STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235589	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Center (the)	26900 Franklin Road Southfield, MI 48034

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review, the facility failed to ensure the comprehensive care plan was revised to reflect non-pharmacological interventions for one resident (R42) of one resident reviewed for psychotropic medications. Findings include: On 11/17/24 the medical record for R42 was reviewed and revealed the following: R42 was initially admitted to the facility on [DATE] and had diagnoses including: major depressive disorder-recurrent. A review of R42's Minimum Data Set (MDS) with an assessment reference date of of 6/11/24 revealed R42 needed assistance from facility staff with most activities of daily living. A Psychiatric provider evaluation dated 10/25/24 revealed the following: ASSESSMENT & PLAN Adjustment insomnia .Plan: Continue with trazodone (medication used for off label purpose of sleep) Pt (patient) reports sleep to be stable on his current dose of trazodone Monitor for sleep impairment and document. Counseled patient on sleep hygiene, relaxation therapy, and stimulus-control therapy Mood disorder due to known physiological condition with depressive features .Plan: HX (history) of Abilify (psychiatric medication) and Zoloft (anti-depressant medication) Continue with Wellbutrin (anti-depressant medication) .Continue to document any changes in mood or behavior. Encourage non-pharmaceutical techniques including increasing sunlight exposure, regular human contact and reducing stimulants. Psych (Psychiatric services) will continue to follow-up. Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety .Plan: noted in pt's (patient's) chart underlying cause of mood d/o (disorder) Continue with support and soft redirection Disposition: Sleep enhancement interventions: maintain regular sleep awake cycle, keeping the nighttime dark and daytime bright and stimulating, avoid awakenings if possible.; Document any symptoms of ANXIETY: i.e. inability to sit still, inability to sleep, excessive worry, extreme focus on self, nail biting, shortness of breath, difficulty in concentrating, fearful, pacing, yelling out, excessive call light use, demanding.; Document any symptoms of DEPRESSION: i.e. excessive crying, refusals to eat, more withdrawn, feelings of despair, decrease in motivation, anger, difficulty in sleeping, mood swings, suicidal thoughts, hopelessness, helplessness, poor self esteem, constant negativity.; RvB (risks vs benefits) of TRAZODONE: Risks include Drowsiness, dizziness, headache, nervousness, fatigue, dry mouth, nausea and blurred vision. Benefits include improved anxiety, mood, sleep, health, and quality of life (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R42's Psychotropic medications revealed the following: Start date: 6/6/24 (Wellbutrin)-buPROPion HBr ER Oral Tablet Extended Release 24 Hour (Bupropion Hydrobromide) Give 300 mg by mouth one time a day for ANTIDEPRESSANTS Start date: 6/6/24-TraZODone HCl Tablet 100 MG Give 1 tablet by mouth at bedtime for insomnia A review of R42's care plans did not reveal any plan of care addressing R42's depression or insomnia including individualized/person centered non-pharmacological interventions for the use of antidepressant medications for depression and insomnia. On 11/18/24 at approximately 2:58 p.m., the care plans for R42 were reviewed with Social Worker G (SW G) . Social Worker G was queried what the plan of care was for R42's identified depression and insomnia. SW G indicated they did have have a plan of care for the insomnia or the depression and reported they would have to add the plan of care and non-pharmacological interventions to the plan of care for R42.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure services met professional standards for two residents (R#'s 13 and 45) of four residents reviewed for professional standards during medication pass. Findings include: On 11/17/24 at 9:38 AM, Nurse 'I' was observed preparing medications for administration to R13. Nurse 'I' prepared multiple medications including Miralax (laxative powder mixed with water). Nurse 'I' proceeded to R13's room to administer the medications. R13 informed Nurse 'I' they did not want the Miralax medication. Nurse 'I' did not administer the medication and disposed of it. On 11/18/24 at 8:49 AM, a reconciliation of medications observed administered to R13 was compared to the medication administration record (MAR). During the reconciliation it was discovered Nurse 'I' signed the Miralax medication off as given, despite R13 having refused the medication. On 11/18/24 at approximately 2:20 PM, an interview was conducted with the Director of Nursing and they said if a resident refused a medication it should be documented as a refusal. A review of a facility provided policy titled, Medication Administration issued 8/2023 was conducted and read, .Resident refusal of medication: Non-controlled medication-Dispose of medication per policy or state specific guidance-Document refusal on MAR . 