STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235556	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodward Hills Health and Rehabilitation Ctr	39312 Woodward Bloomfield Hills, MI 48304

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview and record review, the facility failed to provide an environment that promoted and enhanced resident's dignity for five residents (R53, R286, R292, R336, and R387) of seven residents reviewed for dignity. Findings include: R53 On 12/2/24 at 11:09 AM, R53 was interviewed about their stay in the facility. They said they recently received a shower and while in the shower the Certified Nurse Aide (CNA) squeezed the shampoo onto their head and told them they could, do it themselves. R53 said they were able to shampoo their own hair, but found the CNA's attitude and tone to be, unnecessary and, rude. R286 On 12/2/24 at 9:37 AM, R286 was observed from the hallway in their bed. They were not covered fully with a blanket and their upper thigh and buttock were visible. They were asked permission to enter the room, and they said they were on the bed pan. They were then asked if they would like the door closed for privacy and said they would. At that time, Certified Nurse Aide 'W' was observed coming down the hallway. They stopped outside R286's room and said, I just left out of there. They were asked why the room door was wide open when R286 was on the bed pan and said they thought they closed it. R292 On 12/2/24 at 3:05 PM, an interview was conducted with R292. They said they finally got a shower but said it, wasn't a good one. When asked what they meant, they said the CNA was not prepared. They continued to say the aide left them in the bathroom several times to retrieve supplies. They further said they asked to use the shower chair and was told no; they could use the shower bench. They also reported the aide was engaging with their cell phone when they were supposed to be assisting them. On 12/3/24 at 1:55 PM, CNA 'X' was observed sitting at the nursing station on the 100 unit scrolling through their cell phone. On 12/3/24 at 2:07 PM, Nurse 'Y' was observed sitting at the nurse's station on the 300 unit scrolling through their cell phone. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	34275 R336 On 12/2/24 at approximately 10:26 AM, R336 was observed sitting on their bed. The resident was alert and able to answer questions asked. The resident's family member was also present. R336 was asked about care provided in the facility and they noted that it depends on who is providing care as some nurses and aides are rude not only to them, but they observed issues with other residents. R336 and their family member reported that over the weekend (11/30/24) the resident had a shower scheduled and a CNA, came in and handed the family member a pile of towels and told them to clean up the resident. The resident did not know how to respond, and the family member tried their best to clean up the resident but felt it was not their job. R336 felt it was rude of the CNA. They noted they reported their concern to Nurse Supervisor Y. While they could not remember the name of the CNA, they noted Supervisor Y knew who the CNA was. A review of R336's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included myopathy and colostomy care. The resident had a BIMS score of 13/15 (intact cognition). On 12/4/24 at approximately 11:30 AM, Nurse Y was asked about the incident reported by R336. NurseY reported that they recalled R336, and their family member did report a concern. While they could not recall the name of the CNA, they believed the CNA noted the family member asked to complete the bed bath and nothing further was addressed. 39592 R387 On 12/2/24 at 10:32 AM, R387 was observed standing at the sink in their room, a bandage was observed on R387's right ankle and foot. R387 was asked about the care at the facility. R387 explained a couple nights previous, they had pushed their call light on and when the CNA came in they told her they thought they (the CNA) could do it themselves, but wanted someone there just in case, then the CNA looked at them and told them 'OK, get up' and did not even offer them her hand or any other assistance, she just stood there. R387 continued to explain another time they had asked a CNA to put their socks on, but as they had a bandage on their right foot, to only pull it up halfway to avoid their wound, the CNA just pulled the sock up, they yelled 'why did you do that, it hurt', the CNA just turned, looked at them, then walked out of the room. R387 then explained they were requesting to be transferred to another facility. Review of the clinical record revealed R387 was admitted into the facility on [DATE] with diagnoses that included: cutaneous abscess of right food, aftercare following surgery on the skin and subcutaneous tissue and peripheral venous insufficiency. According to a Brief Interview for Mental Status (BIMS) exam dated 12/1/24, R387 scored 12/15, indicating moderately impaired cognition. On 12/2/24 at 10:50 AM, a resident who wished to remain anonymous was interviewed. The resident explained when they pushed their call light the other night, a CNA came into their room and told them they had put their call light on during meal pass two days in a row and told them not to put it on again during meal pass. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 2:43 PM, the Administrator, Administrator in Training (AIT) and DON were interviewed and told of residents' complaints of staff not treating them with respect and dignity. The AIT explained they expected all residents to be treated with respect and dignity. Review of a facility policy titled, Dignity dated 9/21/23 read in part, .Residents will be treated with dignity and respect at all times . Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures . Demeaning practices and standards of care that compromise dignity are prohibited .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 22960 Based on observation, interview, and record review, the facility failed to maintain comfortable ambient air temperatures in multiple resident rooms (Rooms 100, 101, 103, 105, 107, 111, 201, 203, 205, and 207). Findings include: On 12/2/24 between 12:34 PM-1:05 PM, the following resident room air temperatures were measured with Maintenance Director V: 100- 69 degrees Fahrenheit there was a pillow observed over the window to block the draft. 101- 65 degrees Fahrenheit the Resident in the room was observed sitting in a wheelchair, wrapped up in a blanket, wearing a winter hat and stated she was cold. 103- 60 degrees Fahrenheit 105- 64 degrees Fahrenheit 107- 65 degrees Fahrenheit 111- 62 degrees Fahrenheit (vacant room) 201- 68 degrees Fahrenheit 203- 66 degrees Fahrenheit (vacant room) 205- 68 degrees Fahrenheit 207- 69 degrees Fahrenheit On 12/2/24 at 1:25 PM, the room air temperature monitoring logs were requested from Maintenance Director V. Maintenance Director V stated that room temperatures are monitored, but that he does not record them. Review of the facility's policy Recommendations to Health Facilities for Handling Heat and Humidity in Summer Months, issued 11/22/2010 noted: Section 483.15 (4)(6), Quality of Life, has a requirement to maintain comfortable and safe temperature levels. This section also states that facilities initially certified after October 1, 1990, must maintain a temperature level of 71-81 degrees Fahrenheit.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on interview and record review, the facility failed to ensure a referral was made for a level II evaluation (a comprehensive evaluation completed by the local community mental health agency) in a timely manner for one (R24) of two residents reviewed for PASARR (Preadmission Screening/Annual Resident Review) screenings. Findings include: On 12/2/24 at 4:01 PM, a review of R24's clinical record revealed R24 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: paranoid schizophrenia, vascular dementia, schizoaffective disorder bipolar type, and major depressive disorder. A review of a Minimum Data Set (MDS) assessment revealed R24 had severely impaired cognition. A review of a PASARR Level I Screening form (DCH-3877) signed and dated on 4/19/24 revealed R24 had diagnoses of mental illness and dementia, indicated by marking 'Yes' in sections 1 and 2. The instructions on the form included If any answers to items 1-6 section II is 'Yes, send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested . Further review of R24's clinical record revealed no evidence of a Level II evaluation or a DCH-3878 form for an exemption request. On 12/3/24 at 12:42 PM, an interview was conducted with the Director of Social Work (Social Worker - SW 'O'). When queried about the Level II evaluation for R24, SW 'O' reported they would look for it. On 12/4/24 at approximately 3:00 PM, a follow up interview was conducted with SW 'O'. SW 'O' reported a 3878-exemption form was not completed until 12/3/24. A review of a facility policy titled, PASARR, revised on 7/15/20, revealed, in part, the following: Pre-admission Screening/Annual Resident Review (PASARR) in Michigan is a two-level screening and evaluation process. The purpose of the PASARR process is to encourage community care by supporting the placement of individuals with Mental Illness (MI) or those with Intellectual Disabilities (ID) in a nursing facility only when their medical needs clearly indicate that they require the level of care provided by a nursing facility. For individuals with mental illness or intellectual disabilities, the PASARR process ensures the appropriate determination of the need for nursing facility services and the need for specialized services. The PASARR process must be completed: PRIOR to admission to a nursing facility; After a significant change in the resident ' s physical or medical condition; and Not less than annually .A Level I screening is considered completed when the DCH 3877 has been filled out, signed, distributed or, if exemption criteria are met, both the DCH 3877 and DCH 3878 have been filled out, signed and distributed. For a screening or evaluation to be correct, the completed form must contain information consistent with documentation in the resident ' s nursing facility medical record .