stated, No I am not doing alright, I have been telling the facility that I am more congested so it is hard for me to breath. I think I have pneumonia or something. They took my foley catheter out so now I don't know if I'm using the bathroom or not. I can't tell if I'm going or not or if I have gone. And lastly my bottom hurts it is very sore. But other than that the facility is okay, they just don't have enough staff that's why I decided to discharge and hire a private sitter. A record review revealed that R355 was admitted to the facility on [DATE] with the diagnosis of acute respiratory failure, fluid overload and heart failure and had a brief interview for mental status score of 15, indicating an intact cognition. On 7/15/24 at 1:53 PM an observation of R355's skin was made with the Nurse. There were two dime size openings on the left buttocks cheek and general redness of the peri area, and the surrounding skin was darkened. A review of the record revealed that R355 had an order for an air loss mattress and there was a progress note from the wound care nurse dated 07/15/2024 that read there were no open areas, no need for an air loss mattress at this time. On 7/15/24 at 2:13 PM an interview was conducted with the Wound Care Nurse. The Wound Care Nurse was asked when was the last time she assessed R355's skin and what did it present as. The Wound Care nurse explained that she had observed his skin on last Thursday when they do wound care rounds and there were no open areas. The Wound Care Nurse was asked if she observed the skin today (7/15/24) and stated, No. Wound Care Nurse was then asked how did she put in a progress not for today stating that the skin was observed and no air mattress was needed since their were two open areas observed on the buttocks today. The Wound Care Nurse stated she should have dated the note as a late entry and for the day she had observed the skin. On 7/16/24 at 2:00PM, the Director of Nursing(DON) was interviewed and asked how long does it take for an air loss mattress to be delivered to the facility. The DON explained that it takes about 24 hours for a mattress to arrive. The DON was then asked was she aware that the wound care documentation did not reflect the current condition of the Resident's skin and the DON replied, Yes, we spoke and will correct the issue. No additional information was provided by the exit of the survey.

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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** 34275 Based on observation, interview and record review, the facility failed to ensure a resident was transferred appropriately to prevent injury and ensure a thorough investigation was completed for one (R26) out of three residents reviewed for accidents/falls. Findings include: On 7/15/24 at approximately 9:30 AM, R26 was observed in their wheelchair outside the nurse's station. The resident was alert, but not able to accurately answer most questions asked. A review of R26's clinical record revealed the resident was originally admitted to the facility on [DATE] with diagnoses that included: heart failure, diabetes type II, dementia and bipolar disease. A review of the Minimum Data Set (MDS) dated [DATE] noted that the resident had a Brief Interview for Mental Status (BIMS) score of 5/15 (severe cognitive impairment). The resident's care plan (5/30/24) noted the resident was a two-person assist for transfers utilizing a [NAME] sit-to-stand machine. Continued review of R26's clinical record documented, in part, the following: 7/1/24- Nursing Progress Note: CNA (certified nursing assistant) reported to writer that resident while being transferred via [NAME] lift and machine rubbed her right knee causing a skin abrasion, writer cleansed and covered with DD (dry dressing). Order to monitor instantiated as well. It should be noted that it was determined that the CNA R was the staff person who transferred R26. 7/2/24-Administration Note: cleanse right skin abrasion with N/S (normal saline) and apply band aid until resolved everyday shift . 7/13/24- Administration Note: cleanser right skin abrasion with N/S apply band aide until resolved every day shift . A request was made for IA (incident/accident) reports pertaining to R26. On 7/17/24 at approximately 1:04 PM, an interview was conducted with the Director of Nursing (DON). The DON was aware that R26 was bumped by the [NAME] sit-to-stand lift and noted that an IA report should have been completed and would attempt to locate it. *It should be noted that no IA was provided by the end of the Survey. On 7/17/24 at approximately 1:33 PM, a phone interview was conducted with CNA R. When asked about the transfer that led to R26's right knee skin abrasion, CNA R reported that they were getting the resident up on their own using the sit to stand. There were no other staff members in the room to assist with the sit to stand. CNA R noted that they believed they reported the incident to Nurse S. On 7/17/24 at approximately 2:19 PM, an (2nd)interview was conducted with the DON whom reported that an incident report was not completed by Nurse 'S and confirmed that the resident required a two person assist when using the [NAME] sit-to-stand lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Lifting Machine, using a Mechanical documented, the following: Purpose: the purpose of this procedure is to establish the principles of safe lifting using a mechanical lifting device .At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. The exception is this to the Sara Steady that may have 1-2 people based on therapy and nursing evaluations . *Again, it should be noted that it was determined that R26 was a two person assist with the [NAME] lift.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to ensure medication regimen reviews were conducted by the consultant pharmacist monthly for one (R18) of five residents reviewed for medication regimen reviews. Findings include: Review of R18's monthly medication regimen reviews from August 2023 to July 2024 revealed there were no monthly regimen reviews documented in the clinical record for August 2023, December 2023, and March 2024. Further review of the clinical record revealed R18 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy, cognitive communication deficit, other pericardial effusion, candidal stomatitis, bacteremia, dysphagia, epilepsy, osteoarthritis, cerebral ischemia, urinary tract infection,benign paroxysmal vertigo bilateral, presence of neurostimulator, major depressive disorder recurrent, moderate, insomnia, bipolar disorder, unspecified severe protein-calorie malnutrition, essential hypertension, hallucinations, unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, celiac disease, and ulcerative pancolitis without complications. According to the resident's census information, R18 did not have any discharges from the facility during August 2023, or December 2023, and was discharged to the hospital from 3/15/24 to 3/20/24. There was no documentation in the clinical record that a review had been attempted but not able to be completed. On 7/16/24 at 3:58 PM, the facility was requested via email to provide R18's pharmacy medication regimen reviews for August 2023, December 2023, and March 2024. On 7/17/24 at 8:45 AM, review of the pharmacy documentation provided by the facility revealed a pharmacy search for R18 from 8/1/2023 to 3/30/24 which documented only 1 review on 9/29/23. There were none provided for the dates requested. On 7/17/24 at 9:09 AM, an interview was conducted with the Director of Nursing (DON). When asked to review the documentation provided from Pharmacy Consultant (Consultant 'P'), the DON reported they had emailed Consultant 'P' and had confirmed with them there was no pharmacy consult completed for R18 for August, December, or March. The DON confirmed they should be done monthly and was unable to explain why that had not been done for R18. On 7/17/24 at 2:00 PM, Consultant 'P' was attempted to be contacted via phone. There was no answer and a message was left to return the call however, there was no return call by the end of the survey. According to the facility's pharmacy contract dated 4/14/2020: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Community requires pharmaceutical products and related pharmacy services for the Facilities in accordance with applicable .federal laws and regulations .Consultant shall provide the required Consultant Services set forth in Schedule3.1(a) hereto, in accordance with Applicable Law .Compliance with Healthcare Laws .will comply in all .regulations .and other laws of any governmental entity .