41415 R45 On 11/17/24 at 10:13 AM, R45 was seen sitting in their wheelchair in their room. When asked if they had any concerns with their care, R45 said one of the newer nurses was administering their insulin late. R45 explained how they had to remind the nurse two times their insulin had to be administered before they went to sleep. R45 further said they were scared they would fall asleep and wouldn't get their insulin. R45 said the nurse eventually administered the medication at around midnight. A review of the medical record revealed R45 was initially admitted to the facility on [DATE], with a readmitted [DATE] with primary diagnosis of type 2 diabetes mellitus with diabetic chronic kidney disease. On 11/18/24 at 12:18 PM, the medication audit for R45 for November 2024 was requested from the Director of Nursing (DON) and the Administrator. Review of the Medication Audit revealed Licensed Practical Nurse (LPN) B administered R45's 11/17/24 insulin glargine 20 units at 4:45 AM on 11/18/24. On 11/18/24 at 3:01 PM, LPN B was interviewed via telephone. When asked about the late insulin administration for R45, LPN B said they believe that night they were busy with another resident with a tracheostomy, but said they administered R45's insulin on time. LPN B further explained they were very busy that night and signed for R45's medications late, but maintained they gave them on time. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Medication Administration dated 8/7/23, documented in part . POLICY OVERVIEW: To safely and accurately prepare and administer medication according to physician order, professional standards of practice, and resident needs . Administer medication . Sign MAR (Medication Administration Record) after administered . On 11/19/24 at 3:02 PM, the DON was interviewed regarding R45's late administration and documentation by LPN B and said the expectation is for the facility nurses to administer the resident's medications per the time set by the physician. The DON further explained the nurses had an hour before or after the scheduled time to administer the resident's medications. The DON acknowledged all nurses should sign for administered medications after the administration.

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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. 34208 Based on observation, interview, and record review, the facility failed to consistently follow physician's orders for notification of abnormal blood glucose levels and obtain additional orders for treatment for one resident, (R46) of one resident reviewed for insulin medication, resulting in the potential for adverse outcomes related to elevated blood glucose levels. Findings include: On 11/17/24 at 11:00 AM, R46 was observed in their bed. At that time, an interview was conducted and they said the facility was not giving them enough insulin to keep their blood glucose levels down. They were asked how high their levels had been running and said as high as 400 and 500. It is noted the recommended blood glucose levels for people with diabetes is 80-130 before meals and less than 180 one-to-two hours after meals. On 11/18/24 at 12:11 PM, a review of R46's physician's orders for insulin coverage was reviewed and indicated that if a blood glucose level over 400 was obtained, the nurse was to contact the physician. A review of R46's blood glucose levels were reviewed and revealed the following: 11/2/24 9:00 PM, 461 documented by Nurse 'R' 11/3/24 1:39 PM, 417 documented by Nurse 'S' 11/6/24 9:45 AM, 555 documented by Nurse 'I' 11/6/24 5:11 PM, 465 documented by Nurse 'I' 11/8/24 10:15 AM, 425 documented by Nurse 'T' 11/8/24 11:57 AM, 493 documented by Nurse 'T' 11/10/24 7:30 AM, 459 documented by Nurse 'U' 11/10/24 10:50 AM, 432 documented by Nurse 'V' 11/12/24 8:36 PM, 455 documented by Nurse 'W' 11/13/24 12:09 AM, 455 documented by Nurse 'W' It was further noted there were 18 additional blood glucose readings greater than 350 but less than 400 between 11/2/24 and 11/13/24. A review of R46's progress notes was conducted and revealed no documented evidence the physician/nurse practitioner had been made aware of the blood glucose levels greater than 400. The record further revealed there were no one time orders or entries on the medication administration record that indicated additional insulin coverage had been ordered or given. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 1:38 PM, an interview was conducted with Nurse 'S'. They were asked if they notified the physician/nurse practitioner of their recorded blood glucose of 417 on 11/3/24. They said they did but didn't remember if the physician ordered any additional insulin coverage. They were then asked if they put a progress note in the record regarding notifying the physician and said they did not remember. On 11/18/24 at 1:59 PM, an interview was conducted with Nurse 'I' regarding their recorded blood glucose level of 555 on 11/16/26. They were asked if they informed the physician/nurse practitioner and said they were training with Nurse 'X' and Nurse 'X' informed the physician. On 11/18/24 at 3:00 PM, an interview was conducted with Nurse 'X'. They were asked if they notified the physician of R46's blood glucose level of 555 on 11/16/24 and said they did not remember. They were asked if they entered a note into the record, and after reviewing the record, Nurse 'X' said they did not enter a note. On 11/19/24 at 10:08 AM, a telephone interview was conducted with Nurse Practitioner (NP) 'K'. They were asked about R46's elevated blood sugars and said they were aware and had been changing the insulin orders. They were asked if they would order additional insulin for elevated values and said they would. They were then asked if nursing staff had been calling them when R46's blood glucose levels were greater than 400 and said sometimes they received a text message from nursing staff. Finally, they were asked about the recorded value of 555 on 11/6/24 and said they remembered and had given an order for additional insulin coverage. At that time, NP 'K' was made aware there was no order in the computer for additional coverage, nor was there an entry on the medication administration record (MAR) to indicate any additional insulin had been given on that date. On 11/19/24 at 11:42 AM, an interview was conducted with the facility's Director of Nursing (DON) regarding R46's blood sugar levels. The DON said they believed staff were notifying the physician and receiving additional orders but were not documenting their contact with the physician/nurse practitioner. They were asked if staff should document notifying the physician and said they should. At that time, they were made aware there were no orders in the computer for any additional insulin coverage for any of the values greater than 400, to include the 555 value; nor did the MAR reflect any additional coverage had ever been given. A review of a facility provided policy titled, Change in Condition Notification issued 8/2023 was conducted and read, It is the policy of the facility to notify the resident, his or her attending physician/practitioner .of changes in the resident's medical/mental condition and/or status .The nurse will document in the resident's medical record information relative to the resident's change in medical/mental condition .

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on interview and record review, the facility failed to ensure physician's notes were entered into the record at each visit and accurately addressed the resident's total program of care for one resident (R69), of one resident reviewed for physician visits. Findings include: On [DATE] at 11:14 AM, a review of R69's closed clinical record revealed they admitted to the facility on [DATE] and expired in the facility on [DATE]. R69's facility physician, Dr. 'J's progress notes were reviewed and revealed the following: A progress note effective [DATE] entered into the record on [DATE] at 8:20 PM. A progress note effective [DATE] entered into the record on [DATE] at 8:21 PM. A progress note effective [DATE] entered into the record on [DATE] at 8:17 PM. A discharge note effective [DATE] entered into the record on [DATE] at 9:56 PM. Continued review of R69's clinical record revealed a nursing progress note dated [DATE] at 12:05 AM that read, .resident on the floor .Pt (patient) does have a lump on the left neck area between ear and jaw. M.D. (medical doctor) notified .Order X Ray <sic> for cervical Spine <sic> .Facial bones and orbits and left jaw . Review of additional notes in R69's record revealed the following: A nursing progress note dated [DATE] at 10:42 AM was reviewed and read, Writer spoke with (Dr. 'J') regarding pt (patient) status and regarding lump on left side of resident face/neck. (Dr. 'J') does not want to send resident out to hospital, will come this afternoon to assess . A nursing progress note dated [DATE] at 12:34 PM that read, (Dr. 'J') came in to assess resident and gave order to transfer resident to hospital for mental status changes. A review of Dr. 'J's progress notes for [DATE], [DATE], and [DATE] was conducted and did not reveal any documentation to reference R69's fall requiring a transfer to the emergency department on [DATE]. Continued review of R69's record revealed a nursing progress note dated [DATE] at 7:22 AM that read, .At approximately 0453 (4:53 AM), writer rounded and noted absent chest rise and fall. Writer checked pulse. No pulse noted, CPR (cardiopulmonary resuscitation) initiated, 911 called, AED (automated external defibrillator) applied. 