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation has three (3) deficient practice statements (DPS). DPS #1 Based on observation, interview and record review the facility failed to timely identify and assess a facial bruise for one (R36) of four residents reviewed for falls. Findings include: On 12/2/24 at approximately 8:59 AM, R36 was observed lying in bed. The resident had a brownish bruise below their left eye. Behind the resident's bed was a document that noted the resident was a two person assist for bed transfers. When asked about the bruise around their eye, the resident thought they fell but could not specify the date, time, where and how the fall occurred. A review of the resident's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: left femur fracture, malnutrition and COPD (chronic obstructive pulmonary disease). A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status score of 4/15 (severely impaired cognition). 10/28/24: Note Text: At the beginning of the shift noted bruising to her left orbital eye with multiple stages of healing. Resident unable to stated <sic> what happened. No other bruise noted. Notified shift supervisor. (Authored by Nurse CC). The facility was asked to provide all IA (investigation/Accident) reports pertaining to R36. Only one IA was provided and documented, in part, the following: Un-witnessed Fall .date: 10/20/24) .Nurse walked into room after patient care to patient on the floor screaming help .resident description: I rolled out of bed and hit my head .no injuries observed at the time of incident . *No additional IAs were provided. A Skin-Total Body Eval dated 10/22/24 was reviewed and documented, in part, the following: .Skin color . Normal. Does the resident have any skin abnormalities .Yes .Left hip .Groin .Slight redness to buttocks and both heels . *There was no indication of bruising to any part of the resident's face. On 12/4/24 at approximately 2:53 PM, Nurse CC' was interviewed over the phone. Nurse CC was asked about the note created on 10/28/24 that addressed a bruise on R36's left eye. Nurse CC' reported that when they worked on 10/28/24 they were assigned to R36. When they entered their room, they noticed that the resident had a large bruise around their entire left eye. They did not see any notes in the resident's record that addressed the bruise, and the resident was not able to report what happened. When they did not see any information in the record, they believe they let their supervisor and/or the Director of Nursing (DON)/Administrator in Training (AIT) A know as it was an injury of unknown origin. They were then told it may have come from the fall on 10/20/24 and therefore there was no need to complete an I/A report. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at approximately 3:00 PM, an interview was conducted with AIT A. The Administrator was also present during the interview. AIT A was asked whether the facility considered the bruise an injury of unknown origin as it was identified on 10/28/24 and there was no indication that it came from the resident's fall on 10/20/24 (eight days earlier). AIT A reported that while there was no documentation as to the bruising before 10/28/24 they felt the bruising did occur during the fall, but that staff failed to document anything until Nurse CC' reported it on 10/28/24. When asked about the skin assessment that was completed on 10/22/24 that did not address any bruising, AIT A noted that it they believed the bruising stemmed from the fall on 10/20/24. The facility provided a document titled, Color stages of a Bruise that showed pictures of what a bruise would look like after a certain amount of time. It noted that within 24 hours of an injury one would see bruising as red, after one to two days, one would see skin looking a deep purple color and the next 5-10 there after one would see purple and yellow colored skin. *As noted above there was a skin assessment completed on 10/22/24, two days following the fall that did not note a change in skin color. 32568 DPS #2 Based on observation, interview, and record review, the facility failed to ensure medications were administered on time and according to physician's orders for two (R87 and R287) of three residents reviewed for medications. Findings include: On 12/2/24 at 10:24 AM, R87 was heard from the hallway yelling out Ow ow ow ow. When interviewed R87 said she had pain in her hip and did not receive her morning medications yet. When queried about when she was supposed to get her morning medications, R87 stated, They come at all different times. It is not consistent. When queried about how she alerted staff when she needed something, R87 did not appear to know how to use the call light. R87 was observed at 10:28 AM and 10:36 AM yelling out for the Certified Nursing Assistant (CNA) by name, who was not present in the hallway at the time and saying, Ow ow ow. On 12/2/24 at 10:30 AM, a review of R87's Physician's Orders and Medication Administration Record (MAR) for December 2024 revealed the following medications were scheduled for 9:00 AM and had not yet been administered (as evidenced by no electronic signature from the nurse): 1. Polyethylene Glycol for constipation 2. Insulin Glargine for diabetes 3. Sertraline for depression 4. Docusate Sodium for constipation (ordered for two times a day, at 9:00 AM and 9:00 PM) 5. Gabapentin for pain (ordered for two times a day, at 9:00 AM and 9:00 PM) 6. Levetiracetam for seizures (ordered for two times a day at 9:00 AM and 9:00 PM) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Baclofen for muscle spasticity (ordered three times a day at 9:00 AM, 2:00 PM, and 9:00 PM) A review of R87's MAR at 11:00 AM revealed the above medications had not been administered. At approximately 11:30 AM, the MAR indicated the above medications were administered, two and a half hours after they were due. A review of R87's clinical record revealed R87 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: hemiplegia and hemiparesis left non-dominant side, osteoarthritis, lymphedema, type 2 diabetes mellitus with diabetic neuropathy, anxiety disorder, seizures, and osteoarthritis. A review of a Minimum Data Set (MDS) assessment dated [DATE], revealed R87 had moderately impaired cognition. On 12/2/24 at 12:28 PM, an interview was conducted with R87's assigned nurse, Registered Nurse (RN) 'R'. When queried about when medications due at 9:00 AM were to be administered, RN 'R' reported they could be given one hour before or one hour after (the scheduled time of 9:00 AM). When queried about whether R87 received their medications within the required time frame, RN 'R' reported they were behind schedule and confirmed they were administered somewhere between 11:00 AM and 11:30 AM. When asked why, RN 'R' reported things came up such as looking for supplies, having to redo another resident's treatment, and talking to family. On 12/3/24 at 9:00 AM, further review of R87's clinical record revealed no progress notes written by RN 'R' on 12/2/24 that indicated their 9:00 AM medications were administered late or that a physician was contacted. R287 On 12/2/24 at 10:53 AM, an interview was conducted with R287. They said they weren't feeling well and were having pain in their chest at their surgical site. They were asked if they requested any pain medication and said they requested their pain medication around 10:00 AM but hadn't received it. At that time, a review of their medication administration record (MAR) was conducted and revealed an order for oxycodone 2.5 milligrams every four hours as needed. The last documented administration on the MAR was 12/1/24 at 10:55 PM. They were then asked if they received their regular scheduled morning medications and said they had not, but they were going to call the nurse for them. On 12/2/24 at approximately 11:45 AM, a second review of R287's MAR was conducted and revealed they had administered their 9:00 AM medications and their as needed oxycodone at 11:31 AM, an hour and a half after they had been requested. On 12/4/24 at 8:45 AM, an interview was conducted with the former Director of Nursing (DON) who was currently an Administrator in Training (AIT) in the presence of the new DON. The AIT reported there was a one-hour window before and after a scheduled medication time to administer the medication. If a medication was going to be passed later than one hour after the scheduled time, a physician was contacted for instructions. A review of a facility policy titled, Medication Administration, dated 8/7/23, revealed, in part, the following, . Medications are administered in accordance with the following rights of medication administration .Right time . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	34208 R288 Based on observation, interview, and record review, the facility failed to ensure a physician's order for wound care for one resident, (R288) of one resident reviewed for wound care. Findings include: On 12/3/24 at 9:31 AM, R288 was observed in their room in a geri-chair. They were observed to have, an undated bulky dressing wrapped around their right elbow and forearm. They were asked about the dressing, however; they were not able to communicate any information about it. On 12/3/24 at 10:21 AM, a review of R288's orders was conducted and did not reveal an order for a dressing the right arm. A review of the most recent skin assessment dated [DATE] documented no evidence of a wound requiring a dressing the R288's right arm. R288's progress notes were also reviewed and revealed no indication for the dressing to the right arm. On 12/3/24 at 11:46 AM, an interview was conducted with Nurse 'Z', R288's assigned nurse. They were asked if R288 had an order for a dressing to their right arm and said they thought there was one because R288 frequently picked at their skin. They were then asked if they applied the undated bulky dressing to R288's arm on their shift and said they did not, it must have been done on the previous shift. On 12/4/24 at 9:07 AM, an interview was conducted with the former Director of Nursing (DON) who was currently an Administrator in Training (AIT) in the presence of the new DON. The AIT reported there should be a physician's order for a dressing and dressings should be dated when they were applied. A review of a facility provided policy titled, Skin and Wound-Treatment Education dated 2/2024 was conducted and read, Treatments are ordered by the medical practitioner .Dressings should be initialed and dated by the licensed nurse when completed .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review the facility failed to prevent a facility acquired pressure ulcer for one (R59) out of four residents reviewed for pressure ulcers, resulting in the development of an unstageable pressure ulcer (full thickness skin and tissue loss with obscured wound bed) to the left heel and sepsis infection from tight fitting shoes. Findings include: On 12/2/24 at approximately 8:55 AM, R59 was observed lying in bed. The resident was alert but confused and not able to answer questions asked. The resident was not wearing shoes and had yellow skid socks on. A review of R59's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Dementia, type II diabetes and atrial fibrillation. A review of the resident Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 1/15 (severely cognitively impaired). Continued review of the MDS (7/5/24) noted the resident had no physical and/or verbal behaviors directed towards others. Continued review of R59's clinical record revealed, in part, the following: Care Plan: Focus: Risk for Pressure Ulcer Formation related to generalized debility and weakness as evidenced by decreased mobility in bed and wheelchair .Resident need staff assistance with incontinence care, turning and repositioning, Braden score <17 .10/4/23-no pressure ulcers noted .7/8/24 - no pressure ulcer noted .9/3/24: LEFT HEEL UNSTAGEABLE PRESSURE ULCER .Date initiated: 10/2/22 .Interventions: Encourage resident to float heels and/or wear heel boots (10/2/22) . Skin and Wound Evaluation (date 8/19/24- lock date: 8/29/24): .Describe: Type: Pressure .Stage: Unstageable (obscured full-thickness skin and tissue loss) .Location: Left medial calf .acquired: In house Acquired .Wound measurements .length 2.6 cm .width 1.0 cm .Notes on pain: Patient complained of pain during dressing change .Goal of care: Slow to heal .Education: Patient educated on the importance of not wearing shoes while in bed, or that they are too tight, as the wound was caused by her shoe . 8/17/24: Note Test: assisted cna (certified nursing assistant) with changing the patient and notice a swollen ankle and bleeding heel. Pt (patient) refused to let me examine further but did say she would allow an x-ray. The patient states it hurts, I can't stand, and the pain started yesterday. 8/19/24: Physician Team: R59 .has history of significant Alzheimer's dementia, atrial fibrillation .and diabetes mellitus .is seen today for left ankle pain and bleeding .she apparently keeps her shoes on while in bed and that is rubbing against her left Achilles area and left heel she started having a wound with intermittent bleeding and swelling of the left heel .she has refused to allow staff to dress her left heel and ankle . Impression and plan: Left ankle wound likely from her shoes that she refuses to remove while lying in bed, we will have patient seen by wound care services, she appears that she has secondary cellulitis she will be started on Augmentin (antibiotic) every 8 hours for 5 days, apply TAO (triple antibiotic ointment) and wrap with Kerlix and removed shoe when she is in bed keep he <sic>is floated while in bed (continued on next page)

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Woodward Hills Health and Rehabilitation Ctr	39312 Woodward Bloomfield Hills, MI 48304

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	8/19/24: Nursing Skin/Wound Note: Late Entry: Wound care consulted for left ankle wound. Wound care able to remove shoes from residents' feet. Observed by wound care left ankle and top of foot is swollen, left Achilles has an area of eschar tender to touch. Area has some moisture damage from edema. Resident being treated for cellulitis. Will apply adaptic <sic> with dry dressing. Wound care to follow. No shoes. Supplied grip socks for resident to wear. Will encourage elevation of heels while in bed . 8/31/24: Wound Rounds: Patient (R59) .is being seen for the management of a wound that she has acquired on the left heel close to the Achilles. It is trauma induced, as she was wearing tight shoe and refusing to take it off .has history of advanced Alzheimer's type dementia The examination was focused on left foot . During the record review that included facility staff notes, care plans, Task/Kardex interventions there were no documents as to the resident either wearing shoes in bed prior to 8/19/24, refusing to take off their shoes, or attempts to remove the resident's shoes while in bed. On 12/4/24 at approximately 9:30 AM, an interview was conducted with Wound Nurse Coordinator P and Nurse Q who reported they were working with Nurse P. Both were asked as to the protocol for preventing and treating wounds. Wound Nurse P reported that they do not work with residents until they receive a report of a concern with skin. When asked about R59, Nurse P reported that they received information about R59 on 8/19/24 and noted it was the first time they had seen the resident. When asked about the facility acquired wound on R59's heel, they noted that they believed the root cause was due to R59 refusing to remove their shoes that were too tight. However, they indicated again that they had never seen the resident for wound care prior to 8/19/24. On 12/4/24 at approximately 9:41AM, an interview was conducted with both the Director of Nursing (DON) and Former DON/Administrator in Training (AIT)A. Both were asked about R59's facility acquired unstageable wound to the left heel. AIT A reported that it was determined the wound stemmed from the resident's shoe and their refusal to have staff remove them while lying in bed. AIT A was asked to provide any documentation that attempts were made to remove the resident's shoe(s) and their refusal to have it removed. In addition, AIT A was asked to provide any interventions initiated regarding shoe removal. On 12/4/24 at approximately 10:01 AM, R59 was observed attempting to get out of their bed. The resident had yellow gripper socks on, was alert, non-combative, but confused as to where they were and where they wanted to go. Their call light was out of reach. CNA S was asked to come assist the resident who appeared confused. CNA S reported they had worked at the facility for over [AGE] years and was familiar with the resident. When asked if they were aware that R59 refused to have her shoes removed during care. CNA S noted that they did not recall that the resident refused. On 12/4/24 at approximately 11:16 AM, an interview was conducted with Medical Director (MD) U. MD U was asked about R59's facility acquired unstageable wound to the left heel and noted that he saw the resident right after the wound was found and noted that they remember removing the resident's shoe to view the wound. MD U was not certain as to interventions that were tried prior to discovering the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Prior to the end of the Survey, the facility provided documentation regarding R59's wound however, the documentation provided did not contain any evidence that attempts were made to remove the resident's shoes while in bed and/or documentation that the resident refused prior to 8/19/24. There was also no documentation as to whether the resident feet were floated and/or heel boots were provided as noted in the resident's care plan.(10/2/22).