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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** 30675 Based on observation, interview, & record reviews the facility failed to ensure residents were free from significant medication errors in regard to seizure medications for two (R18 and R88) of two residents reviewed for medication errors, resulting in delayed administration, delayed physician notification, and increased seizure risk. Findings include: R18: On 7/15/24 at 11:28 AM, Nurse 'H' was observed across the hall from R18's room. When asked about whether the resident had received their morning medications, Nurse 'H' reported they had not and were currently trying to cover as there was a call-in. 07/15/24 12:26 PM, review of R18's Medication Administration Records (MARs) revealed they had not yet received their morning medication as prescribed by the physician. Further review of these medications included the following anti-seizure medication: Clobazam Oral Tablet 10 MG (Milligram)- give 2 tablet by mouth two times a day for anticonvulsant (ordered to be given at 9:00 AM and 9:00 PM). The last documented administration was on 7/14/24 at 9:00 PM. Divalproex Sodium Oral Tablet Delayed Release 500 MG Give 1 tablet by mouth in the morning for anticonvulsant Do not crush, chew or split (ordered to be given at 9:00 AM). The last documented administration was on 7/14/24 at 9:00 AM. Lacosamide Oral Tablet 200 MG Give 1 tablet by mouth two times a day for seizures (ordered to be given at 9:00 AM and 9:00 PM). The last documented administration was on 7/14/24 at 9:00 PM. On 7/15/24 at 1:00 PM, Nurse 'L' was observed with the medication cart just in front of R18's room preparing medications. When asked if those were the resident's morning medications, Nurse 'L' reported Yeah, I just got here. Further review of the clinical record revealed R18 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: epilepsy and presence of neurostimulator. According to the Minimum Data Set (MDS) assessment dated [DATE], R18 had severely impaired cognition, and was dependent upon staff for most aspects of care. Further review of the clinical record revealed an entry on 7/15/24 at 6:03 PM by Nurse 'L' that the physician had been notified of the late morning medication pass. This did not occur at the time of actual medication administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/6/24 at 11:00 AM, a phone interview was conducted with Physician 'G'. When asked about whether they were notified of R18's late medications from 7/15, especially the anti-seizure medications, Physician 'G' reported they (Nurse) didn't contact them personally but if it was done after hours, they would've spoken to a physician on-call. When asked about whether the next dose should've been held, Physician 'G' reported, No, unless the delay is significant. When asked what they would consider significant, Physician 'G' reported would hold probably if more than six hours delay, the solution is to administer when able, most of those medications are long acting and a few hours change won't do anything. On 7/17/24 at 10:50 AM, the Director of Nursing (DON) was asked about the facility's process for notifying the Physician when a medication was administered beyond the scheduled timeframe and the DON reported that should be done at the time of the administration. When asked why that was not done for R18 on 7/15/24, the DON reported they were the one to direct the Nurse to call the physician but was unable to recall any specific details. The DON was informed of the discussion with Physician 'G' and of the continued concern with late significant medication administration and timely notification to the Physician. On 7/17/24 at 10:47 AM, the facility was requested via email to provide additional policies for Medication Administration and Documentation of Medication Administration, as the policy provided for Administering Oral Medications referenced these specific policies and did not include time frame of medication, or notification to the Physician for potential further instructions. There was no further documentation provided for review by the end of the survey. 49272 R88 On 7/15/24 at 10:57 AM, R88 was interviewed and reported not getting their seizure medication for multiple days. Review of R88's medication administration record (MAR) revealed Epidolax 100mg oral solution (anti-seizure medication) should be administered twice daily. On 7/13/24 and 7/14/24 no doses were documented as being administered, on 7/15/24 the morning dose was documented as not given however the evening dose was documented as given, on 7/16/24 no doses were documented as being administered and on 7/17/24 the morning dose was documented as not given. At the time of last review R88 had missed seven doses of their anti-seizure medication, beginning on 7/13/24. Further review of the clinical record revealed that the physician was not notified of each missed dose and no documentation of increased monitoring for seizure activity was found. Further review of the clinical record revealed R88 was initially admitted into the facility on [DATE] with diagnoses that included: seizures and transient ischemic attack (brief blockage of blood flow to the brain). According to the MDS assessment dated [DATE], R88 had intact cognition, and was dependent upon staff for most aspects of care. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 2:50 PM an interview was conducted with the Director of Nursing (DON). The DON reviewed R88's MAR and was made aware of the missing doses of their seizure medication. When queried what their policy was for missing medication doses they reported they would need to look up the policy in order to quote it accurately but reported in their professional opinion residents should not miss a medication for more than three days and that the doctor should be notified. The DON indicated that they would need to clarify whether physician notification should occur with each dose or not. On 7/17/24 at 10:05 AM a follow-up interview was conducted with the DON regarding when to notify the physician of missing medication doses. The DON reported that to her knowledge the physician should be notified with each missing dose. The DON was notified that R88's electronic medical record does not reflect that is occurring. Review of the facilities Administering Oral Medications policy, revised October 2010, revealed no specific instructions regarding missing doses.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review, the facility failed to timely notify the physician of abnormal laboratory results for one (R26) of two reviewed for laboratory services. Findings include: On 7/15/24 at approximately 9:30 AM, R26 was observed in their wheelchair outside the nurse's station. The resident was alert, but not able to accurately answer most questions asked. A review of R26's clinical record revealed the resident was originally admitted to the facility on [DATE] with diagnoses that included: heart failure, diabetes type II, dementia and bipolar disease. A review of the Minimum Data Set (MDS) noted that the resident had a Brief Interview for Mental Status (BIMS) score of 5/15 (severe cognitive impairment). Continued review of R26's clinical record noted the following: Behavior Note (7/8/24): R26 continues to yell help repeatedly, again tonight .She is not sleeping and has not had any quiet rest periods for more than few minutes at a time tonight .continues to lay in bed yelling out help but unable to tell staff of any needs . Order Administration Note (7/10/24): R refused COVID test .Guest stated she did not want writer to touch her . Nursing Progress Note (7/11/24): Resident continues to be awake and intermittently calling out for help . yelling No I don't want to get into the chair. Leave me alone .go away and don't touch me! . Nursing Progress Note (7/11/24): UA (urinalysis) PCR (polymerase chain reaction - a rapid method to diagnosis certain infectious diseases). Urine obtained via straight cath and placed in fridge on first floor for pick up. *An attempt was made to try to locate the results of the UA in the resident's electronic medical record (EMR). No documents were found. Order Note (7/16/24): .Macrobid (antibiotic) Oral Capsule 100 MG (milligram) give 1 capsule for UTI (urinary tract infection) for 7 days . On 7/16/24 at approximately 1:35 PM, an interview and record review were conducted with Unit Manager (UM) 'Q. UM Q reported that they are responsible for