6 EMT's arrived EMT's completed 30 min of CPR, no pulse regained. Pronounced deceased at 0550 (5:50 AM) by Dr. ('P') . It was noted a Death in Facility Minimum Data Set Assessment had been completed for R69 after their passing. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Dr. 'J's Discharge Summary note for R69 entered into the record on [DATE] (more than 30 days after R69 expired) was conducted and read, .Disposition: DC (discharge) home with home health care . Assessments/Plans: PEG (feeding tube) in place and patent .At risk for decubitus wounds, reposition frequently . It was further noted Dr. 'J' entered findings of a physical exam completed on R69 upon discharge. The note continued to read, Instructions: Prescriptions given for 30 days. Follow-up with PCP (Primary Care Provider) . On [DATE] at 10:29 AM, a telephone interview was conducted with Dr. 'J'. They were asked when they documented their progress notes on residents and said they had 30 days from the visit but liked to do it the same day. They were then asked specifically about their discharge summary that documented a physical exam, follow-up discharge instructions, and the disposition of discharging home with home care when R69 expired in the facility and cited a mistake saying, I go to so many buildings. They further indicated the electronic medical record system, Should not have allowed me to document a note for discharge home with home care when the resident expired in the facility. On [DATE] at 2:30 PM, an interview was conducted with the facility's Administrator regarding Dr. 'J's documentation. The Administrator acknowledged the concern and indicated they would be looking into it. A review of a facility provided policy titled, Physician Services revised ,d+[DATE] was conducted and read, . During the required visits the physician, physician's assistant, or nurse practitioner: Will evaluate the resident's condition and total program of care .Document a progress note regarding their visit .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41415 This citation pertains to intake #MI00147045. Based on observation, interviews, and record review, the facility failed to consistently ensure sufficient nursing staff was provided for residents who resided in the facility, resulting in verbalized complaints of delayed care and services and the likelihood for further delayed care and unmet care needs. This deficient practice had the ability to affect all 66 residents in the facility. Findings include: The survey team entered the facility on Sunday 11/17/24 at 8:30 AM. Rounding was completed on the facility units. Licensed Practical Nurse (LPN) A who was assigned to Unit 1 was interviewed. When asked, LPN A said their unit had two nurses and two certified nursing assistants (CNA) assigned to Unit 1. LPN E who was assigned to Unit 2, reported they were the only nurse assigned to Unit two with 2 CNAs. CNA H who was assigned to Unit 3 was interviewed and said the unit was currently assigned with one nurse, two CNAs, and one CNA in orientation. The facility's census was confirmed to be 66 on entrance. On 11/17/24 at 12:29 PM, an interview was conducted with a resident who wished to remain anonymous. They were observed lying on their back in bed. When asked, they explained the facility was short staffed on the evening and night-shifts. They explained how one nurse is responsible to cover the care for two units at once. They said it was hard to get help from staff at night. They further said their call bells go unanswered and they make calls to the nursing station which also go unanswered. They said sometimes they were able to catch a CNA passing by their door and would ask for the nurse to which the CNA would reply they were unsure of where the nurse was. They said they had consistent delays in receiving their pain medication and care. They said staffing was an ongoing concern. On 11/19/24 at 12:43 PM, Staff CNA M was interviewed via telephone and when asked, said the facility needed to work on the staffing. CNA M further said Unit 1 needed improvements because of the acuity of the resident population. CNA M said staffing affected the care provided to the residents. On 11/19/24 at 2:20 PM, Staff CNA L was interviewed via telephone and when asked, said the facility is short staffed, especially on weekends. CNA L said care is not always provided timely due to the staffing and the care that needs to be provided. Review of staffing data submitted via the PBJ (payroll based journal) system revealed the facility had low weekend staffing for the second quarter of April 2024 to June 2024. Review of the facility assignment sheets and call in records for April 2024 