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F 0689 Level of Harm - 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** 32568 This citation pertains to Intake Number(s): MI00148148 and MI00147901 Based on observation, interview, and record review, the facility failed to transfer a resident in a safe manner, provide adequate supervision, and implement effective interventions to prevent falls for three (R7, R129, R59) of four residents reviewed for accidents, resulting in R7 falling and sustaining a right oblique humerus fracture (broken at an angle) and right fifth digit (finger) fracture which caused a decline with additional assistance needed (substantial to dependent). Findings include: R7 On 12/2/24 at 9:50 AM, R7 was observed seated in a wheelchair in their room. At that time, an interview was conducted with R7 regarding the care in the facility. R7 reported they fell multiple times due to not being able to stand like they used to. R7 reported the worst fall was several months ago and occurred when a Certified Nursing Assistant (CNA) did not assist them to get back into the bed after using the bathroom. R7 reported when they asked the CNA to help get back in bed, the CNA told R7, You can do it yourself. It's only 2 or 3 steps. According to R7, their legs gave out and they fell to the floor and broke the big bone in my arm and some fingers. R7 stated, My arm still bothers me sometimes. A review of R7's progress notes revealed the following: On 2/26/24, it was documented in a Physician Team - Progress Note that R7 had cough, congestion, body aches, hypoxia (low oxygen levels) with fatigue. On 2/27/24 at 10:42 PM, it was documented in a Nursing-Progress Note that the on-call doctor ordered a complete x-ray for the right arm. It was documented Writer and care team placed resident back in wheelchair then placed in bed and R7 had small bruising on right arm. On 2/28/24 at 7:36 AM, it was documented in a Nursing-Progress Note that it was one day status post a witnessed fall and R7 complained of pain to the right arm. It was documented an x-ray was pending. On 2/28/24 at 1:13 PM, it was documented in a Physician Team-Progress Note that R7 was seen for follow-up after a witnessed fall the previous night while being assisted from a transfer into bed from the wheelchair. It was documented R7's legs became weak and they landed on the floor. R7 had pain in her right arm, an x-ray was ordered, and they were unable to move their arm due to pain. On 2/28/24 at 7:27 PM, it was documented in a Nursing-Progress Note that R7 was transferred to the hospital due to an oblique fracture involving the humeral neck. On 3/2/24, it was documented in a Nursing-Admission Note that R7 was readmitted into the facility from the hospital with acute pain/fx (fracture) to right arm from recent fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/4/24, it was documented in a Physician Team - H&P (History and Physical) that R7 returned from the hospital with a right proximal humerus fracture. R7's arm was placed in a sling and due to pain in their right hand, an x-ray was done at the hospital which revealed a nondisplaced fracture of the base of the proximal base of the right fifth digit and was placed in a special brace and non-weightbearing in the right upper extremity. On 12/3/24 at 10:28 AM, the Administrator and Director of Nursing were asked to provide all incident reports with any associated investigation documentation since February 2024 for R7. A review of an incident report for R7 dated 2/27/24 at 9:25 PM revealed R7 had a witnessed fall on that date. It was documented by the nurse that upon entrance to R7's room, R7 was on the floor sitting on her bottom with (CNA) standing right behide <sic> resident .Resident states that her legs became weak and could no longer complete the stand pivot to bed. It was documented an x-ray to the right arm was ordered. In the section labeled statements, no name was included. R7's pain level was noted as seven out of 10 with 10 being the highest level of pain. There were no additional documents that indicated the incident was investigated to determine the root cause of the fall. A review of R7's clinical record revealed R7 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: hemiplegia and hemiparesis right dominant side and osteoarthritis. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R7 had moderately impaired cognition and required substantial/maximum assistance for bed mobility, transfers, including toilet transfers, and partial/moderate assistance to walk 10 feet. R7 did not have any falls within the assessment period. R7 was assessed to have occasional mild pain. A review of a significant change MDS dated [DATE] (after R7's fall resulting in a fracture) revealed R7 had severely impaired cognition and was dependent on staff for bed mobility and transfers and was unable to walk. Further review of R7's incident reports revealed on 6/11/24 at 7:50 AM, R7 fell during a staff assisted transfer from the bed to the wheelchair. It was documented R7 was unable to continue standing and was assisted to the floor by staff. The staff member involved was not included in the information provided. In the notes section, the following was documented, IDT (Interdisciplinary Team) reviewed fall .Care Plan was updated to reflect educating staff on the use of gait belt when transferring resident . On 12/4/24 at 9:01 AM, an interview was conducted with the former Director of Nursing (DON), Administrator in Training (AIT) 'A'. When queried about what was done to investigate the root cause of R7's fall that occurred during the CNA assisted transfers on 2/27/28 and 6/11/24, AIT 'A' reported education was provided to the CNAs and he will provide it. At that time, the name of the CNAs involved were requested and AIT 'A' reported he would get that information. A review of R7's care plans revealed the following: A care plan initiated on 5/31/23 revealed R7 had ADL and mobility deficits R/T (related to) ongoing health events, minimal right sided weakness. An intervention initiated on 11/14/23, indicated R7 required 2 person assist for bed mobility and toileting. It was documented that R7 required 2 person assist for transfers at the time of the falls on 2/27/24 and 6/11/24. According to the care plan, as of 5/31/24, R7 required 2 person assist with a sit to stand lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/4/24 at 12:05 PM, an interview was conducted with CNA DD'. CNA 'DD' was able to recall the incident with R7 on 2/27/24. When queried about what happened, CNA 'DD' reported she was getting her in the bed using a gait belt after taking her to the toilet and R7 was unable to stand and pivot and her legs gave out and CNA 'DD' was unable to hold her up and she fell and sustained an injury. At the time of the fall, CNA 'DD' was the only CNA providing assistance. When queried about any education that was provided to CNA 'DD' after the incident, CNA 'DD' reported she talked to the DON (AIT 'A') and R7 was changed to use a sit to stand lift. The facility provided a document titled, Employee Counseling & Corrective Action Record dated 6/19/24 for CNA 'EE'. The document noted CNA 'EE' did not follow the resident's (R7's) plan of care for transfers (two person assist). No further information was provided for the incident with R7 that occurred on 2/27/24. On 12/4/24 at 1:31 PM, a follow up interview was conducted with the DON and AIT 'A'. AIT 'A' reported additional information was unable to be located and acknowledged R7 was not assisted by two people on 2/27/24 and 6/11/24 according to their plan of care. 34208 R129 On 12/2/24 at 12:00 PM and 2:00 PM, R129 was observed seated in their wheelchair in the common area near the 100 unit. Dycem (a non-slip, rubber-like material used to stabilize surfaces and improve grip) could not be observed in the seat of the wheelchair. On 12/3/24 at approximately 10:00 AM, R129 was observed sleeping in their bed. Their wheelchair was at the bedside and there was no Dycem on top of the wheelchair cushion. The top of the wheelchair cushion was observed to be slightly shiny and had a slippery texture. On 12/3/24 Nurse 'AA' and Certified Nurse Aide (CAN) 'X' were asked if R129 could stand with assist and said they could. They were asked if they could assist them to stand so an observation of the wheelchair cushion could be made. Nurse 'AA' and CAN 'X' assisted R129 to stand and no Dycem to the top of the wheelchair cushion was observed. They did say Dycem was under the cushion to prevent the cushion