STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235592	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huron Woods Nursing Center	1395 S Huron Rd Kawkawlin, MI 48631

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39059 Based on interview and record review, the facility failed to respond to residents' needs timely and in a dignified manner for an anonymous group of residents, resulting in feelings of having to wait, needing to engage call lights over again to get help and call light complaints going unresolved by management. Findings include: On 11/19/24, at 10:35 AM, During the Resident Council task, the following complaints were voiced regarding staff answering call lights: They turn them off and you have to wait for them to come back My call light was on 20 minutes when they canceled it and then I it was 25 more minutes for them to come back and I had to put my light on again. If they don't come back in 10 minutes after canceling my light, I put it back on. Sometimes, they completely forget about you. They will say, I had another call light to answer first some CNA's are hard on ya; they might complain when I have to get up to go the bathroom with me, I need a Hoyer and they need two people. It's hard sometimes to get that second person. In the meantime, I am waiting with the Hoyer connected Resident Council group was asked what management has done to fix the call light response complaints. Resident council group complained that they were told to put their call light back on if staff doesn't come back in ten minutes. Resident council group also stated that management will often respond to the call light complaints we're working on it. Council members offered that they felt they didn't matter. (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 - Few	On 11/19/2024, at 1:30 PM, Recreation Director D was asked to provide the last 6 months of resident council meeting minutes and Recreation Director D offered, that they had provided the copies to the administrator for uploading. The council meeting minutes were not provided prior to exiting the survey. According to the HCAM Resident rights booklet, . Respect and Dignity You have a right to be treated with respect and dignity, including: . The right to reside and receive services in the facility with reasonable accommodation of your needs and preferences .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 39059 Based on observation, interview and record review, the facility failed to ensure dignified Activities of Daily Living (ADL) care for one resident (Resident #6) of 3 residents reviewed for ADL care, resulting in soiled clothing, bedding and bathroom. Findings include: Resident #6: On 11/18/24, at 1:31 PM, Resident #6's doorway was shut. There was a strong urine/bowel odor noted in the hallway outside the closed door. Upon entry to the room, the odor was noted to stronger. CNA's F entered and was asked if the bedding had been changed recently and CNA's F pulled back the sheets. The mattress was in good clean repair. An observation of the bathroom revealed a large amount of bowel movement on the toilet seat. Resident #6 was not in their room. Resident #6's roommate (husband) entered the room to use the toilet and quickly left back out. CNA's F was asked if the bathroom should be dirty with bowel movement and CNA's F offered, it's usually (Resident #6) and we try to catch (Resident #6) after lunch and that they are ambulatory. On 11/18/24, at 2:30 PM, Resident #6 was ambulating in the hallway. There was an approximate 5 inch wide by 6 inch long area that was dirty with a brown residue on the backside near their bottom. On 11/19/24, at 7:59 AM, Resident #6 was sitting in the dining room for breakfast. Resident #6 had on the same clothes as the day prior. On 11/19/24, at 8:51 AM, Resident #6 was noted wandering into another resident room. They lied down on the bed on their side. Resident #6's shirt was rolled up slightly which revealed a solid brown residue noted that appeared like bowel movement. On 11/19/24, at 12:55 PM, Resident #6 was resting in their own bed with the same clothes on. There was a strong odor to the room. On 11/19/2024, at 1:15 PM, a record review of Resident #6's electronic medical record revealed an admission on 8/03/2022 with diagnoses that included Dementia, need for assistance with personal care and Alzheimer's disease. Resident #6 had severely impaired cognition. On 11/20/24, at 7:53 AM, Resident #6 was sitting in the dining room for breakfast. They had on new clean clothes and appeared to have showered as their hair was wet. On 11/20/24, at 7:54 AM, CNA's G was interviewed regarding the Activities of Daily Living (ADL) care for Resident #6. CNA's G offered at times they are resistant to changing their clothes but if you show Resident #6 the hair dryer and encourage hair care you can get (Resident #6) in the shower. On 11/20/24, at 11:57 AM, Resident #6 was resting in bed with their dirty clothes on. The resident had their shoes on and was under the covers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24, at 12:36 PM, the Director of Nursing (DON) was interviewed regarding the Resident #6 soiled clothing. The DON offered, that the resident can be difficult with ADL care at times. The DON was alerted of the soiled clothing the resident had on for the two days prior and that it appeared like bowel movement. The DON offered, that they did observe their dirty shirt but was unable to tuck it in. The DON was asked if they felt they were doing everything they could to assist Resident #6 with their ADL care and the DON offered, we try and if you offer hair care or have the dryer in your hand, you can usually get her in the shower. The DON offered that they had moved Resident #6's shower days to ensure the same staff to assist. A review of the Task list documentation for completed showers along with the DON revealed no missed recent showers. On 11/20/24, at 3:06 PM, the DON offered that they had Interdisciplinary Team meeting regarding Resident #6 and that they updated the care plan. On 11/21/24, at 9:00 AM, a review of the Focus (Resident #6) has the potential for altered functional mobility and ADL's related to her impaired cognition with a supporting diagnoses of Dementia . Revision on: 06/20/2023 Goal Provide oversight with dressing in clean clothes daily, assist with bathing, nurse to assist with medication set up . Interventions . Able to leave on toilet: Yes Date Initiated: 08/04/2022 ADL's DEFINE INDIVIDUAL PREFERENCES: Chooses her own clothing; prefers medications whole. Wanders throughout the facility and prefers her husband to be with here. Doorway deterrent strap across doorway intermittently as desired, to deter guests until invited. Check and change bedding daily as needed. Date