obtaining lab results and placing them in a location for physicians to review. When asked if they could locate the results of the UA taken on 7/11/24, UM Q reported that they had a paper copy that had not been scanned into the resident's record. They also reported that it needed to be reviewed by the physician. UM Q was able to print a copy for the Surveyor. A review of the (name redacted) laboratory results documented, in part, the following: .Patient: R26 .Coll (collection) date 7/11/24. Coll time: 11:45 PM .Recv. Date 7/13/24 (11:50 AM) .Final Report date: 7/14/24 (no time) .Report status:. Bacterial .Proteus mirabilis (bacteria that cause infection stones in the urinary traction leading to infection). (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at approximately 10:52 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked if the laboratory results should have been provided to the physician on the day they were received. The DON responded that the nurse should have followed up in a timely manner. A review of the facility policy titled, Lab and Diagnostic Test Results-Clinical Protocol documented, in part: . The physician will identify and order diagnostic and lab testing .the staff will process test requisitions and arrange for tests .the laboratory .will report test results to the facility .A nurse will review all results .The person who is to communicate results to the physician will review and be prepared to discuss the .individuals current condition .A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individuals current condition .Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab .results .the result is something that should be conveyed to a physician regardless of other circumstances .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review the facility failed to ensure enough kitchen staff were available to prepare and serve meals in a timely manner. This deficient practice had the ability to affect multiple residents who received meals at the facility, including but not limited to R5, R28 and R64. Findings include: R5 On 7/15/24 at approximately 11:57 AM, R5 was observed sitting in a chair in their room. The resident's family member was present as well. R5 was alert but not able to answer all questions asked. R5's family member was interviewed at that time. The family member reported that R5 had been in the facility for about seven months and noted that their biggest concern was with staffing, specifically related to food services. The family member reported that on Saturday (7/13/24), R5 did receive their lunch very late (approximately 1:30 PM) and stated that the meal was incorrect and by the time they corrected it was about 15-20 minutes later. The family member noted that it was not the first time, R5, received a late or incorrect meal. 39083 During an interview on 7/15/24 at 12:08 PM, Dietary Staff W was queried on dietary staffing and stated they are short every day. During an interview on 7/16/24 at 12:06 PM, Dietary Staff W explained that things get bottlenecked with dietary and CNA staff being short resulting in meals being served late. 38271 R64 On 7/15/24 at approximately 9:56 a.m., R64 was observed in their room, laying in their bed. R64 was queried if they had any concerns and they reported that they never got served dinner the day before. 64 indicated that they had complained to the Nurse and the CNA (Certified Nursing Assistant) but they never got their tray so they ate a bag of chips that they had in their room. R64 reported that the food is always late, never gets served on time and that they thought that the kitchen did not have enough help. On 7/15/24 the medical record for R64 was reviewed and revealed the following: R64 was initially admitted to the facility on [DATE] and had diagnoses including Heart failure and Chronic pain. A review of R64's MDS (minimum data set) with an ARD (assessment reference date) of 2/14/23 revealed R64 needed some assistance with their activities of daily living. R64's BIMS score (brief interview for mental status) was 14 indicating R64 had intact cognition. (continued on next page)

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Canterbury on the Lake	5601 Hatchery Rd Waterford, MI 48329

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/16/24 at approximately 10:42 a.m., during the group interview, multiple residents (who preferred to remain anonymous) reported that the kitchen does not have enough help and that the meals are late and that some residents do not get their trays. On 7/16/24 at approximately 2:25 p.m., Chef C was queried regarding the late meal times that had been observed during the survey as well as reports of cold food and food items being ordered but not provided and they reported that they are short dietary staff (servers) and stated that to operate at an efficient level they would have to have 11 servers but currently the only have two or three and that was why the concerns in the kitchen and with meals were being identified. R28 On 7/17/24 at approximately 9:16 a.m., R28 was observed in their room, up in their wheelchair. R28 indicated they did not like their breakfast and did not get what they ordered. R28 reported that they had ordered a sunny side up egg and diet cola. At that time, R28's meal ticket was observed to have sunny side up egg written on it along with diet Pepsi circled. R28's breakfast tray was observed to contain scrambled eggs and non-diet root beer. R28 indicated that the kitchen must be short of staff. On 7/17/24 at approximately 9:30 a.m., Chef C was queried why R28 was not provided a sunny side up egg as indicated by their preference on their meal ticket and they reported that someone had messed up and that they do have a burner that can make the egg but that they were still short on staff. A review of the December 2023 Resident Council meeting minutes dated 1/31/23 (date error) revealed the following: Old Business:-Dietary-This was the first resident council meeting with [contracted dietary staff] representation. They clarified mealtimes which are as follows: Breakfast 8am Lunch 12pm, Dinner 6pm. Residents expressed that the meals consistently run a half an hour behind and they would prefer them to be earlier in general .New Business:-Dietary-Dietary representation was present at resident council meeting and able to address concerns. These concerns were consistent with what we have heard from the previous month. These concerns include: Quality of food, Hard, Difficult to eat, Too salty/spicy, Coffee too strong .Not receiving all food ordered, Not receiving all beverages ordered .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #MI00145467. Based on observation, interview and record review, the facility failed to ensure resident food preferences were honored for six residents (R28, R36, R49, R56, R72, R74, and R78) as well as multiple attendees at the confidential resident council meeting, resulting in verbalized complaints and dissatisfaction with meals. Findings include: Review of a complaint reported to the State Agency alleged ongoing issues with the facility's food and read, . The facility has been out of a lot of different foods since last week .Residents are getting cold food and don't have many options for meal choices .the residents are being served peanut butter & jelly sandwiches for meals. According to the facility's policy titled, Food Preferences dated 5/2023: .Resident food and beverage preferences will be obtained upon admission and periodically as needed to assist the Food & Nutrition Services department in providing preferred food and beverages to enhance/maintain quality of life and nutritional status . On 7/15/24 from 9:00 AM to 9:30 AM, observations of the second floor revealed resident's food was served on disposable foam plates (don't retain heat) with plastic cups and silverware. R36 & R74: On 7/15/24 at 10:22 AM, an interview was conducted concurrently with R36 and R74 to discuss concerns they had regarding the facility's food. Both residents report ongoing issues with food regarding running out of food. R36 reported they bring it up at resident council frequently and they don't follow-through with what they say they will do, for example they said they would add sloppy joe once a month but only get it one or two times a year. R74 reported they were supposed to get spaghetti for dinner last night, but they ran out and was given a salad near 7:00 PM and reported who wants to eat salad when you could've had spaghetti. Both residents reported ongoing frustration over the food and reported the facility Administration is well aware of these concerns. They also reported the food is cold at times and comes in Styrofoam containers. On 7/17/24 at 3:43 PM, a family member approached the survey team (in the presence of the Infection Preventionist) to report ongoing concerns with the facility not providing meals per resident preferences. They reported that although R36 prefers a fruit plate, they were told they were not able to receive this and had to have it with cottage cheese, but that was not the resident's preference. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical records for R36 and R74 revealed they were both cognitively intact and had no communication concerns. 34275 R49 On 7/15/24 at approximately 10:19 AM, R49 was observed lying in bed. The resident was alert but had trouble answering all questions asked. The resident's brother was sitting by the bedside and was interviewed as to life in the facility. R49's brother reported that the resident had been in the building for approximately two years. They noted that staffing was a concern and often the facility was not able to provide the resident with preferred food choices. R49's brother noted that they had addressed their concerns with the facility. A review of R49's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease, migraines and falls. A review of the resident's Minimum Data Set (MDS) dated [DATE] noted the resident had a Brief Interview for Mental Status (BIMS) score of 3/15 (severely cognitively impaired cognition). The resident's brother was noted as the resident's legal representative. A request was made for any grievances pertaining to R49. A grievance dated 6/10/24 was provided and documented, in part, the following: Grievance and Concern Form .R49 .date: 6/10/24 .complaint receive from R49's brother .Complaint: Brother of resident has complaint about the texture of the food being served as well as being served things that the patient had documented as being disliked .guest was served shredded hashbrown, egg and sausage with canned (not able to decipher the type of fruit). Guest has eggs and canned fruit as a dislike. Brother also has concerns about texture .guest is on a mechanical soft diet and family concern .Shredded hashbrowns this AM where crispy and difficult to eat .Response/Resolution . Educated CNAs (certified nursing assistants) on reviewing patient preferences prior to serving tray .nurse to review trays to ensure compliance . 38271 Resident Council Interview: On 7/16/24 at approximately 10:42 a.m., during the group interview, multiple resident (who preferred to remain anonymous) reported that the kitchen does not have enough help and that the meals are late and that some residents do not get their trays. On 7/16/24 at approximately 2:25 p.m., Chef C was queried regarding the late meal times that had been observed during the survey as well as reports of cold food and food items being ordered but not provided and they reported that they are short dietary staff (servers) and stated that to operate at an efficient level they would have to have 11 servers but currently they only have two or three and that was why the concerns in the kitchen and with meals were being identified. R28 (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at approximately 9:16 a.m., R28 was observed in their room, up in their wheelchair. R28 indicated they did not like their breakfast and did not get what they ordered. R28 reported that they had ordered a sunny side up egg and diet cola. At that time, R28's meal ticket was observed to have sunny side up egg written on it along with diet Pepsi circled. R28's breakfast tray was observed to contain scrambled eggs and non-diet root beer. R28 indicated that the kitchen must be short of staff. On 7/17/24 at approximately 9:30 a.m., Chef C was queried why R28 was not provided a sunny side up egg as indicated by their preference on their meal ticket and they reported that someone had messed up and that they do have a burner that can make the egg but that they were still short staff. A review of the December 2023 Resident Council meeting minutes dated 1/31/23 (date error) revealed the following: Old Business:-Dietary-This was the first resident council meeting with [contracted dietary staff] representation. They clarified mealtimes which are as follows: Breakfast 8am Lunch 12pm, Dinner 6pm. Residents expressed that the meals consistently run a half an hour behind and they would prefer them to be earlier in general New Business:-Dietary-Dietary representation was present at resident council meeting and able to address concerns. These concerns were consistent with what we have heard from the previous month. These concerns include: Quality of food, Hard, Difficult to eat, Too salty/spicy, Coffee too strong, .Not receiving all food ordered, Not receiving all beverages ordered . 49272 On 7/15/24 from approximately 9:39 AM to 10:26 AM, observations of the second-floor revealed resident's food was served on disposable foam plates with plastic cups and silverware. R56 & R72 On 7/15/23 at approximately 1:10 PM, an interview was conducted concurrently with R56 and R72. Both residents reported ongoing issues with food, including meat (turkey and pork) being tough and difficult to cut and chew, not getting what they ordered, meals arrive cold and meals are difficult to eat with plastic utensils. Review of the clinical records for R56 and R72 revealed they were both cognitively intact and had no communication concerns. R78 On 7/15/24 at 10:39 AM, an interview was conducted with R78. R78 reported issues with not receiving what they order and items not being available (example provided was prune juice). Review of the clinical records for R78 revealed they were cognitively intact and had no communication concerns.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 39083 Based on observation, interview, and record review, the facility failed to provide timely meals, resulting in late meal times outside of resident preferences and needs, affecting residents on the 2nd floor and in resident council. Findings include: On 7/16/24 at 9:30 AM, the breakfast meal time was observed to still be in progress. During an interview on 7/16/24 at 12:06 PM, Dietary Staff W confirmed that meals are often served late due to staffing issues. On 7/16/24 at 1:30 PM, the last meal tray was observed to be delivered on the 2nd floor. During an interview on 7/16/24 at 1:33 PM, LPN K was queried on the lunch times and stated that lunch usually finishes around 1:00PM to 1:30 PM. According to the Meal Times, document posted at each dining room, it notes, Breakfast: 1st Floor Pavilion: 7:30 AM, 2nd Floor Pavilion: 8:00 AM, 3rd Floor Pavilion: 7:30 AM Lunch: 1st Floor Pavilion: 11:30 AM, 2nd Floor Pavilion: 12:00 PM, 3rd Floor Pavilion: 11:30 AM Dinner: 1st Floor Pavilion: 5:30 PM, 2nd Floor Pavilion: 6:00 PM, 3rd Floor Pavilion: 5:30 PM 38271 On 7/16/24 at approximately 10:42 a.m., during the group interview, multiple residents (who preferred to remain anonymous) reported that the kitchen does not have enough help and that the meals are late and that some residents do not get their trays. On 7/16/24 at approximately 2:25 p.m., Chef C was queried regarding the late meal times that had been observed during the survey as well as reports of cold food and food items being ordered but not provided and they reported that they are short dietary staff (servers). Chef C further stated that to operate at an efficient level they would have to have 11 servers but currently they only have two or three and that was why the concerns in the kitchen and with meals were being identified. A review of the December 2023 Resident Council meeting minutes dated 1/31/23 (date error) revealed the following: Old Business:-Dietary-This was the first resident council meeting with [contracted dietary staff] representation. They clarified mealtimes which are as follows: Breakfast 8am Lunch 12pm, Dinner 6pm. Residents expressed that the meals consistently run a half an hour behind and they would prefer them to be earlier in general .New Business:-Dietary-Dietary representation was present at resident council meeting and able to address concerns. These concerns were consistent with what we have heard from the previous month. These concerns include: Quality of food, Hard, Difficult to eat, Too salty/spicy, Coffee too strong Not receiving all food ordered, Not receiving all beverages ordered .