from sliding out of the wheelchair. They were asked what was in place to prevent R129 from sliding off the top of the slippery cushion and they said Dycem should probably be on the top of the cushion as well. A review of R129's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: dementia and repeated falls. R129's most recent Minimum Data Set assessment revealed they had severe cognitive impairment. A review of R129's progress notes revealed they sustained a fall on 11/12/24. A note dated 11/12/24 at 6:35 PM read, .writer waked by room and observed staff in room with resident sitting at the edge of the bed. writer <sic> asked staff what happened. staff <sic> member informed resident was found sitting on the ground . No incident report or investigation into the fall was provided by the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Continued review of R129's progress notes revealed a note dated 11/13/24 that indicated R129 had an unwitnessed fall in the bathroom. An incident/accident report was provided, and indicated R129 was ambulatory without assistance Predisposing factors to the fall listed on the report included: poor lighting, confusion, incontinence, impaired memory, weakness, improper footwear, and ambulating without assistance. A new care plan intervention after the fall on 11/13/24 was to apply dycem to R129's wheelchair. A progress note dated 11/22/24 was reviewed and read, Pt. (patient) was leaning too far forward and slid out of wheelchair onto his buttocks . A follow-up progress note dated 11/23/24 read, IDT (interdisciplinary team) team reviewed. Care plan updated to reflect the use of dycem in the wheelchair to prevent sliding . It was noted this was not a new intervention as it had been added on 11/13/24. It was unclear from the investigation whether R129 had dycem in the wheelchair at the time of the fall on 11/22/24 as suggested by the care plan intervention on 11/13/24. On 12/4/24 at 8:45 AM, an interview was conducted with the former Director of Nursing (DON) who was currently an Administrator in Training (AIT) in the presence of the new DON. They explained that when a fall occurs, staff should implement new and appropriate interventions. A review of a facility provided policy titled, Fall Management Workflow dated 12/2023 was conducted and read, .Post-Fall Evaluation: .Attempt to determine the root cause of the event and initiate modifications to the resident's care plan as indicated. Complete an incident report in risk management . 34275 R59 On 12/2/24 at approximately 8:55 AM, R59 was observed lying in bed. The resident was alert but confused and not able to answer questions asked. On 12/4/24 at approximately 10:01 AM, R59 was observed attempting to get out of their bed. The resident had yellow gripper socks on, was alert, non-combative, but confused as to where they were and where they wanted to go. Their call light was out of reach. CAN S was asked to come assist the resident who appeared confused and was trying to get out of bed on their own. A review of R59's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Dementia, type II diabetes and atrial fibrillation. A review of the resident Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 1/15 (severely cognitively impaired). Continued review of R59's clinical record revealed, in part, the following: 5/28/24: Note Text: Resident observed on floor sitting on buttocks holding on to wheelchair . 10/8/24: Note: Resident found sitting on floor . 10/26/24: Note: Pt (Patient) usually stands up on her own to transfer, when attempting to transfer patient fell on the floor . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	12/1/24: Note: resident in wheelchair asking for help with her bed, writer told the resident ok, head back to your room and I will assist you. When going to assist the resident, observed resident in room [ROOM NUMBER]P (not the resident's assigned room) trying to transfer herself to the bed when the resident lost balance and fell on her buttock . 12/2/24: IDT (interdisciplinary team): IDT team reviewed fall .Care plan was updated to reflect Staff was educated on the importance of taking the resident back to her room and assisting her into the bed . Review of R59's care plan revealed, in part, Focus: Resident is at Risk for Falls and Potential for Injury r/t (due to): Gait/balance problems; confusion with Dementia .use of psychoactive and/or narcotic medications(s) .date initiated 10/2/22 .Interventions/Task .fall intervention per facility protocol (10/2/22) .Staff is to do frequent rounding on resident (5/31/24) .staff was educated on the importance of taking the resident back to her room and assisting her into bed (12/2/24) . On 12/4/24 at approximately 2:00 PM an interview was conducted with AIT A. AIT A was queried as to the interventions put into place to prevent falls for R59 who had a history of falls and was noted as having severe dementia. AIT A reported that they were aware of the resident's inability to follow directions provided and reported that the last fall on 12/2/24 the Nurse was provided education as to assisting resident into their room for assistance into bed. A review of the facility policy titled, Fall Management Workflow (12.13.24) revealed, in part: .To provide a workflow for licensed nurses in conjunction with the Fall Management Guidelines Policy to assist with fall risk .The fall risk evaluation should be completed: upon admission .Quarterly .After a resident falls- to ensure there are no new or changed risk factors for the resident that need to be addressed .with a significant change of condition .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review the facility failed to ensure appropriate orders for peripherally inserted central catheter (PICC) dressing changes and monitoring of dressings for two (R387 and R291) of two residents reviewed for PICC lines. Findings include: R387 On 12/2/24 at 10:32 AM, R387 was observed standing at the sink in their room, an intravenous (IV) pump on a pole was observed. R387 was asked if they were receiving antibiotics. R387 explained they were through a PICC line in their right arm. R387 was asked about the dressing over their PICC line. R387 gingerly took their right arm out of their long-sleeved shirt, pulling the shirt away from the dressing. The dressing appeared to be mostly hanging loose, only attached at the top part, the rest of the clear dressing was not adhered to R387's arm. Review of the clinical record revealed R387 was admitted into the facility on [DATE] with diagnoses that included: cutaneous abscess of right foot, cellulitis of right lower limb and long term (current) use of antibiotics. According to a Brief Interview for Mental Status (BIMS) exam dated 12/1/24, R387 scored 12/15, indicating moderately impaired cognition. Review of physician orders revealed an order dated 12/2/24 that read, Change PICC Line Dressing according to policy right arm . every day shift every Tue, Sun for safety monitoring AND as needed for safety monitoring. Review of discontinued physician orders revealed an order dated 11/27/24 that read, Change Dressing according to policy . every day shift every 7 day(s) for safety monitoring AND as needed for safety monitoring. There was no indication of what dressing was to be changed, where the dressing was, or what type of dressing to use. On 12/4/24 at 8:59 AM, the Administrator in Training (AIT), who was the former Director of Nursing (DON) and current DON were interviewed and asked when a PICC line dressing change should be ordered. The AIT explained an order should be put in when someone is admitted with a PICC line. When informed there had been no order for a PICC line dressing change for R387's PICC line from 11/26/24 until 12/2/24, the AIT had no explanation. The AIT was asked about the order for a dressing change dated 11/27/24 that had no specific information as to what dressing. The AIT explained they had a template that was used when entering orders and there was one for PICC line dressings. When told of the observation of the dressing barely attached and hanging loosely, the AIT explained the dressing should have been changed.