Initiated: 06/20/2023 Revision on: 11/20/2024 ADL'S: Staff to anticipate needs and give physical and verbal cueing for tasks Date Initiated: 06/20/2023 . BATHING: One person assist with bathing, encouraging the resident to do as much for self as able. (Resident #6) is more accepting of bathing when (husband/roommate) is present. (Resident #6) likes the warmth of the blow dryer and she may accept a shower if she feels the warm air of the blow dryer. Date Initiated: 08/04/2022 Revision on: 11/20/2024 . COMMUNICATION ABILITY: Alert to person only . DRESSING: One assist with cueing and encourage to do as much for self as able. (Resident #6) will refuse assistance with dressing most days, frequent reproach may be necessary. If (husband/roommate) is out of sight then she may accept assistance with dressing. If she is in the restroom already she is more accepting of changing clothes and washing up. May offer a hair brush as she enjoys brushing her hair. Date Initiated: 08/04/2022 Revision on: 11/20/2024 . ELIMINATION: Independent with toilet use, staff is encouraged to assist with toileting before and after meals, HS and prn. Wears incontinence products. Check and assist (Resident #6) every shift for cleanliness and assist with peri care. Date Initiated: 06/20/2023 Revision on: 11/20/2024 . PSYCHOSOCIAL: (Resident #6) is alert, only to self and her husband . She has poor short and long term memory recall . Document behaviors in the log . On 11/21/24, at 10:09 AM, there was a strong odor of bowel movement in the hallway outside Resident #6's room. Upon entry, CNA's H was noted to be offering a change of clothes. There was a bottle of bleach wipes on the over bed table. CNA's H offered, that they had to clean the bathroom due to bowel movement all over the toilet. CNA's H offered socks and then began to put on Resident #6's tennis shoes and stopped. CNA's H cleaned bowel movement off the shoes prior to putting on the shoes. Resident #6 appeared calm and repeated, oh no over and over when CNA's H was cleaning off the bowel movement from their shoes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24, at 1:36 PM, CNA's H was interviewed regarding Resident #6's ADL needs and care. CNA's H offered they work with Resident #6 about once a week. CNA's H was asked why they had changed Resident #6's clothes and CNA's H offered, that (Resident #6) had soiled themselves pretty bad. They had bowel movement all over their pants, a little on their shirt and all over their socks and shoes. CNA's H was asked what the bleach wipes were used for and CNA's H offered, they used them to clean the toilet and also offered, you could see where (Resident #6) had tried to clean the bowel movement off the toilet with toilet paper. CNA's H was asked why they thought that and CNA's H stated, there was a pile of toilet paper in the trash with a large amount of bowel movement and the toilet seat had appeared to be wiped off despite the remaining bowel movement. CNA's H was asked why the bedding was removed off the bed and CNA's H offered, there was BM on the bedding/sheets. CNA's H offered they bleach wiped the bed and areas that had BM on it. CNA's H was asked how they were alerted that Resident #6 required ADL assistance and CNA's H offered, that when they were in the hallway you could smell it referring to the BM smell. CNA's H offered that Resident #6 can be difficult at times but if you catch (Resident #6) right after they eat you can usually prevent the mess. According to the HCAM Resident rights booklet, . Respect and Dignity You have a right to be treated with respect and dignity, including: . The right to reside and receive services in the facility with reasonable accommodation of your needs and preferences .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to ensure timely assessment and implementation of interventions for pressure ulcer prevention for one resident (Resident #5) of three residents reviewed for pressure ulcers. Findings include: Resident #5: On 11/18/24 at 2:07 PM, Resident #5 was observed in their room. The Resident was in bed positioned on their back with their eyes open. The Resident's legs and feet were positioned directly against the mattress. When spoke to, Resident #5 responded verbally but did not provide meaningful responses to questions. Record review revealed Resident #5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included heart failure, cerebral infarction (stroke), and urinary retention. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and was dependent upon staff for bed mobility and transferring. The MDS further revealed the Resident was at risk for pressure ulcer development but had no pressure ulcers. Review of Resident #5's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #5) has potential risk for impaired skin integrity related to: History of fragile skin, History of or actual impairment . (Initiated and Revised: 11/17/24). The care plan included the interventions: - Bridge heels in bed . (Initiated: 11/17/24) - Measure open areas upon admission, weekly, prn (as needed) (Initiated: 11/17/24) A second care plan entitled, (Resident #5) . is alert and oriented 1-2 with garbled speech and is difficult to understand at times originally admitted to hospital for weakness and alerted mental status with a new finding of Covid pneumonia and received treatment . (Initiated: 10/24/24; Revised: 11/15/24). The care plan included the interventions: - Skin: Apply barrier cream with incontinence care prn; inspect skin with bathing and care . APM (alternating pressure mattress) mattress set to residents' level of comfort (Initiated: 10/25/24; Revised: 11/15/24) - Skin Impairment Location: Coccyx (Initiated: 11/15/24) - Skin: Heels elevated in bed as tolerated (Initiated: 10/24/24) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of documentation in Resident #5's EMR revealed a Wound assessment dated [DATE] at 4:05 PM which detailed, Wound Measurement . Coccyx . Pressure . Length: 4.5 (centimeters [cm]) . Width: 5 (CM) . Stage: Suspected Deep Tissue Injury (SDTI- pressure ulcer with unknown depth) . Wound Bed . Pink / Red - Clean, open area, red/pink Tissue . Exudate: Serous . Assessment Notes: wound was developed during hospital stay and was present upon admission. A fluid filled blister on coccyx with purple blue SDTI present . An Interdisciplinary Documentation Note in the EMR, dated 11/15/24 at 10:55 AM specified, . Skin Assessment noted 1+ Slight Pitting (edema) disappears rapidly, Skin is dry and intact . Review of Resident #5's EMR revealed the Resident had an external health care provider appointment on 11/11/24 and were admitted to the hospital from the appointment for further testing. Resident #5 returned to the facility on [DATE] at approximately 5:00 