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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. 39083 Based on observation, interview, and record review, the facility failed to maintain a sanitary kitchen, maintain equipment in good repair, and safely store and handle food, resulting in an increased risk of foodborne illness, affecting all residents in the facility. Findings include: On 7/15/24 at 9:18 AM, during an inspection of the kitchen, the following observation were made: 9:18 AM, a container of cooked eggs, tomato sauce, cheese, sliced ham, shrimp, deli meat, and chicken salad were observed to be stored in the walk-in cooler with no date marking to identify the discard date. Additionally, the floor in the walk-in cooler was observed to be soiled with dried spills and food debris. According to the 2017 FDA Food Code Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Pf 9:29 AM, the condenser line coming out of the wall of the walk-in unit, was observed to not be attached to an exterior copper pipe that properly disposes the condensate into the floor drain. Instead, the condensate was observed to be coming out of the wall pipe straight onto the floor. The floor tile was wet and the grout was beginning to dissolve away. 9:32 AM, the reach-in cooler, located next to the milk/egg cooler, was observed to have significant water accumulating in the bottom interior surface. A cloth was observed to be in the interior bottom surface and was saturated. When the reach-in door was opened, water would drip out onto the floor. 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. 9:34 AM, a container of milky water, with an ice scoop stored in it, was observed on top of the ice cream freezer. 9:37 AM, the cookline hood ventilation filters were observed to be layered with grease. Droplets of grease were observed to be forming on the lower edge of the hood vent. Additionally, the floor drain grates, located at the cookline, were observed to be caked with grease. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9:43 AM, food debris accumulation was observed in four utensil bins stored on the utensil shelf. Additionally, a mechanical scoop was observed to have encrusted food debris. 9:46 AM, bulk containers of flour and sugar were observed to have food debris accumulation on the container lids. 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. 9:52 AM, pots and pans were observed to be piled up at the three-compartment sink. Anonymous Employee X was queried on the pots and pans and stated that staff will leave out dirty dishes from the previous day or even two days. 9:58 AM, a package of ground beef, located in the walk-in cooler, was observed to be stored directly on a box of pork chops. At this time, Execute Chef (EC) C proceeded to relocate the ground beef to a safe storage location. Additionally, a tub of ice cream, located in the walk-in freezer, was observed to be stored on the floor. According to the 2017 FDA Food Code Section 3-302.11Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables,P (b) Cooked READY-TO-EAT FOOD, P and (c) Fruits and vegetables before they are washed; P (d) Frozen, commercially processed and packaged raw animal FOOD may be stored or displayed with or above frozen, commercially processed and packaged, ready-to-eat food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(2) Except when combined as ingredients, separating types of raw animal FOODS from each other such as beef, FISH, lamb, pork, and POULTRY during storage, preparation, holding, and display by: (a) Using separate EQUIPMENT for each type, P or (b) Arranging each type of FOOD in EQUIPMENT so that cross contamination of one type with another is prevented, P and (c) Preparing each type of FOOD at different times or in separate areas; . 10:07 AM, the egg/milk cooler, located next to the ice cream freezer, was observed to feel cool but not cold. A reading of the internal ambient thermometer measured 45 degrees F. A temperature was taken from a carton of liquid eggs and was found to be 43.7 degrees F. EC C proceeded to instruct staff to discard the liquid egg cartons. A review of the Refrigerator Temperature Log, for the egg production cooler in the month of July, noted no entry for 7/15/24. 10:24 AM, EC C was prompted to test the sanitizer concentration of the low temp/chemical sanitizing dish machine. At this time, Dishwasher AA stated that the test strips stopped showing sanitizer available in the dish machine sometime last week. EC C proceeded to test the dish machine with color indicating test strips and no chlorine residual was detected. Dishwasher AA continued to say that the sanitizer would turn the test strip the right color in the past, but now the test strip stays white. At 10:26 AM, EC C stated that this is the first time he has been made aware of the issue and that they will utilize the sanitizer compartment of the three-compartment sink to sanitize dishware until a service tech can fix the dish machine. At 1:43 PM, Dietary Staff Z was observed to be using the dish machine to wash bowls and was stacking them on a cart. At this time, Dietary Staff Z was queried if they knew the dish machine wasn't working properly and stated no, they were not aware. According to the 2017 FDA Food Code Section 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under S7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, P and shall be used as follows: (A) A chlorine solution shall have a minimum temperature based on the concentration and PH of the solution as listed in the following chart; P Concentration Minimum Temp pH 10 or Less C/(F) Minimum Temp pH 8 or Less C/(F) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Range 25-49 49(120 49(120) 50-99 38(100) 24(75) 100 13(55) 13(55) 11:56 AM, the water in the 3rd floor kitchenette steam table was observed to be discolored and had food debris accumulation. At this time, Dietary Staff V was queried on how often the water is to be changed and stated the water is supposed to be changed daily but it doesn't look like it was changed. 12:08 PM, two gallons of opened milk cartons, located in the 2nd floor kitchenette reach-in cooler, were observed to not be dated with an expiration date. At this time, Dietary Staff W stated that she got busy and hasn't dated them yet. 12:14 PM, the hand sink, located in the 1st floor kitchenette, was observed to be blocked by a warming cart and a trash can. The surveyor could not access the hand sink at this time to wash hands. Additionally, plastic utensils, cup lids, and paper place mats were observed to be stored underneath a sink in the kitchenette. According to the 2017 FDA Food Code Section 5-205.11 Using a Handwashing Sink. (A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use. Pf (B) A HANDWASHING SINK may not be used for purposes other than handwashing. (C) An automatic handwashing facility shall be used in accordance with manufacturer's instructions. Pf 12:32 PM a container of egg salad, noodles, raw salmon, hot dogs, chicken salad, cheese, shrimp, and slaw were observed to be stored in deep containers, in the cold well across from the cookline. At this time, Dietary Staff Y was queried and stated that the food stays in the cold wells all day. At 1:36 PM, EC C was prompted to take temperatures of the food products in the cold well to ensure proper cold holding and found the following temperatures: egg salad @ 46 degrees F, chicken salad @ 45 degrees F, and shrimp @ 42.9 degrees F. EC C proceeded to instruct staff to move the food product into shallow metal containers to maximize surface area in contact with the cold well. 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 (B) EGGS that have not been treated to destroy all viable Salmonellae shall be stored in refrigerated EQUIPMENT that maintains an ambient air temperature of 7 C (45 F) or less. P (C) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD in a homogenous liquid form may be maintained outside of the temperature control requirements, as specified under (A) of this section, while contained within specially designed EQUIPMENT that complies with the design and construction requirements as specified under 4 204.13(E). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1:33 PM, the meat slicer blade was observed to have encrusted food debris on the underside of the blade. Additionally, the commercial mixer was observed to have encrusted food debris on the protective cage. On 7/16/24 at 12:13 PM, the interior surfaces of the warming cart, located on the 3rd floor kitchenette, was observed to be soiled with grease, food debris, and liquids. On 7/16/24 at 12:26 PM, the interior surfaces of the warming cart, located on the 1st floor kitchenette, was observed to be soiled with grease, food debris, and liquids.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48680 Based on interview and record review, the facility failed to ensure the Infection Control Preventionist attended the QAPI (Quality Assurance and Performance Improvement) meetings at least quarterly, resulting in the potential for lack of coordination of resident care policies and overall medical care that could affect all 101 residents residing in the facility. Findings include: On 7/17/24 at 2:44PM, a review of the facility's QAPI program was conducted with the Nursing Home Administrator (NHA). Upon review of the sign-in sheets for the QAPI meetings held in 2024, it was noted that the infection control preventionist did not sign in at the January through June 2024 QAPI meetings. This was confirmed by the NHA, who stated she was not present at all meetings and there was no sign in for her but she should have signed if she was present. The Director of Nursing(DON) stated that the infection Control Preventionist joined the meetings via zoom. She was asked does she have any proof that they hold zoom QAPI meetings. The DON stated there was no way to show a zoom meeting. At 3:20PM, the Infection control preventionist was asked if she attends the QAPI meetings, she replied Yes. She was asked was she physically present for the meetings and she stated, Yes. The infection control preventionist was then asked why did the DON state that she is present via zoom for meetings and the Infection control preventionist stated that she is on zoom at times, she will dial in (instead of in person). No additional information provided by the exit of the survey

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272 Based on observations, interview and record review, the facility failed to ensure all staff followed proper infection control practices and protocols including transmission-based precautions and Enhanced barrier precautions for five (R7, R18, R49, R63, R298) of five residents reviewed for Infection Control. Findings include: Prior to entering R7's room at approximately 9:47 AM on 7/15/24, an Enhanced Barrier Precaution (EBP) sign was observed near the resident's door. There was no personal protective equipment (PPE) in or near the resident's room, multiple staff members were observed entering and exiting the room without any PPE on or performing hand hygiene. Upon entering the room no PPE was noted to be disposed of in the trash can. R7 was observed to be lying on their back. On 7/15/24 at 12:17 PM, LPN L was observed outside of R7's room with the medication cart. LPN L was observed to have came out of the room with a used medication syringe. When asked which resident was on EBP they stated that they believed it was R7 (R7 had a roommate). LPN L reviewed the Electronic Medical Record (EMR) in an attempt to clarify which resident was on EBP. They then reported that they would go to the nurse's desk to clarify which resident was on EBP. Approximately three minutes later, LPN L returned to R7's room and stated that R7 was on EBP for a wound on their coccyx. On 7/15/24 at 12:41 PM CNA U was observed to enter R7's room without performing any hand hygiene, shortly after they were observed exiting R7's room without performing any hand hygiene. On 7/15/24 at approximately 12:45 PM a brief interview was conducted with CNA U, when asked if there was anything that should have occurred prior to entering R7's room (with EBP in place), CNA U asked if they were supposed to grab a gown and reported that they weren't sure if that resident still needed to be on precautions. When asked how they would clarify that information they responded they should go ask their manager. A review of R7's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease, lack of coordination and hallucinations. A review of the resident's Minimum Data Set (MDS) dated [DATE] noted the resident had a Brief Interview for Mental Status (BIMS) score of 14/15 (intact cognition). Continued review of R7's clinical record documented an active order for Enhanced Barrier Precautions due to Coccyx ulcer, Please practice hand hygiene and put on gown and gloves prior to entering resident's room for high contact activities. High Contact activities are listed on the EBP sign next to the resident's room. Wear eye protection and surgical mask for splash potential care. Remove/dispose of used PPE prior to exiting resident's room. Practice hand hygiene. On 7/17/24 at approximately 11:05 AM, an interview was conducted with the Director of Nursing (DON) as the Infection Preventionist (IP Nurse 'A') was not available for interview (not in facility). The DON was informed of the multiple observations throughout the survey with the concerns for infection control practices and acknowledged similar concerns. They reported they were made aware of some of these concerns by the staff directly and further reported they would have to implement a plan of correction to address that. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	30675 R18: On 7/15/24 at 11:18 AM, R18's call light was observed activated (lit up in hallway outside of the room). There was signage posted outside the door that identified R18 was on transmission-based precautions, specifically contact precautions. There was no Personal Protective Equipment (PPE) available near the room, or hallway. There was no signage on where to obtain the required PPE. Upon entry into the resident's room, there was a garbage can inside the bathroom, but no Personal Protective Equipment (PPE) was observed discarded. R18 was seen laying in bed and was unable to respond to simple questions asked. On 7/15/24 at 11:19 AM, a staff member was observed walking down the hallway and when asked where the PPE was located for R18, they reported that it was down the hallway, behind the nursing desk. When asked how visitors would know to get the PPE from there, the staff reported they would find out, but never returned. On 7/15/24 at 11:22 AM, Certified Nursing Assistant (CNA 'I') was observed entering the room of R18 without donning a gown, gloves, or use of hand-sanitizer (they were already wearing an N95 mask due to covid outbreak in the facility). Upon their exit from the room, they also were not seen washing hands, or using hand-sanitizer. On 7/15/24 at 11:25 AM, when CNA 'I' was asked about the lack of PPE prior to entering R18's room, they reported some of the residents had that so when you are providing care and thought they were on enhanced barrier precautions. When asked if they saw the signage that indicated they were on contact precautions, and if they knew what the specific reason was for, CNA 'I' reported they were not sure as they just returned to work and this was their first day back. When asked where they would obtain the PPE to don/doff, they reported that would be down the hall at the nursing desk. On 7/15/24 at 11:28 AM, Nurse 'H' who was at a medication cart across from R18's room was asked if they knew what the reason for why R18 was on contact precautions and reported they were not sure since they never worked with the resident before, but would find out before they went in to give the resident their medications. When asked if they were assigned to R18, they only reported they were down one nurse and covering multiple hallways. On 7/15/24 at 1:00 PM, Nurse 'L' was observed with the medication cart just in front of R18's room preparing medications. When asked if those were the resident's morning medications, Nurse 'L' reported Yeah, I just got here. Nurse 'L' was then observed to enter the resident's room without donning/doffing any PPE except for an N95 mask. Upon Nurse 'L's exit from the room, when asked what they should've done since the resident was on contact precautions, Nurse 'L' reported they should've donned/doffed PPE (including gown and gloves). Review of R18's physician orders included: Macrobid (an antibiotic) Oral Capsule 100 MG (Milligrams) Give 1 capsule by mouth two times a day for UTI (Urinary Tract Infection) 2nd (Secondary) to MDRO (Multi-Drug Resistant Organism) for 5 days. This was first documented as administered on 7/11/24 at 9:00 AM. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Utilize Contact Precautions r/t (related to) MDRO in urine. Practice hand hygiene. Put on gown and gloves prior to entering resident's room. Where <sic> goggles/Shield for splash potential care. Remove/dispose of used PPE prior to exiting Resident's room. Practice hand hygiene. Every shift until 07/17/2024 01:00 (1:00 AM). On 7/16/24 at 9:57 AM. Laundry Aide (Staff 'M) was observed entering R18's room to deliver clothing. Staff 'M' was not observed to wash hands, or utilize hand-sanitizer prior to entering the room, or upon exiting the room, and also did not don/doff the required PPE prior to entering the resident's room. Staff 'M' was then observed to enter the room next door (that was not on TBP without handwashing/hand-sanitizer upon exiting R18's room). On 7/16/24 at 9:59 AM, an interview was conducted with Staff 'M'. They reported they were helping to cover for laundry and usually worked on the independent living side of the facility. When asked about whether they were aware R18 was on contact precautions and what PPE was required upon entering the room, Staff 'M' reported they were not aware as there was no cart with PPE placed outside the room. When asked if they saw the signage posted at the door, Staff 'M' reported they did not. When asked if handwashing should be done upon exiting a resident's room on contact precautions, Staff 'M' confirmed they did not and also didn't use hand-sanitizer, but they should always do that, they just weren't aware of R18's contact precautions. R63: On 7/16/24 at 9:28 AM, Nurse 'N' was observed inside R63's room pushing them in the wheelchair towards the bathroom. Signage outside the resident's room indicated R63 was on contact precautions. There was a PPE cart outside the room that was observed to have hand sanitizer in the top drawer of the 3 drawer bin, including gloves, gowns, N95 masks, and face shields. There was no hand sanitizer observed inside the room, or readily available outside the room. A brief review of the clinical record revealed R63 was placed on contact precautions for c-difficule (clostridioides difficile, formerly known as clostridium difficule, is a germ that causes diarrhea and colitis (inflammation of the colon) which is highly contagious and can be life-threatening as of 7/15/24. On 7/16/24 at 9:30 AM, Nurse 'N' was observed closing the bathroom door, and exited the room without using any hand-sanitizer, or washing their hands. Upon exit of the room, when asked about the signage for contact precautions and what should be donned/doffed, Nurse 'N' reported they were just helping out and they didn't usually work on the floor, and that they usually are in an office but they should've put it all on (gown, gloves). When asked whether they should've used hand-sanitizer upon exiting the room if they weren't going to wash their hands, Nurse 'N' reported they looked for the hand-sanitizer in the room but there wasn't any, and they didn't have any on them. Nurse 'N' confirmed they would have to exit the room, go down the hallway to the nursing desk to use the hand-sanitizer on the wall. Nurse 'N' denied being aware of the reasons for contact precautions and further reported they thought R63 had been on enhanced barrier precautions, not contact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/17/24 at 10:54 AM, an interview was conducted with the Director of Nursing (DON) as the Infection Preventionist (IP Nurse 'A') was not available for interview (not in facility). The DON was informed of the multiple observations throughout the survey with the concerns for infection control practices and acknowledged similar concerns. They reported they were made aware of some of these concerns by the staff directly and further reported they would have to implement a plan of correction to address that. On 7/17/24 at 3:05 PM, IP Nurse 'A' arrived to the conference room. When asked about the facility's process for infection control practices for residents on transmission-based precautions, PPE equipment, and handwashing and/or use of hand-sanitizer, IP Nurse 'A' reported all residents on TBP for contact, droplet, etc. should have the PPE cart posted just outside their room, with signage. They clarified that the residents on EBP were identified as being able to have the PPE cart at the nursing desk. When asked about how staff should dispose of PPE in TBP rooms, they reported there should be separate container in room to dispose of inside the room before going into the hallway. When asked about the use of hand-sanitizer or handwashing, IP Nurse 'A' reported the facility recently ordered additional hand-sanitizer units to be placed at the kiosk and end of halls. When informed of the multiple observations, and interviews with staff regarding the concerns with infection control practices, especially since the facility had previously been cited during an abbreviated survey on 4/30/24 with alleged compliance date of 5/21/24, IP Nurse 'A' reported they were not sure since they had done a lot of training. 38271 R298 On 07/15/24 at approximately 9:34 a.m., R298 was observed in their room, laying in their bed. R298 was observed to a have a foley catheter in place with blood in tube. On 7/16/24 at approximately 8:37 a.m., R298 was observed in their room, laying in their bed. R298 was observed to have a foley catheter in place. No signage on the door or PPE bins indicating R298 was on EBP. On 7/16/24 at approximately 9:31 a.m., R298 was observed to have EBP signage up and PPE bin by door. Queried Nurse and they indicated they did not see any signage or bins containing PPE and had gone into R298's room and noted that they had a catheter. Stated at that time they made sure to notify staff that R298 needed to be on enhanced barrier precautions. On 7/16/24 the medical record for R298 was reviewed and revealed the following: R298 was initially admitted to the facility on [DATE] and had diagnoses including Malignant Carcinoid of the Rectum. A Physician's order for R298 dated 7/8/24 revealed the following: Change Foley Bag and Tubing as needed for Foley Bag Change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A second Physician's order dated 7/8/24 revealed the following: Enhanced Barrier Precautions r/t (related to) (MDRO colonization/Indwelling device/Wound). Practice hand hygiene and put on gown and gloves when providing high contact care. Wear eye protection (gown/goggles) and surgical mask for splash potential high contact care. Remove/dispose of used PPE prior to exiting resident?s room. Practice hand hygiene. PPE found at nurses station or Clean Utility room. Resident is not on Isolation. 34275 R49 Prior to entering R49's room on 7/15/24 at approximately 10:30 AM, an EBP sign was observed near the resident's door. There were no PPE in or near the resident's room. Again on 7/16/24 at approximately 8:33 AM, the EBP sign was again observed outside the resident's door. Again, no PPE was observed near or in the resident's room. No disposal of PPE was noted in the resident's room. R49 was observed lying in bed. While alert, the resident was not able to answer all questions asked. The resident's brother/legal representative was sitting next to the resident. R49's brother reported that they visit the resident daily. When asked if they were aware the resident was on EBP, they stated they never see staff wearing PPE when entering the residents room. On 7/16/24 at approximately 8:40 AM, Nurse T who was assigned to R49, was asked about the EBP sign posted outside the resident's door. R49 stated that they were not aware the resident was on EBP and thought the sign was posted in error. A review of R49's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease, migraines and falls. A review of the resident's Minimum Data Set (MDS) dated [DATE] noted the resident had a Brief Interview for Mental Status (BIMS) score of 3/15 (severely impaired cognition). The resident's brother was noted as the resident's legal representative. Continued review of R49's clinical record documented the following: Order Details (4/3/24): Enhanced Barrier Precautions r/t (due to) Coccyx Ulcer. Please practice hand hygiene and put on gown and gloves prior to entering resident's room for high contact activities. High Contact activities are listed on the EBP sign next to the resident's room. Wear eye protection and surgical mask for splash potential care. Remove/dispose of used PPE prior to exiting resident's room. Practice hand hygiene.