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 34208 Based on interview and record review, the facility failed to follow-up for guardianship for one resident (R49) of one resident reviewed for guardianship. Findings include: On 12/4/24 at 11:51 AM, a review of R49's clinical revealed a competency evaluation dated 10/18/24 signed by two physicians indicated R49 was not competent to make complex medical decisions, provide informed consent, or participate in decisions regarding their financial affairs. A progress note dated 10/17/24 entered into the record by Social Work Director 'O' was reviewed and read, . (R49's son) made aware that resident was seen for capacity evaluation and deemed incapable of making medical and financial decisions at this time. (R49's son) understands that a guardian will need to be appointed and states he will go to the court on 10/21 and file for emergency guardianship appointment. SW (Social Work) will cont (continue) to follow up and assist son as needed. On 12/4/24 at 12:19 PM, Social Work Director 'O' was asked to provide any documentation or evidence they had followed up with R49's son for guardianship. No evidence of any additional follow-up after 10/17/24 was provided by the end of the survey. On 12/4/24 at 1:29 PM, the former Director of Nursing (DON) who was currently an Administrator in Training (AIT) was asked about guardianship and said the Social Work Department was responsible to follow-up. A review of a Social Work Job description provided by the facility was reviewed and read, .The Staff Social Worker provides medically related social services to assigned caseload that assist the residents to attain or maintain the highest practical, physical, mental and psychosocial well-being .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to ensure all controlled substances were accounted for and accurately documented for one (82) of four residents reviewed for pain management. Findings include: On 12/2/24 at 12:56 PM, R82 was observed in their room. An interview was conducted with R82 regarding his care in the facility. R82 reported that they often run out of his pain medication, which included oxycontin and oxycodone (Schedule II Controlled Substances - Drugs that have a high potential for abuse and dependence). R82 reported that when they run out, he had to wait up to 14 hours to receive the next dose and in that time, he would experience pain. R82 reported the last time the facility ran out was a few days ago. A review of R82's clinical record revealed R82 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: hemiplegia and hemiparesis, charcot joint (a disease that attacks the bones, joints, and soft tissue in your feet, often occurring in people who have nerve damage in their feet) of the ankle, and Parkinson's Disease. R82 received hospice services from 6/29/24 through 11/13/24. A review of R82's Minimum Data Set (MDS) assessment dated [DATE] revealed R82 had intact cognition, received scheduled and as needed (PRN) pain medication, and experienced moderate pain during the assessment period. A review of R82's Physician's Orders revealed the following active orders: Oxycodone HCl 15 milligrams (mg) every four hours as needed for severe pain (start date 11/12/24) Oxycontin Extended Release (ER) 30 mg twice a day (BID) A review of R82's previous Oxycodone orders revealed the following orders: From 10/21/24 through 11/7/24, R82 was prescribed 15 mg, 0.5 tablet every 12 hours PRN. From 11/7/24 through 11/12/24, R82 was prescribed 15 mg, 0.5 tablet every 4 hours PRN. A review of R82's Controlled Drug/Receipt/Record/Disposition Form (Proof of Use form) for Oxycodone 15 mg take 1 tablet by mouth every 4 hours as needed for severe pain revealed 30 tablets were received by the facility on 11/12/24. According to the form, Every dose must be accounted for and requires charting on the Medication Administration Record. This form was compared with R82's Medication Administration Record (MAR) for November 2024 and the following was revealed: There were no tablets pulled from the supply on 11/12/24 on the form mentioned above. No previous form from the previous supply was provided by the facility. According to the MAR, R82 received PRN doses of Oxycodone (Roxicodone) on 11/12/24 at 5:42 PM and 9:47 PM and on 11/13/24 at 5:26 AM and 1:06 AM. There was no record provided that showed evidence that those doses were available and pulled from the supply to administer to R82. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The first tablet taken from the supply delivered on 11/12/24 was on 11/14/24 at 11:40 AM, in addition to tablets removed at 3:45 PM and 8:00 PM. It was documented on the MAR that R82 received a dose at 4:49 AM, but it was not documented as pulled from the supply. On 11/16/24, it was documented on the MAR that three doses were given. However, only two tablets were pulled from the supply on that date according to the Proof of Use form. On 11/19/24 at 1:00 PM, it was documented on the Proof of Use sheet that one tablet was pulled from the supply. It was not signed out on the MAR that it was administered to R82. There was no documentation that indicated that tablet was wasted. On 11/21/24 at 5:00 AM, a tablet was pulled from the supply but not documented as administered on the MAR. On 11/22/24, three tablets were removed from the supply and only two doses were documented as administered on the MAR. On 11/23/24, It was documented on the MAR that a dose was administered at 4:26 AM, but no tablet was removed from the supply at that time according to the proof of use form. At 10:00 PM, one tablet was removed from the supply but not documented on the MAR as administered. On 11/26/24, five tablets were removed from the supply according to the Proof of Use Form. Three doses were documented on the MAR as administered. On 11/27/24, four tablets were pulled and only three were documented as administered. On 11/29/24, four tablets were pulled and only three were documented as administered. On 11/30/24, it was documented on the Proof of Use form that a tablet was pulled at 2:00 AM, 7:31 AM, and 1:00 PM. According to the MAR, R82 only received a dose at 2:58 AM. There was no documentation to indicate what happened to the other tablets that were pulled from the supply. A review of a Proof of Use form with a dispensed date of 11/30/24 Oxycodone 15 mg every 6 hours PRN (It should be noted that the physician's order transcribed on the MAR was for every 4 hours PRN) revealed no nurse's signature that indicated when the medication was delivered and how many tablets were received. There was no documentation regarding the discrepancy between the physician's order and the order documented on the Proof of Use form. On 12/2/24, five tablets were pulled from the supply according to the documentation on the Proof of Use form, but only three doses were administered according to the documentation on the December 2024 MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/3/24 at 3:53 PM, an interview was conducted with R82's assigned nurse, Licensed Practical Nurse (LPN) 'FF'. When queried about the facility's protocol for administering controlled substances, LPN 'FF' explained if it was a PRN medication and the resident requested the medication, they would check the physician's order, compare the medication in the cart to the order, pull the tablet, document on the Proof of Use Form the date and time the tablet was pulled and update the count, administer the medication to the resident, and document on the MAR that the medication was given. If a resident refused the medication after it was pulled from the supply, they would get a second nurse to witness wasting of the medication and both nurses signed off on the Proof of Use sheet that it was wasted. At that time, a review of R82's Proof of Use form and MAR were reviewed. It was discovered that on 12/3/24 at 12:00 PM (documented as 12/4 in error), LPN 'FF' pulled one tablet from the supply, but did not document on the MAR that it was administered to the resident. A review of R82's Pain Summary for November 2024 and December 2024 revealed on 11/26/24, 11/27/24, 11/28/24, and 11/29/24, R82's experienced pain levels between 8 and 10 at times. Further review of R82's Physician's orders revealed R82 had an order for Oxycodone HCl 15 mg every 6 hours PRN from 6/15/24 until 10/21/24. On 10/21/24 the order was changed to 15 mg 0.5 mg tablet every 12 hours PRN and then changed again on 11/7/24 to 15 mg 0.5 tablet every 4 hours PRN. A review of a Proof of Use form for oxycodone 15 mg every 6 hours PRN, dispensed on 10/17/24 and received by the facility on 10/18/24 revealed the following: On 10/21/24, two tablets were pulled from the supply and none were documented as administered on the MAR under the original order of 1 tablet every 6 hours. A review of the MAR under the new order for 0.5 tablet every 12 hours revealed one dose was administered on that date at 11:03 PM. According