PM. A review of Resident #5's skin assessment documentation prior to their appointment and hospitalization on [DATE] revealed skin assessments were completed on 10/26/24 and 11/2/24. A review of the Skin assessment dated [DATE] indicated the Resident had no alterations in skin integrity. On 11/19/24 at 1:01 PM, Resident #5 was observed in their room. The Resident was in bed positioned on their back. The Resident's heels were positioned directly against a pillow and the bottom of their right foot was pressing against the footboard of the bed. On 11/19/24 at 3:00 PM, Resident #5 was observed in their room. The Resident was in bed positioned on their back. The Resident's heels were positioned directly against a pillow and the bottom of their right foot was pressing against the footboard of the bed. At 3:24 PM on 11/19/24, an observation of Resident #5 was completed with Clinical Registered Nurse (RN) O. Resident #5 remained in bed, positioned on their back with their heels directly against a pillow and their right foot pressing against the footboard of the bed. When queried regarding the Resident's positioning, RN O confirmed positioning concerns and indicated the Resident's heels should be floated and the bottom of their foot should not be pressing against the footboard of the bed. RN O stated, We have a bari (larger) bed we can get (Resident #5). On 11/20/24 at 11:03 AM, an interview was completed with Certified Nursing Assistant (CNA's) A. When asked if Resident #5 had any wounds, CNA's A stated, (Resident #5) has a sore on their bottom. An interview was completed with Wound Care Registered Nurse (RN) P on 11/20/24 at 12:33 PM. When queried how frequently skin assessments are completed by nursing staff, RN P stated, Weekly. When asked why Resident #5 did not have an assessment completed in nine days, from 11/2/24 until they went to an external appointment and were hospitalized on [DATE], RN P reviewed the EMR and confirmed a skin assessment had not been completed. When queried how they knew the Resident's pressure ulcer started at the hospital and not the facility when an assessment had not been completed and documented, RN P responded that pressure ulcer was not present when the Resident was discharged and indicated they would review the documentation further. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of Resident #5's wound care was completed on 11/20/24 at 2:15 PM with RN P and CNA's A. Upon removing the prior dressing, the wound bed was observed to be open. RN P measured the wound bed and stated it was 8 (cm) by 2 (cm) on the coccyx. Two separate, dark discolored areas were observed on the Resident's left sacrum/buttocks area. When queried regarding the areas, RN P assessed the areas and stated the tissue was non-blanchable. RN P measured the areas and said the top area was 6 cm x 5 cm and the lower area was 4 cm X 4 cm. After application of a new dressing, RN P and CNA's A repositioned the Resident in bed. The Resident's heels were positioned directly on a pillow. When queried regarding the Resident's heels, RN P stated, Should be floating. When asked if the Resident's heels were currently floating, RN P confirmed they were not. Review of facility provided policy/procedure entitled, Skin at Risk Assessment Documentation, Staging & Treatment (Revised: 1/2020) revealed, It is the policy of this facility to assess resident risk factors for the development of impaired skin integrity and intervene as indicated . It is the policy of this facility to assess skin on a regular basis to determine whether changes in the patient's skin condition have occurred .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview, and record review, the facility failed to implement and operationalize a comprehensive Restorative Nursing Program (RNP) for two residents (Resident #15 and Resident #30) of three residents reviewed, resulting in a lack of communication and implementation of planned RNP per Therapy recommendations, Resident #15's verbalization of increased pain and decreased Range of Motion (ROM), and Resident #30 developing a contracture (permanent tightening of muscles, tendons, skin, and tissues causing stiff and immobile joints), and the potential for further functional decline, diminished mobility, and unnecessary, increased pain. Findings include: Resident #15: On 11/18/24 at 1:12 PM, Resident #15 was observed sitting in a wheelchair in their room. A walker was observed in the room. An interview was completed at this time. When queried regarding the walker in their room, Resident #15 verbalized they use the walker to go to the bathroom but revealed they are only able to walk when staff are with them and usually use the wheelchair. Resident #15 was asked if they were receiving Therapy services and indicated they were but had been discharged . When asked if they were receiving Restorative Nursing Services, Resident #15 stated, No. Resident #15 was then asked if they have any pain or limited ROM and stated, I can't use my right arm. The pain is getting worse. When asked if they had hurt their arm, Resident #15 revealed they thought it was from Arthritis. Resident #15 then stated, I can't cut anything with it. When asked what they meant, Resident #15 revealed they were having trouble cutting up their food due to the increasing pain in their right arm. When asked if that was new for them, Resident #15 revealed it was getting worse. Resident #15 also stated, I have quite a bit of pain in my legs. When queried if they were receiving medication to help with their pain, Resident #15 revealed they were taking something when they were getting therapy but did not believe they were getting anything now. When queried if they had informed nursing staff about their increased pain and difficulty using their right arm, Resident #15 verbalized they had. Record Review revealed Resident #15 was admitted to the facility on [DATE] with diagnoses which included heart disease, depression, and difficulty walking. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to moderate assistance for toileting, bathing, and dressing. The MDS further detailed the Resident had one-sided upper extremity impaired Range of Motion (ROM). Review of Resident #15's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #15) has altered functional mobility and ADL's (Activities of Daily Living) related to: weakness . has a history of falls . has dizziness and Vertigo (Initiated: 10/12/19; Revised: 9/28/21). The care plan included the interventions: - Ambulation: One Assist FWW (Four Wheeled Walker) (Initiated: 10/12/19; Revised: 7/26/24) (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Eating: Provide set up assist as desired . is right hand dominant, however due to limited ROM in right shoulder . uses left hand to feed self (Initiated: 10/12/19; Revised: 1/8/21) - ROM: Independent, Impaired ROM to right shoulder due to Arthritis (Initiated: 10/12/19; Revised: 1/8/21) - Transfer: One Assist (Initiated: 10/12/19) An interview was completed with Certified Nursing Assistant (CNA's) A on 11/20/24 at 2:48 PM. When queried regarding the facility RNP, CNA's A revealed that floor CNA's staff complete Restorative Nursing tasks that are ordered and show on the task section of the EMR. CNA's A was then asked if Resident #15 was receiving Restorative Nursing Services and responded they were not. When queried if the Resident had any ROM limitations, CNA's A stated, Can't pull up their pants and has trouble with bra. With further inquiry, CNA's A revealed the reason Resident #15 had difficulty pulling up their pants and with their bra was because they had difficulty moving their arm. On 11/21/24 at 8:46 AM, an interview was conducted with Physical Therapist (PT) B and Occupational Therapist (OT) C. When queried if Resident #15 was receiving Therapy Services, PT B and OT C revealed Resident #15 had been discharged on [DATE] from PT and OT. OT C was then asked about Resident #15's ROM and replied, Full range passively. When queried regarding the MDS assessment specifying the Resident had impaired one-sided, upper extremity ROM, OT C confirmed they did in their shoulder. When asked which shoulder had impaired ROM, OT C replied, Right. When asked why Resident #15 had been on Therapy Services, PT B and OT C both revealed the Resident had been picked up for Covid recovery. A copy of the Resident's OT and PT evaluation and discharge documentation was requested at this time. When queried regarding the facility RNP, both PT B and OT C revealed the facility did not have a designed RNP CNA's and that the residents assigned floor CNA's complete Restorative Nursing tasks. When asked if Resident #15 had been discharged to RNP following therapy discharge, PT B reviewed their documentation and stated, Did exercise class. PT B further revealed the Resident also walked to the bathroom with staff as part their RNP. When queried what the exercise class was, PT B replied, There is an exercise class at 10:00 (AM) almost every day. With further inquiry regarding the exercise class, PT B revealed the class was part of the facility Activities program. When queried regarding staff stating the Resident was unable to pull up their pants independently and Resident #15 stating they were no longer able to cut up their food and having increased pain, OT C stated, When I had (Resident #15) a month ago, they were able to pull up their pants so that could be new. OT C and PT B were asked if they were made aware of Resident #15's complaints and the change/decline by nursing staff and verbalized they were not. A review of Resident #15's Activity Task documentation for the prior 30 days revealed the Resident had completed Exercises two times on 11/16/24 and 11/19/24. Review of Resident #15's Physical Therapy Discharge Summary dated 10/21/24 revealed, Discharge Status and Recommendations . Prognosis to Maintain CLOF (Current Level of Functioning) = Good with consistent staff follow-through . RNP . Res. to ambulate with staff to bathroom as tolerated, attend exercise class . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Activity Director D on 11/21/24 at 9:56 AM. When queried if they were familiar with Resident #15, Activity Director D verbalized they were. When asked what the exercise class was, Activity Director D revealed exercises were offered as an activity. With further inquiry regarding what the exercise class included, Activity Director D revealed it was different activities games with balls. When queried where exercise activities are documented, Activity Director D verbalized they are all documented under Exercises in the task documentation. Resident #15's Activity Task Documentation was reviewed with Activity Director D at this time. When asked if Resident #15 had only attended exercises two times in the past 30 days, Activity Director D reviewed Resident's the documentation and confirmed. When asked if they were aware that Therapy Services recommended Resident #15 attend exercise class as part of their RNP, Activity Director D indicated they did not know that. Resident #15's Physical Therapy Discharge Summary dated 10/21/24 was reviewed with Activity Director D at this time. After reviewing the Resident's Therapy Discharge documentation, Activity Director D stated that was Not communicated with me. Activity Director D further revealed they would have implemented an individual one to one exercise program for Resident #15 if they would have been made aware of Therapy RNP recommendations. An interview was conducted with the Director of Nursing (DON) on 11/21/24 at 10:09 AM. Resident #15's Physical Therapy Discharge Summary dated 10/21/24 recommendations for RNP were reviewed with the DON at this time. The DON was informed of Resident #15's verbalization of difficulty completing ADL's due to limited ROM and pain, CNA's staff statements related to limited ROM, and Therapy staff statements related to being unaware of the Resident's difficulties as well as recent discharge and RNP recommendations. The DON was asked why the RNP recommendations from 10/21/24 were not implemented on the Resident's care plan, the DON did not provide an explanation. When queried if Activities Staff are included in communication pertaining to the RNP, the DON verbalized they were not. When queried regarding the Resident only attending exercises with Activities twice during the prior thirty-day period, the DON reviewed the documentation and confirmed. When asked why the RNP recommendations from Therapy were not communicated and implemented, the DON confirmed and verbalized understanding but did not provide further explanation. Resident #30: On 11/18/24 at 1:41 PM, an observation occurred of Resident #30 in their room. The room was dark with the lights off and the window blinds closed. The Resident was in bed, positioned on their back. The Resident's fingers were bent inward toward their palm and their right knee was observed to be bend. The Resident's left leg was unable to be visualized. Resident #30 had tube feeding infusing via pump and the head of their bed was elevated at a 30-degree angle. When spoke to and asked questions, Resident #30 made eye contact and responded with garbled, unintelligible verbalizations. Record review revealed Resident #30 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebral infarction (stroke) with left sided paralysis, dysphagia (difficulty swallowing), gastrostomy (surgically created opening through the abdomen into the stomach for the provision of nutrition), and weakness. Review of the MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and was dependent upon staff for completion of all ADL's. The MDS further specified that Resident #30 had impaired Bilateral Upper Extremity (BUE) and Bilateral Lower Extremity (BLE) ROM. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #30's EMR revealed a care plan entitled, (Resident #30) has the potential for altered functional mobility and ADL's . Dependent on staff . (Initiated: 3/9/22; Revised: 6/20/23). The care plan included the interventions: - Restorative: Bilateral lower extremity PROM (Passive Range of Motion), Bilateral hip, knees, and ankles. 10 reps x 2, in all planes of motion. PROM to bilateral upper extremities in all planes of motion. 10 reps x 2. 5-7 x week for length of stay. Impaired ROM to Right knee/leg (Initiated: 4/13/22; Revised: 12/14/22). - Palm guards to bilateral hands as tolerated . (Initiated: 3/9/22; Revised: 6/4/24) On 11/19/24 at 12:57 PM, Resident #30 was observed in their room. The Resident was in bed, positioned on their back. The Resident's right knee was bent. When queried if they were able to move their legs, Resident #30 responded verbally but the response was unintelligible. The Resident was asked to move their arms or legs if able and no movement was observed. The Resident did not have palm/hand protectors in place. An interview was completed with CNA's A on 11/20/24 at 2:48 PM. When queried regarding Resident #30, CNA's A revealed they were not the Resident's assigned CNA's and specified CNA's E was. CNA's A was asked if they were familiar with the Resident and/or if they had provided care to them and confirmed they had. When queried regarding Resident #30's ROM, CNA's A responded that Resident #30 had contractures. With further inquiry regarding the Resident's contractures, CNA's A revealed the Resident required total assistance and had ROM limitations in their upper and lower extremities. When asked if the Resident was receiving Restorative Nursing Services, CNA's A indicated they were. Review of Task documentation in Resident #30's EMR revealed, Task: Restorative-Other program/ ROM: Bilateral lower extremity PROM, Bilateral hip, knees, and ankles. 10 reps x 2, in all planes of motion. PROM to bilateral upper extremities in all planes of motion. 10 reps x 2. Daily and PRN (as needed) 5-7 x week for length of stay. Impaired ROM to Right knee/leg. A review of Resident #30's Documentation Survey Report for November 2024 in the EMR revealed the task was documented as being completed as ordered. CNA's E had documented completion of the Resident #30's Restorative Nursing Task during the month of November. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with CNA's E on 11/20/24 at 3:08 PM. When queried if Resident #30 had contractures, CNA's E stated they did. CNA's E was asked where the Resident had contractures and replied, Left arm move a little bit. CNA's E then stated, When you touch (Resident #30), they don't like it. I think it hurts when you spread their legs. CNA's E was asked why they think it hurts Resident #30 to spread their legs and stated, (Resident #30) told me it hurts. CNA's E continued, (Resident #30) can't move their head up and down. When queried if they complete and document Restorative Nursing tasks for/with Resident #30, CNA's E verbalized Restorative tasks are part of their daily CNA's tasks. CNA's E was asked what they do for Resident #30's Restorative and replied, I do (Resident #30's) arms but I really don't do their legs because it hurts. When queried what they do when completing ROM for the Resident's upper extremities, CNA's E revealed they move their arms. When ask if they extend all joints in all planes of motion, CNA's E indicated they move the Resident's extremities when providing ADL care. CNA's E did not state they provide ROM for all joints in all planes of motion for a specific number of reputations. With further inquiry, CNA's E reiterated they do not complete ROM on the Resident's legs due to pain. When queried if they documented the task as completed in the EMR, even though ROM was not completed, CNA's E revealed they document the task as completed if they attempt to provide ROM. An interview was conducted with PT B and OT C on 11/21/24 at 9:00 AM. When queried regarding Resident #30, PT B revealed the Resident was last seen by Physical therapy in April 2022 and by Occupational Therapy in November 2023. When queried regarding a RNP, OT C stated, (Resident #30) is on a Restorative program for ROM. With further inquiry regarding the RNP, OT C revealed the OT Discharge (dated 11/14/23) specified, PROM BUE times all planes of movement and Bilateral palm protectors daily. When queried regarding the Resident's LE's, PT B reviewed the Physical Therapy Discharge documentation (dated 4/12/22) and indicated a referral for a RNP to include BLE ROM was initiated at that time. When queried if Resident #30 had any contractures when last seen by Therapy services, both PT B and OT C verbalized the Resident did not have any contractures when last seen/evaluated by therapy. When queried if they had been made aware of staff not being able to complete ROM on the Resident's LE's due to pain, both PT B and OT C verbalized they were not notified of any changes in ROM and/or increased pain with movement by nursing staff. When asked if the Resident should have bilateral palm protectors in place, both Therapy Staff indicated they should. When asked why the Resident had not had palm protectors in place at any observation, PT B and OT C were unable to provide an explanation. With further inquiry regarding Resident #30's current level of functioning and ROM, PT B and OT C indicated they would assess Resident #30. Resident #30's current joint ROM measurements as well as their most recent OT and PT evaluation and discharge documentation was requested at this time. Review of Resident #30's most recent Therapy Documentation revealed the following: - PT Evaluation and Plan of Treatment . Certification Period 3/11/22 - 6/6/22 revealed, Current Referral . referred to PT due to new onset of decrease in transfers . Measurements . RLE ROM = WFL (PROM). LLE ROM = WFL . RUE ROM = WFL (PROM). LUE ROM = WFL . Joints: Right Hip = WFL (PROM); Knee - WFL; Ankle = WFL, Ankle = WFL . Interventions Provided . ankle pumps and straight leg raises and knee extension in supine (laying on back) - AAROM (Active Assist Range of Motion) . - PT Discharge Summary dated 4/12/22 revealed, Prognosis to Maintain CLOF = Excellent with consistent staff support . RNP . Restorative program for BLE ROM, contracture prevention . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- OT Evaluation and Plan of Treatment . Certification Period 10/10/23-11/28/23 revealed, Current Referral . referred for OT evaluation due to . declines with ROM specifically hand ROM with possible need for palm protectors . new onset of decrease in range of motion placing patient at risk for contractures and decreased skin integrity . Measurements . RUE ROM = Impaired (MCP [Metacarpal joint- finger joint] -30 degrees of extension)' LUE ROM = impaired (MCP joints -30 degrees of extension) . RLE ROM = WFL (Within Function Limits); LLE WFL . Shoulder = WFL; Elbow/Forearm = WFL; Wrist = WFL; Shoulder = WFL; Elbow/Forearm = WFL; Wrist = WFL . - OT Discharge Summary dated 11/14/23 revealed, Discharge: 0 degrees of B MCP joint extension . Skill: Interventions Provided . PROM to B (bilateral) hand X all joints with prolonged stretch for improved ROM to prevent contracture and prevent pain . tolerating bilateral palm protectors . Discharge Status and Recommendations . Prognosis to Maintain CLOF = Excellent with consistent staff support . RNP . PROM performed for BUE X all planes of movement and resident to wear B (bilateral) palm protectors daily . On 11/21/24 at 9:20 AM, Resident #30 was observed in their room in bed with their eyes open. The room lights were off, and the window shade was closed. Upon approaching the Resident, their face was noted to be shiny, and they were visibly sweating. The Resident was observed to be covered with multiple blankets. When asked how they were, Resident #30 loudly and clearly stated, I'm burning up. When queried if they had called for staff assistance, Resident #30 replied, Can't. With further observation, the Resident's call light was observed on the floor. At 9:25 AM on 11/21/24, CNA's H was observed in the hallway of the facility and asked to assist Resident #30. An observation of care was completed at this time. CNA's H confirmed Resident #30 was sweating and began to remove blankets and reposition the Resident. Upon removing the blankets, Resident #30's hands were observed to bend with their fingers inward towards their palms. The Resident's right knee was bent upward at a defined angle. When queried if Resident #30 was supposed to have palm protectors, CNA's H stated, I haven't seen any. As CNA's H attempted to move Resident #30's legs to reposition them, the Resident began to yell out. When asked why they were yelling, Resident #30 revealed moving their leg caused pain. An interview was completed with Registered Nurse (RN) M on 11/21/24 at 9:32 AM. When queried regarding Resident #30's pain, RN M indicated the Resident had a lot of pain and receives scheduled Norco (narcotic pain medication) twice a day as well as a topic medication for pain relief. When queried if the Resident has contractures, RN M replied, Yes. RN M was asked how long the contractures had been present and revealed the Resident had contractures for as long as they could remember. An interview was completed with the DON on 11/21/24 at 10:12 AM. When queried regarding Resident #30's ROM including the Resident not having palm protectors in place, staff verbalization of worsening ROM and pain and not completing ROM as indicated per the RNP task/plan but documenting as completed, the DON verbalized understanding of concern but did not provide further explanation. The DON was informed that Therapy Staff verbalized they would assess Resident #30 and would follow up. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 11:18 AM, an interview was completed with OT C. When queried regarding Resident #30, OT C revealed the Resident was assessed by therapy and ROM measurements were obtained. When queried, OT C revealed Resident #30 had a contracture in their right knee and also had a decrease in other ROM measurements. The measurements were reviewed with OT C at this time. OT C verbalized Resident #30's right shoulder ROM was 0-110 degrees and their left shoulder ROM was 0-120 degrees. OT C revealed the Resident's other UE ROM measurements were WFL passively. When queried regarding the Resident's BLE ROM, OT C stated, Ankles are plantar flexed (toes pointed downward away from the head) and their right knee is 80-140 degrees with contracture. OT C verbalized Resident #30's right hip external rotation was midline, and their right hip flexion was 80 degrees. When asked about the Resident's left knee, OT C stated the Resident would not allow them to assess it. OT C was asked to clarify if they were saying the Resident developed a right knee contracture and other declines in ROM at the facility, OT C confirmed. When queried why Therapy had not been informed of the Resident's decline in ROM by nursing staff prior to contracture development, OT C was unable to provide an explanation. A follow up interview was completed with the DON on 11/21/24 at 1:09 PM. When queried regarding Resident #30's ROM measurements including decline in ROM and contracture development. The DON validated concern but did not provide further explanation. Review of facility policy/procedure entitled, Restorative Nursing Program (Revised: November 2021) revealed, It is the policy of this facility to evaluate residents on an individual basis for inclusion in a restorative program to assist the resident to attain or maintain their highest possible functional level . Procedure: 1. A restorative program may be established with any of the following: a. As a continuation of therapeutic programs by a Certified Nursing Assistant following rehabilitation . b. By the clinical manager to evaluate a resident through a restorative maintenance program to ensure the resident has maintained their highest functional level . 5. The restorative program will be assessed periodically with changes or discontinuation.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview, and record review, the facility failed to ensure the availability and provision of fluids to maintain appropriate hydration for one resident (Resident #5) of three residents reviewed, resulting in Resident #5 not having fluids available and verbalizations of thirst. Findings include: Resident #5: On 11/18/24 at 2:07 PM, Resident #5 was observed in their room. The Resident was in bed positioned on their back with their eyes open. The Resident's mouth was open. Resident #5's mouth and tongue were visibly dry, and their lips were chapped. The Resident did not have a beverage in their room. When spoke to, Resident #5 responded verbally but responses were unable to be understood. Record review revealed Resident #5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included heart failure, cerebral infarction (stroke), and urinary retention. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and was dependent upon staff for bed mobility/transferring and required supervision/touching assistance for eating. On 11/19/24 at 1:01 PM, Resident #5 was observed in their room, positioned on their back in bed. The Resident's lips remained dry and chapped. A beverage was not present in their room. On 11/19/24 at 3:00 PM, Resident #5 was observed in their room. The Resident positioned on their back in bed. The Resident's lips remain dry and cracked. When asked how they were, Resident #5 clearly stated, Can I get a sip of water? Resident #5 was asked if they were thirsty and indicated they were. Resident #5's call light was turned on and a CNA's entered the room. The CNA's obtained a beverage and held the Kennedy cup (adaptive cup with handles and non-spill lid) to the Resident's mouth. Resident #5 drank the entire glass of water. The CNA's exited the room, got another cup of water, reentered the room, and placed the cup on the overbed table next to the Resident's bed. At 3:24 PM on 11/19/24, an observation of Resident #5 was completed with Clinical Director Registered Nurse (RN) O. Resident #5 remained in the same position in bed. Upon entering the room, Resident #5 asked for another drink of water. With RN O's assistance, Resident #5 was observed drinking another entire cup of water. After exiting Resident #5's room, RN O was queried regarding facility policy/procedure related to the availability of fluids/beverages and indicated Residents should have a drink available unless they are NPO (nothing by mouth). Review of Resident #5's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #5) . is alert and oriented 1-2 with garbled speech and is difficult to understand at times originally admitted to hospital for weakness and alerted mental status with a new finding of Covid pneumonia and received treatment . (Initiated: 10/24/24; Revised: 11/15/24). The care plan included the interventions: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Adaptive equipment: Cups with Lids for Hot Liquids (Initiated and Revised: 10/30/24) - Liquids: Nectar thick (Initiated: 11/19/24) - Diet: Regular Diet, Mechanical Soft Texture, nectar Liquid Consistency. Cups with Lids for Hot Liquids. Likes Fruit Juice, Hot Tea, Milk (Initiated: 10/24/24; Revised: 11/19/24) The discontinued intervention, Resolved: Liquids: Thin-regular, covered hot liquids (Initiated: 10/24/23; Discontinued: 11/19/24) was noted in Resident #5's EMR. An interview was conducted with the Director of Nursing (DON) on 11/21/24 at 10:22 AM. When queried how frequently water/beverages are passed to residents, the DON stated, At the end of the shift. When queried regarding observations of Resident #5 not having water, their oral cavity and lips being dry, and how much they drank upon request, the DON verbalized Residents should have fresh water and be assisted to drink if needed. No further explanation was provided. A policy/procedure related to hydration was requested at this time but not received by the conclusion of the survey.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 39059 Based on observation, interview and record review, the facility failed to ensure a thyroid hormone medication was given appropriately for one resident (Resident #14) of five residents reviewed for unnecessary medications, resulting in abnormal lab values and complaints of signs and symptoms of hypothyroidism. Findings include: Resident #14: On 11/19/24, at 12:57 PM, Resident #14 was resting in bed eating their lunch. Resident #14 was unsure if they were getting out of bed as they complained of feeling tired that day. On 11/19/24, at 2:23 PM, Resident #14 was resting in bed. They complained of feeling constipated at times, felt tired and wanted to stay in bed. On 11/20/24, at 7:49 AM, The Director of Nursing (DON) was alerted that the resident complained of constipation at times and didn't want to get out of bed as they felt tired in the middle of the day. The DON offered that Resident #14 started a new medication to aide in appetite. The (DON) was asked why Resident #14 was taking their thyroid hormone replacement medication with other medications and the DON offered, that they would look into it. The DON was asked to provide a detailed medication administration record for the prior week for the resident. On 11/21/24, at 9:30 AM, a record review of Resident #14's electronic medical record revealed an admission on 3/15/2024 with diagnoses that included Hypothyroidism, Dementia and Mood Disturbance. Resident #14 required assistance with Activities of Daily Living. A review of the Physician orders revealed the following: Levothyroxine Sodium 25 MCG Start Date 6/19/2024 20:00 End Date 10/15/2025 . an increase in the dosage was noted as follows: Levothyroxine . 50 MCG . Start Date 10/16/2024 06:00 Revision Date 11/20/2024 . Despite the ordered 6:00 AM administration time the resident had been receiving it in the evening. The following medications were ordered to be given at 8:00 PM: Rexult, Mirtazapine, Acetaminophen, Tamsulosin, and Atorvastatin Calcium On 11/21/24, at 10:52 AM, The DON was reminded of the need to review the detailed medication administration record for Resident #14's medications and was asked why they were taking the levothyroxine with other medications. The DON responded, oh at 8 PM. The DON offered, that they had talked to the nurse that changed the time. A record review of the Medication Admin Audit Report Schedule Date: 11/13/2024-11/20/2024 revealed the resident received their levothyroxine medication along with other medications within 10 minutes and/or routinely at the same time. For the dates of . 11/19/24 21:23 11/18/24 22:14 11/17/24 20:50 11/16/24 20:57 11/15/24 19:51 (the other medications were given 10 minutes later) 11/14/24 21:48 the resident also received their evening snack about the same time. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the snack intake for the previous week revealed that Resident #14 received and accepted their snack every night at 21:59. According to American Thyroid Association.com, Thyroid hormone stays in your system for a long time, it is taken once a day, and this results in very stable levels of thyroid hormone in the bloodstream. When thyroid hormone is used to treat hypothyroidism, the goal of treatment is to keep thyroid function within the same range as a person without thyroid problems. This is done by keeping the TSH level in the normal range. The best time to take thyroid hormone is typically first thing in the morning on an empty stomach. This is because food in the stomach can affect the absorption of thyroid hormone. If you are taking several other medications, you should discuss the timing of your thyroid hormone dose with your physician. Taking other medications can sometimes cause people to need an adjustment of their thyroid hormone dose. Other medications and supplements can prevent the absorption of the full dose of thyroid hormone. These include iron, calcium, soy, certain antacids and some cholesterol lowering medications .