through June 2024 identified multiple shifts with low staffing scheduled including the following: On 4/13/24 six call off were documented. Four from night shift (three CNAs & one Nurse) and Two from day shift (one CNA & one Nurse). The assignments revealed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Night Shift: Unit 1- One nurse & Two CNAs Unit 2- One Nurse & One CNA Unit 3- No nurse noted & One CNA Unit 4- One Nurse & One CNA Day Shift: Unit 1- Two CNAs & One Nurse Unit 2- No Nurse documented & One CNA Unit 3- One Nurse & Two CNAs Unit 4- NONE Review of the facility Census for 4/13/24 documented in part: Unit 1- 29 Residents Unit 2- 13 Residents Unit 3- 24 Residents Unit 4- No residents The facility residents included multiple residents requiring extensive assistance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/19/24 at 11:20 AM, the facility Staffing Coordinator (SO) O was interviewed with the Director of Nursing (DON) in attendance. The DON explained they were involved in the scheduling of the facility's staff and was helping to transition SC O into their role as they were newly hired at the facility. SC O was asked how they determine how many staff to schedule for each shift. SC O said they were trained to have a certain amount of staff for each shift based on the census and PPD (Patient Pay per Day). SC O explained the number of staff is supposed to be under 3.59. The DON then said they trained SC O that they are able to squeeze some stuff on some shift as long as they stayed under the 3.59 PPD. SC O and the DON were then asked if the numbering of the scheduled staff ever change from the 3.59 and the DON replied it would change based off of the facility's census. SC O confirmed they go by the facility's census when scheduling. The DON said the facility is different than their other job which is at a hospital that based their scheduling off of acuity rather than the census. When questioned about the concern of the facility not scheduling their staff based off the acuity of the resident population and basing it off of the census, the DON acknowledged the concern and said they were big on advocating and will start advocating for scheduling staff off the acuity rather the census. SC O and the DON were then asked what methods the facility was currently doing to hire more staff and SC O and DON reported they take referrals, they receive phone calls and have a post on Indeed (hiring website). SC O and the DON were asked to provide the facility current open positions for CNAs and Nurses. On 11/19/24 at 1:40 PM, the DON provided the Current Open Positions. The DON noted the list included the fulfillment of Unit 4 upon opening, but further confirmed all positions are current open positions at the facility. A review of the Current Open Positions revealed the following: Nurses- Two full time PM shift & Four part time (two for AM & two for PM). CNAs- Four full time (three AM & one PM) and Four part time (two for both AM & PM). 38271 On 11/18/24 at approximately 10:40 a.m., during the group meeting, the residents were queried if they had any concerns pertaining to the staffing levels at the facility and replied with the following: A resident who wished to remain anonymous indicated they pressed the button for a nurse and waited 1.5 hours for insulin to be given because the unit was short staffed. They further reported waiting for assistance occurred multiple times during the night and weekend shifts. Additionally they said the facility only had 3 CNA's (Certified Nursing Assistant) for the whole building on night shift the previous week. Another resident who wished to remain anonymous reported they pressed the call light button multiple times on the night-shifts because they needed assistance in the restroom, but nobody came to help, or staff came in and turned the light off but never returned. They further reported staff tell them (the resident) they are short frequently.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review, the facility failed to ensure individualized/person centered non-pharmacological interventions were in place for the use of psychotropic medications for one resident (R42) of five residents reviewed for unnecessary psychotropic medications. Findings include: On 11/17/24 the medical record for R42 was reviewed and revealed the following: R42 was initially admitted to the facility on [DATE] with diagnoses that included: major depressive disorder-recurrent. A review of R42's Minimum Data Set assessment with an assessment reference date of 6/11/24 revealed R42 needed assistance from facility staff with most their activities of daily living. A review of R42's Psychotropic medications revealed the following: Start date: 6/6/24 (Wellbutrin)-buPROPion HBr ER Oral Tablet Extended Release 24 Hour (Bupropion Hydrobromide) Give 300 mg by mouth one time