to the Proof of Use form, one tablet was pulled at that time, but there is no documentation to indicate what happened to the other half of the tablet (the order as of 10/21/24 was for one half of a 15 mg tablet). Further review of the MAR revealed on 10/22/24, 10/23/24, and 10/24/24, R82 did not receive any oxycodone. However, the Proof of Use form indicated a total of five tablets were pulled from the supply on those dates. There was no documentation that indicated the tablets were wasted. On 10/24/24, the MAR indicated R82 did not receive any doses of oxycodone. According to the Proof of Use sheet, one tablet was pulled at 5:44 AM and half was wasted, a half tablet was pulled twice at 2:20 PM and half of each was wasted. However, the count indicated it went down by 0.5 for each entry, instead of a whole tablet with half wasted. On 10/25/24, two tablets were pulled, two half tablets were wasted, but only one dose was documented as given on the MAR at 12:22 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 8:45 AM, an interview was conducted with the DON and AIT 'A'. When queried about the facility's protocols for administration of controlled substances, AIT 'A' reported the nurse should check the order, verify the count in the supply with what was documented in the controlled substance book, document the medication when it was removed from the supply, change the count, administer the medication, and sign off the medication as administered on the MAR. If a controlled substance was wasted, two nurses had to witness and sign off on the Proof of Use form. At that time, the discrepancies identified with R82's Proof of Use sheets and MARs for the oxycodone was reviewed with AIT 'A' and the concerns were acknowledged. AIT 'A' reported all medications pulled from the controlled substance supply needed to be accounted for on the MAR or by the process for wasting medications. A review of a facility policy titled, Controlled Medications Guidelines, revised 3/20/24, revealed, in part, the following: .Upon pharmacy delivery of a resident's controlled medication .The licensed nurse will review the controlled substances packing slip to validate the controlled medication package and the Controlled Drug Receipt/Record/Disposition Form match the name of resident, prescription number, Drug name, strength, and dosage, and the quantity received .the licensed nurse will print their name, sign, and date the packing slip and return to pharmacy .If discrepancies are noted, the licensed nurse will contact the pharmacy .The licensed nurse will sign the Controlled Drug Receipt/Record/Disposition Form as nurse receiving medication and document the quantity received and date on the form .When the licensed nurse removed the controlled medication from the package, they will document the quantity removed and the quantity left on the Controlled Drug Receipt/Record/Disposition Form .After administration of the controlled medication the licensed nurse will document the administration on the medication administration record .

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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** 34275 Based on interview and record review the facility failed to ensure monthly drug regimen reviews conducted by the consultant pharmacist were reviewed by the medication provider for recommendations to act on for one (R3) out of five residents reviewed for unnecessary medications. Findings include: A review of R3's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: chronic respiratory failure, chronic kidney disease and type II diabetes. A review of R3's drug regimen reviews revealed the Consultant Pharmacist reviewed R3's medication on 7/8/24 and noted irregularities and/or recommendations. A review of R3's clinical record revealed no report that indicated what the identified irregularities or recommendations were. On 12/4/24 at approximately 3:00 PM an interview and record review were conducted with Director of Nursing/Administrator in Training (AIT) A. AIT A reported that all responses to the consulting pharmacist should be located in the resident's clinical record. AIT A was not able to locate the documentation in the resident's electronic record. AIT A noted that they would try to locate the documentation. No recommendation documentation was provided for that date prior to the end of the Survey.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 32568 Based on interview and record review, the facility failed to prevent a significant med error for one (R20) of five residents reviewed for unnecessary medications, resulting in the resident receiving duplicate doses of a diuretic medication (furosemide) on three days. Findings include: A review of a document titled, Consultant Pharmacist Recommendations to Nursing dated 11/14/24 revealed the pharmacist made the following comments and recommendations regarding R20: The resident has duplicate orders on eMAR (Electronic Medication Administration Record) for: .Furosemide 20 mg (milligrams) once a day .Please clarify and discontinue one of the above orders . The document was signed off my the nurse which indicated it was reviewed. A review of R20's eMAR for November 2024 revealed the following: An order for furosemide 20 mg one time a day with a start date of 8/3/24. An order for furosemide 20 mg one time a day with a start date of 11/13/24. Both orders were active at the same time from 11/13/24 until 11/20/24. It was signed off on the MAR that both doses were administered on 11/17/24, 11/18/24, and 11/20/24 at the same time (9:00 AM). A review of R20's progress notes revealed no notes that indicated a physician was contacted when the error was identified. On 12/4/24 at approximately 4:15 PM, an interview was conducted with the Director of Nursing (DON) and former DON (Administrator in Training - AIT 'A') and the Physician's orders and MAR for R20 were reviewed at that time. According to AIT 'A', R20 went out to the hospital and some of the orders did not get discontinued when she was readmitted and new orders were entered. AIT 'A' reported that the nurse should contact the physician if duplicate orders are identified.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation pertains to Intake #MI00148355 Based on observation, interview and record review the facility failed to timely provide follow-up dental services to one (R25) out of two residents reviewed for dental services. Findings include: A complaint was filed with the State Agency (SA) that alleged R25 was not receiving timely dental services. On 12/3/24 at approximately 2:05 PM, R25 was observed sitting in their room. They were alert and able to answer all questions asked. R25 reported that they had been at the hospital for about two weeks and just returned to the facility. When asked about care in the facility, including, dental services, R25 reported they had not seen a dentist in a long time and would like to see one. R25 opened their mouth and noted that they were missing teeth on their lower/bottom area and wear dentures on their top and were eager to get bottom dentures if possible. A review of R25's clinical record was conducted on 12/3/24 at approximately 2:15 PM. The review revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: acute respiratory failure, diabetes type II and hemiplegia. A review of R25's Minimal Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (intact cognition). Attempts to locate dental services in the electronic record were made, however no documentation that R25 had been seen by dental services were found at that time. On 12/3/24 at approximately 2:35 PM, an interview was conducted with Social Worker Director (SW) O. SW O, who was responsible for ensuring ancillary services, including dental, were provided. SW O noted that residents who received long term care services were seen annually and/or as needed. SW O was asked when the last time R25 was seen by a dentist as there was limited documentation in R25's record. SW O reported that R25 refused dental services. SW O was asked to provide any documentation as to R25 received and/or refused dental care services. The following documentation was provided: 10/30/24- Dental Report: Not Seen. Resident was not seen because Resident was out of facility at appointment per staff. 8/21/23: Dental Report: .Comprehensive Oral Eval-New or established patient .extract 2 lower teeth prn (as needed) in preparation for a lower denture .Patient presents for comprehensive exam. Patient has partial dentition, Denture(s) fit well .Follow-up: Recall .X-Rays .full mouth radiographs ordered . *It should be noted that there was no documentation provided that R25 refused any follow-up dental services following the dental care evaluation noted above. 