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272 Based on interview and record review, the facility failed to implement an antibiotic stewardship program that consistently identified signs and symptoms of infection and failed to provide clinical justification for the use of antibiotic medications with the potential to affect all residents (including R88) requiring antibiotics in the facility. Findings include: On 7/16/24 at 2:13 PM an email was sent to the Nursing Home Administrator (NHA) requesting the infection control logs/books for the past six months. On 7/16/24 at 3:06 PM NHA replied via email, stating that Infection Preventionist (IP) Nurse A would be available on 7/17/24 at 2:30 PM. On 7/16/24 at 3:11 PM an email was sent to NHA stating If at all possible, we will need to have access to this information to review much sooner as there is A LOT of information to review. Is there anyone else that can assist with it? On 7/16/24 at 3:33 PM NHA replied via email stating IP nurse A (name redacted) will have the books ready for you tomorrow morning and will be back at 2:30pm tomorrow for questions. On 7/17/24 at 9:39 AM email received stating that the Infection Control report for the past 6 months had been uploaded to Egress (cloud-based document sharing platform). On 7/17/24 at 9:48 AM email sent to NHA and the director of nursing (DON) which asked where the completed McGeer Criteria could be found (as it was not included in the document that was uploaded to Egress). On 7/17/24 at 10:08 AM a return email was received from DON indicating which line and column McGeer criteria could be found within the line listing that was provided via Egress. On 7/17/24 at 10:10 AM an interview was conducted with the NHA and the DON. It was clarified with the NHA and the DON that the completed criteria would need to be provided for review and not just the line listing. A second request was made for the McGeer criteria which is indicated to be used in the line listing. NHA indicated that they had a 3-ring binder that was reported to have been provided by IP nurse A which might contain antibiotic criteria, however the DON specifically deferred all Infection Control related questions to be directed to IP nurse A. On 07/17/24 at 09:26 AM, the NHA entered the conference room and stated that IP nurse A was in an exam and the requested documents (McGeer criteria) would not be available until possibly 11:30. On 7/17/24 at 2:35 PM IP nurse A was still not available, it was explained to the NHA and the DON that we would be leaving with some concerns regarding their infection control program and Antibiotic Stewardship related to not having access to requested information and IP nurse not being available for interview. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 3:05 PM IP nurse A arrived to the facility as the survey team was preparing for exit. This surveyor and the survey team had multiple questions for IP A who was unavailable for the majority of the survey. At that time IP nurse A provided a 3-ring binder which contained antibiotic criteria. Review of the binder provided by IP nurse A revealed three months of [NAME] definitions of infections for Surveillance in LTC criteria (not McGeer as indicated in the line listing and in the facilities policy). Criteria forms were for January through March 22nd, 2024 (no additional criteria forms were provided past March 22nd, 2024. Due to receiving the requested information late in survey process) a quick review of two random criteria were reviewed and revealed the following: On 1/5/24 a resident was reviewed for criteria for antibiotic use related to a fungal skin infection. The criteria form indicated BOTH criteria a and b must be present, with only box a' checked (indicating a characteristic rash or lesions). Box b was not checked indicating the resident did not meet criteria however the criteria form, and line listing indicated the resident met criteria. Additionally, the line listing did not indicate any testing was completed (criteria b requires diagnosis by a medical provider or a laboratory-confirmed fungal pathogen from a scraping or a medical biopsy). On 1/11 a resident was reviewed for criteria for antibiotic use related to Clostridium Difficile Infection (a bacterial infection that causes diarrhea). The criteria form indicated BOTH criteria 1 and 2 must be present, with only 2 boxes under criteria 1 being checked (indicating Diarrhea and Presence of toxic megacolon). No boxes in section 2 were checked indicating resident did not meet criteria, however the criteria form, and line listing indicated that resident met criteria. Review of Antibiotic Stewardship Spreadsheet revealed no mapping, spreadsheet indicated the facility used McGeer Criteria to determine appropriate antibiotic usage, however criteria that was provided was [NAME] definitions of infections for Surveillance in LTC, a review of data dating back until January 2024 indicated YES for the category Meets McGeer for every entry except nine that were left blank, the last entry was on 7/11/24 with an active Covid outbreak. IP nurse A was not available for a full and thorough interview prior to survey exit. Review of R88's clinical record revealed Amoxicillin was ordered, beginning on 7/10/24. Review of the July line listing does not indicate if antibiotic criteria was met and no indication of symptoms or any testing. Review of the facilities [Facility name] Antibiotic Stewardship Policy for The Pavilion, updated 1/24, documented in part, Assessment of residents suspected of having an infection. Providers will utilize the McGeer Criteria when considering initiation of antibiotics .When UTI (urinary tract infection) is suspected, McGeer should be used to communicate with providers .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235555	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury on the Lake	5601 Hatchery Rd Waterford, MI 48329

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 0925 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 39083 Based on observation, and record review, the facility failed to eliminate pest harborage conditions, resulting in a presence of flying pests, affecting all residents in the facility. Findings include: On 7/15/24 at 9:39 AM, gnat activity was observed in the main kitchen at the floor drain grates provided at the cookline. Grease was observed caked on the floor drain grates providing harborage conditions for the pests. On 7/15/24 at 9:50 AM, gnat activity was observed in the dish washing area near the dish machine and three-compartment sink. Heavy water accumulation was observed on the floor at this time. On 7/15/24 at 11:45 AM, gnat activity was observed in the 1st floor kitchenette. On 7/15/24 at 11:50 AM, gnat activity was observed in the 2nd floor kitchenette. On 7/15/24 at 11:54 AM, gnat activity was observed in the 3rd floor kitchenette. On 7/15/24 at 12:14 PM, gnat activity was continued to be observed in the 1st floor kitchenette, concentrated around the juice machine. Dried spills were observed on the counter where the juice machine was located. On 7/16/24 at 12:51 PM, gnat activity was observed on the 2nd floor dining room behind the folding privacy wall, where soiled napkins were stored in a mesh bag. According to the [Pest Control Operator's] service report, dated 6/14/24, it notes under comments, Serviced exterior perimeter/ seasonal. Treated kitchen area in minors care. Reported roach sighting No sanitation issues in area. Treated kitchen area for flies/gnats . The report from 6/14/24, in conjunction with the facility, failed to identify pest harborage conditions and pest activity beyond the main kitchen.