a day for ANTIDEPRESSANTS Start date: 6/6/24-TraZODone HCl Tablet 100 MG Give 1 tablet by mouth at bedtime for insomnia A review of targeted behaviors for both of medications including the Trazodone for insomnia and bupropion for depression revealed the following auto-populated behaviors for targeting: List Medication: . those residents on psychoactive medications, please identify targeted behaviors to be monitored: [0] No Behavior Noted [1] Crying [2] Change in sleep pattern [3] Change in appetite [4] Flat affect [5] Verbal expressing of depression [6] Verbal expression hopelessness/worthlessness [7] S/S anxiety [8] Change in mood Document Adverse Reactions in Progress Notes and notify physician. Further review of the record did not identify any targeted personalized/individualized behaviors for R42's insomnia or depression diagnoses. Review of R42's care plans and physician orders along with their MAR (medication administration record) did not reveal any individualized/person centered non-pharmacological interventions that addressed R42's diagnosis of depression or insomnia to reduce their psychotropic medication usage. Continued review of R42's MAR for September, October and November 2024 revealed R42 had none of the documented auto-populated targeted behaviors with exception of 10/10/24 and 10/28/24. Further review of R42's record did not reveal any attempted gradual dose reductions of their Trazodone or bupropion since their admitted . (continued on next page)

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	235589	A. Building B. Wing	11/19/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at approximately 2:58 p.m., Social Worker G (SW G) was queried what the plan of care was for R42's identified depression and insomnia including their individualized non-pharmacological interventions and attempted gradual dose reductions. SW G was observed reviewing R42's medical record and indicated there was no plan of care addressing the use of the medications, the individual non-pharmacological interventions or reduction of the use of the medications. SW G was queried if they observed any individualized interventions in plan of care for treating their insomnia or the their depression and for potential reduction of the psychotropic medications and they reported there were none and would have to add some the plan of care.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34208 Based on observation, interview and record review, the facility failed to ensure a medication error rate less than five percent when two medication errors of 26 opportunities for error were observed for two residents (R#'s 13 and 2) of four residents reviewed during the medication administration observation, resulting in a 7. 69% medication error rate. Findings include: A review of a facility provided policy titled, Medication Administration issued 8/2023 was conducted and read, POLICY OVERVIEW: To safely and accurately prepare and administer medication according to physician order, professional standards of practice, and resident needs . R13 On 11/17/24 at 9:38 AM, Nurse 'I' was observed preparing medications for administration to R13. Among the medications prepared was Miralax (laxative) granulated powder. Nurse 'I' was observed to use a medication cup for use with liquid medications to measure the powder. An observation of the cup revealed granules measured up to the 15 milliliter line in the cup. At that time, Nurse 'I' was asked how they measured the granule powder and said they order was for 17 grams so they measured to the 17 milliliter line on the cup. On 11/18/24 at 11:35 AM, the facility's Director of Nursing was asked about the proper way to measure the Miralax dose. The DON said the granules were to be measured to the fill line in the top of the cap from the bottle of Miralax. A review of the National Institutes of Health website at: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrug was reviewed and read, .the bottle top is a measuring cap marked to contain 17 grams of powder when filled to the indicated line . It was noted the granules measured to the 17 milliliter line of a medication cup used for liquid medications did not equal the correct amount of powder for the 17 gram administration. 41415 R2 On 11/18/24 at 8:52 AM, Registered Nurse (RN) C was observed preparing the morning medications for R2. Among the medications prepared, RN C was observed to dispense one Vitamin D 10 mcg (microgram) (equivalent to 400 IU- international unit) tablet from a stock bottle, and proceeded to R2's room to administer the medications. After the administration RN C was asked to remove the Vitamin D medication bottle that contained the dose administered and to review the dosage. RN C was also asked to pull R2's Medication Administration Record (MAR) for review. The Vitamin D 10 mcg bottle was compared to the MAR and a discrepancy was identified. The physician order documented in part . Vitamin D tablet . Give 1000 unit (IU) orally one time a day for Vit D deficiency . RN C acknowledged the discrepancy and said they would follow up per the facility's protocol. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 11:39 AM, the Director of Nursing (DON) was interviewed and informed of the observation with RN C and the medication error made with R2's Vitamin D. The DON replied they were made aware of the incident by RN C, and since the observation, they had followed up with the physician. A review of the facility's policy titled Medication Administration dated 8/7/23, documented in part . Medications are administered in accordance with the following rights of medication administration . Right dose .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41415 Based on observation, interview and record review, the facility failed to ensure medications were not stored at the bedside for R67, expired medications were disposed, and insulin pens were properly dated of in one of three medication carts reviewed. Findings include: On 11/17/24 at 9:16 AM, R67 was observed lying in bed on their back. A tube of hemorrhoid cream in a clear pharmacy bag was observed on their night stand. At that time, R67 was asked about the cream and said sometimes staff applied it and sometimes they did not. R67 further indicated they were not able to reach their backside to apply the medication. A review of R67's medical record revealed no assessments for self-administration of the cream. Review of a facility policy titled Medication and Treatment Storage dated 8/7/23, documented in part .All medications and biologicals will be stored in locked compartments .treatments will be stored in medication rooms and in treatment carts . On 11/18/24 at 9:02 AM, an observation of the Unit 3 medication cart was completed with Registered Nurse (RN) C. A round loose pill was found in the bottom of the first drawer. RN C obtained the pill and disposed of it but was unable to verify the medication. Further review of the cart revealed a half empty bottle of Fish oil 500 mg (milligram) with an expiration date of 9/2024 and a half empty bottle of A loratadine 10 mg (allergy medication) with an expiration date of 1/2024. Continued review of the cart revealed a Humalog Kwikpen (insulin) with an open date of 10/14/24, still in use. At that time, RN C was asked about the facility's policy on the use and discarding of insulin pens and RN C stated they would usually follow the pharmacy label. Lastly, it was observed an open Lantus insulin pen with no open date as to when it was placed in the cart. A review of the facility's policy titled Medication and Treatment Storage dated 8/7/23, documented in part . Expired, discontinued or deteriorated drugs or biologicals will be returned or destroyed per pharmacy return/destruction guidelines . A review of a facility's policy titled Medication - Insulin Administration revised 2/12/24, documented in part . Insulin vials and pens should be disposed of after 28 days or according to manufacturer's recommendation after opening . Check the expiration date on the insulin pen. Discard if expired . Review of the Manufacturer's recommendation for insulin pen documented in part, . In-use Pen . Throw away the HUMALOG Pen you are using after 28 days, even if it still has insulin left in it .

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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. 38271 Based on observation, interview, and record review, the facility failed to ensure the kitchen was maintained in a sanitary manner and potentially hazardous food items were properly labeled and stored. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 11/17/24 at approximately 8:54 a.m., during the tour of the kitchen the following was observed: The reach in freezer contained packages of unsealed/undated sausage patties with ice crystals accumulated on them, unsealed and undated chicken breasts with ice crystal formation, and unsealed and undated hot dogs with ice crystals. At the time of the observation, Dietary Manager Q was queried regarding the observed meats and said they would have to be thrown away. Continued observation of the kitchen revealed the dry racks for pans had pans stored on them with water puddled inside of the pans. Dietary Manager Q was queried regarding the wet pans and indicated they should be not stacked until they were dry. A review of a facility provided policy titled, Kitchen Sanitation to Prevent the Spread of Viral Illness dated 2/2023 was conducted and read, The Food service employees of the facility will practice good sanitation practices in accordance with the state and US Food Codes in order to minimize the risk of cross contamination and spread of illness through food .