6/15/22: Dental Report: .per staff, refused dental services . (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at approximately 1:27 PM, an interview was conducted with the Director of Nursing/Administrator in Training (AIT) A. When asked about dental services for residents at the facility, the reported residents should be seen annually and when needed. When queried as to why there had been no follow-up within the year following the resident's last appointment on 8/21/23, AIT A reported they were not certain. A review of the facility policy titled, Dental Services (Issue Date 4/30/19) documented, in part: Policy: It is the policy of this facility, in accordance with resident's needs, to assist residents in obtaining routine and emergency dental care .Policy explanation .a. Oral/dental status shall be documented according to assessment findings . A review of the facility's Job Description for Social Services documented, in part, .Provides information about community resources .Assists with .procurement of services .Examples include .dental/denture care .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22960 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen, failed to maintain the microwaves in the Cranbrook and [NAME] pantry in a sanitary manner, and failed to ensure food items were covered while transported through the hallways. This deficient practice had the potential to affect all residents in the facility that consume food. Findings include: On 12/2/24 between 8:40 AM-9:10 AM, during an observation of the kitchen with Dietary Director T, the following items were observed: There was a rolling cart with large portions of missing plastic edging. There was exposed porous particle board, and the surface was no longer smooth and easily cleanable. Dietary Director T confirmed the missing edging, but did not provide an explanation for why the cart was still in use. According to the 2017 FDA Food Code section 4-101.19 Nonfood-Contact Surfaces, NonFOOD-CONTACT SURFACES of EQUIPMENT that are exposed to splash, spillage, or other FOOD soiling or that require frequent cleaning shall be constructed of a CORROSION-RESISTANT, nonabsorbent, and SMOOTH material. The Grind master coffee and hot water dispenser was observed with a heavy build up of coffee grounds and debris on the top surface. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, .(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. In the dish machine room, there were numerous areas of grout missing between floor tiles, and there was standing water observed. Several fruit flies were observed flying about in the dish machine area. When queried about the missing tile grout, Dietary Director T stated that it was on the list for Maintenance to complete. On 12/2/24 at 1:30 PM, Maintenance Director V was queried about the missing tile grout in the kitchen, and stated that he was unaware of the issue. According to the 2017 FDA Food Code section 6-501.11 Repairing, Physical facilities shall be maintained in good repair. On 12/2/24 at approximately 9:15 AM, the Cranbrook pantry and [NAME] pantry microwaves were observed with a heavily rusted finish on the inside top surface. Dietary Director T confirmed the surface was no longer smooth and easily cleanable, and stated the microwaves needed to be replaced. According to the 2017 FDA Food Code section 4-101.19 Nonfood-Contact Surfaces, NonFOOD-CONTACT SURFACES of EQUIPMENT that are exposed to splash, spillage, or other FOOD soiling or that require frequent cleaning shall be constructed of a CORROSION-RESISTANT, nonabsorbent, and SMOOTH material. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/2/24, during the lunch trayline service at approximately 12:15 PM, the fruit cups that were being placed on the trays were observed to be uncovered. When queried about the uncovered fruit cups, Dietary Director T stated that they were being transported in a covered cart. When queried as to how they would be protected from contamination while the trays were being carried in the hallways to the resident rooms, Dietary Director T could not provide an explanation. On 12/2/24 at 12:24 PM, an observation of the lunch tray pass on the [NAME] Unit revealed staff removing lunch trays from the meal cart and walking them down the hallway to each resident's room. The fruit cups were observed to be uncovered during transport from the cart to the rooms. According to the 2017 FDA Food Code section 3-307.11 Miscellaneous Sources of Contamination, FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to implement physician ordered transmission based precautions (TBP) for one (R20) of one resident reviewed for TBP. Findings include: On 12/2/24 at 10:38 AM, Certified Nursing Assistant (CNA) 'GG' was observed to enter R20's room and assist the resident with incontinence care and toileting. There was no signage observed on R20's door and no Personal Protective Equipment (PPE) outside of the room. At approximately 11:30 AM, R20 was observed near the nurse's station talking with another resident and they were later brought down to the dining room. A review of R20's Physician's orders indicated R20 was placed on Contact Precautions (TBP used to prevent spread of illness) for VRE (Vancomycin-resistant Enterococci - strain of bacteria resistant to the antibiotic Vancomycin) with a start date of 11/29/24. Further review of R20's clinical record revealed R20 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Urinary Tract Infection. A review of R20s Minimum Data Set (MDS) assessment dated revealed R20 had severely impaired cognition and was frequently incontinent of urine. On 12/2/24 at 2:18 PM, the Infection Control Preventionist, Registered Nurse (RN) 'BB' was observed to hang signage on R20's door that indicated R20 was on contact precautions and placed PPE including gowns and gloves outside of R20's door. When queried, RN 'BB' reported R20 was supposed to be on contact precautions as of the date in the physician's orders and individuals entering R20's environment and/or providing care should wear a gown and gloves. On 12/3/24, there were multiple observations of Licensed Practical Nurse (LPN) 'FF' telling R20 they were not allowed to leave their room. On 12/4/24 at 8:25 AM, an interview was conducted with the Director of Nursing (DON and former DON (Administrator in Training - AIT 'A'). AIT 'A' reported R20 was supposed to be placed on contact precautions as of the date of the physician's order. When queried about whether R20 was allowed to leave the room, AIT 'A' reported they were keeping her in the room because she is incontinent and refused to wear a brief. If family and resident agree to wearing a brief in order to contain the urine, they she can come out of the room during the isolation period. A review of a facility policy titled, Infection Control - Standard and Transmission-Based Precautions, revised on 3/4/24, revealed, in part, the following: .Contact precautions include .Hand hygiene .Personal protective equipment (PPE): Gloves .Gown .Limit transport and movement of residents outside of the room to medically necessary purposes .If transport is necessary, use precautions to reduce the risk of transmission and contamination of environmental surfaces or equipment .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 34208 Based on interview and record review the facility failed to offer the 2024-2025 seasonal influenza (flu)vaccine to one resident (R49) of five residents reviewed for influenza vaccines. Findings include: On 12/4/24 at 11:39 AM, a review of R49's immunization records in the electronic medical record were reviewed. The last documented entry for the influenza vaccine was documented 9/10/24 and indicated the 2023-2024 seasonal vaccine was not offered because they admitted to the facility after the influenza season. There was no evidence they had been offered the 2024-2025 vaccine at the beginning of the new flu season. On 12/4/24 at 12:24 PM, an interview as conducted with Infection Control Preventionist 'BB'. They acknowledged it had not been offered or administered and they would follow up on it. A review of a facility provided policy titled, Vaccination of Residents Upon admitted d 10/2023 was conducted but did not address offering of the influenza vaccine upon the start of the new flu season, between October 1st and March 31st each year.