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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** 34208 Based on observation, interview, and record review the facility failed to ensure appropriate infection control practices related to transmission based precautions (TBP) for five residents (R#'s 39, 48, 2, 51, and 66) of five residents reviewed for transmission based precautions, resulting in the potential for the spread of infection. Findings include: On 11/17/24 at 12:45 PM, a review of rooms marked with signs for enhanced barrier precautions (EBP, a type of transmission based precautions for the use of gown and gloves during high-contact resident care activities for residents at high risk of colonization of multi-drug resistant organisms) was conducted on Unit 3. The following was observed: R39 and R48's rooms had signs that indicated they were on EBP. A review of R39's clinical record revealed an order dated 9/24/24 that indicated they were on EBP related to having an indwelling urinary catheter, however; a progress note dated 11/12/24 revealed R39's catheter had been removed. On 11/18/24 at 8:53 AM, R39 and R48's rooms remained with signs that indicated they were on EBP. R2's room was also observed to have a sign to indicate they were on EBP. A review of R2's clinical record was conducted and did not reveal an order for EBP. On 11/18/24 at 11:31 AM, an interview was conducted with the facility's Director of Nursing regarding the discrepancies between rooms with EBP, orders for EBP and the clinical need for EBP. The DON acknowledged the concerns and said they would look into it. 38271 R51 On 11/19/24 at approximately 10:00 a.m., Nurse A was observed in R51's room repositioning them in the bed without an isolation gown. At that time, R51's room was observed with signage that indicated R51 was on EBP and a gown was required to be worn when direct care was provided. R51's orders revealed an order dated 4/1/24 that read, .Initiate Enhanced Barrier Precautions for Peg tube, and wounds that require dressings 41415 R66 On 11/17/24 at 9:41 AM, R66's room door had signage that read, Contact Precautions The room door was shut and a cart containing personal protective equipment (PPE) supplies was observed to contain one gown, one pair of gloves and a box of surgical masks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the medical record revealed R66 was initially admitted to the facility on [DATE] with a readmitted [DATE] and diagnoses that included: hypercalcemia and malignant neoplasm of rectum. A review of the physician orders revealed no order for the contact precautions to have been initiated. A review of the readmission note dated 11/13/24 at 11:54 PM, documented by the facility's Infection Preventionist (IP) D revealed no documentation of the resident being on contact precautions or the need for the precautions to be implemented. A review of R66's care plans revealed no care plan for contact precautions implemented. On 11/17/24 at 12:15 PM, an attempt was made to enter the room of R66, however the PPE cart contained no gowns. The one gown identified earlier was gone and one pair of gloves remained in the PPE cart. At this time the assigned nurse for R66, Licensed Practical Nurse (LPN) E was asked about gowns not stored in the cart and how to obtain a gown for entry into R66's room. LPN E went down the hall to check the backup supply and said they were unable to find any. LPN E said they would be right back and returned with new pack of isolation gowns. At that time, LPN E was asked why R66 was on contact precautions and LPN E said for C-diff (clostridioides difficile, a contagious gastrointestinal infection). LPN E was asked to review R66's chart and provide the order for contact precautions and the indication for the precautions to be implemented. LPN E reviewed R66's file in the computer and said they were unable to find orders, physician documentation regarding the precautions or any other documentation of a re-admission diagnosis of C-diff. On 11/18/24 at 11:30 AM, an interview was conducted with the Director of Nursing (DON) and also in attendance was a DON from a sister facility covering for the IP Nurse, (Nursing Director- ND F). The DON and ND F were asked about the contact precautions for R66. The DON said they reviewed the hospital discharge summary with the physician and Enhanced Barrier Precautions (EBP) had now been ordered for the resident. The DON explained on R66's initial admission they had been diagnosed with C-diff and so when they were readmitted the staff continued the precautions. The DON was asked about the facility's protocol and who was responsible to review the referrals and hospital discharge records to ensure proper treatment and precautions were in place for the residents admitting to the facility and said the facility had a centralized unit that reviews the referrals, themselves and the IP nurse will also sometimes review the referrals. When asked, the DON said they had not reviewed the referral for R66. The DON was asked how the facility will ensure proper and adequate oversight of the infection control protocols moving forward and said they would follow-up. Review of a facility policy titled Infection Control - Standard and Transmission-Based Precautions revised 3/4/24, documented in part . Residents are isolated only to the degree needed to isolate the infecting organism. The least restrictive method is used while maintaining the integrity of the process . When precautionary measures are initiated, the nurse should notify the resident's attending physician . Infection Preventionist, and DON . An isolation cart should be placed outside of the resident's room to store personal protective equipment (PPE) needed for staff and visitor use . Transmission-based precautions are discontinued when the infection is resolved or ruled out. An infection is resolved when the resident is free from clinical symptoms of infection for 48 hours or criteria specified .