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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. 39059 Based on observation, interview and record review, the facility 1) Failed to ensure a clean and sanitary ice machine and 2) Failed to ensure safe service and holding food temperatures during a breakfast meal for all residents who consumed food, resulting in unsafe serving food temperatures with the likelihood of continued unsafe temperature food service. Findings include: On 11/20/24, at 8:00 AM, an observation of the back dining room revealed the breakfast meal was already in the warmer. On 11/20/24, at 8:04 AM, an observation along with [NAME] I who obtained meal temperatures as follows: Sausage Gravy 159 degrees Fahrenheit, Scrambled eggs 132 degrees Fahrenheit [NAME] I was asked if 135 degrees for the scrambled eggs was ok and [NAME] I looked down to the dial and turned it clockwise. [NAME] I was asked if the steam table was off and [NAME] I offered, no, but I thought it was on medium. It's on medium now. [NAME] I again was asked if the scrambled eggs temperature of 135 degrees was ok and [NAME] I stated, I have to go check and left out to the kitchen. A moment later, [NAME] I returned the scrambled eggs to the kitchen and placed them in the oven. On 11/20/24, at 8:14 AM, Dietary Manager(DM) J entered the kitchen and was asked if 135 degrees Fahrenheit for scrambled eggs service was ok and DM J offered as long as she heats them back up to 165 degrees. [NAME] J then removed the scrambled eggs, placed them in a frying pan and heated the eggs to 190 degrees. At 8:16 AM, [NAME] J moved the scrambled eggs back to the steam table for breakfast service. On 11/20/24, at 8:19 AM, an observation of Dietary Staff K in the front dining room was conducted. Dietary Staff K was asked if they had obtained temperatures of the food they were serving and Dietary Staff K stated, I did, but I forgot to write them down and offered to retemp the foods. Dietary Staff K obtained the following food temperatures: sausage gravy 153.9 degrees, scrambled eggs 142.7. On 11/20/24, at 8:30 AM, Dietary Manager J was asked to provide the breakfast food temperature logs for that morning. In the kitchen with DM J, a record review of the food logs revealed the scrambled eggs were 160 degrees Fahrenheit prior to leaving the kitchen for service. DM J was asked again if the egg temperatures were ok for service and DM J offered, as long as they don't go below 135. DM J was asked how the serving staff ensure safe food temperatures during meal service and DM J offered, that's what I tell them. You push your food cart down there. Put the food in the warmer right away and turn it on high. They're not going to burn the food in that amount of time. DM J was asked to clarify again when the food items are temped prior to service and DM J offered, they temp when done cooking prior to leaving the kitchen. DM J was asked if staff temp the food at the steam tables and DM J stated, they temp again at the end of service. DM J was asked to provide the facility food service, cooking and storage policies. (continued on next page)

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	235592	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huron Woods Nursing Center	1395 S Huron Rd Kawkawlin, MI 48631

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/20/24, at 8:45 AM, an observation of the front dining room revealed that there was one resident tray left to prepare. Dietary Staff K was asked to obtain the temperature of the scrambled eggs which revealed 131.0 degrees. On 11/20/24, at 2:00 PM, a record review along with DM J of the facility provided food policies and there was no mention of scrambled eggs on it. DM J offered that they follow the food code for eggs. DM J was asked to provide the food code for serving scrambled eggs safely. On 11/20/24, at 2:20 PM, Registered Dietician (RD) L entered the conference room and offered the FDA Food code 2022 chapter 3 - 28. RD L was alerted the production logs were not fully completed and revealed storage no less than 135 degrees RD L offered the FDA Food code for review. RD L was alerted that the production logs revealed missing temperatures for food served out of the kitchen and RD L repeated we follow the FDA food code. 37668 On 11/18/24 at 9:31 AM, an ice machine was noted in the facility kitchen. An observation of the ice machine was completed with Dietary Manager J, Dietary Staff Q, and Dietary Staff R. An unknown black colored substance was observed inside the ice machine along in the interior ledge of the plastic in the ice machine. The black colored unknown substance came in contact with the ice. Manager J, Staff Q, and Staff R confirmed the presence of the unknown, black colored substance in the ice machine. When queried regarding the facility policy/procedure related to cleaning the ice machine, Manager J responded that maintenance staff clean the ice machine. When queried if dietary staff maintain and/or clean the ice machine, Staff Q and Staff R verbalized the ice machine is not cleaned by dietary staff. A copy of the cleaning log for the ice machine as well as the facility policy/procedure were requested from Manager J at this time. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted with Dietary Manager J and Dietary Staff K on 11/20/24 at 9:00 AM. The food temperature logs for the past month were requested to review at this time and Manager J indicated they would need to locate the logs. When asked if the logs were maintained in a binder, Manager J revealed they were unable to provide copies of documents without administrative approval. When asked to review the log with them, Manager J provided two log forms for 11/1/24. One log form was for the Front dining room and the other was for the Back. The form contacted columns titled, Food Item, Production, Regular, Mech Soft, Puree, Leftovers, Initials. The rows in the form were divided into Breakfast, Lunch, Dinner and detailed the initial food items served. When asked what Production meant, Manager J explained it was the number of servings prepared. The food temperatures documented on the form for both the front and back dining rooms were identical for every food item. When queried regarding the identical temperatures, Staff K explained the food is prepared at the same time and the temperature is checked when it is removed from the oven. With further inquiry regarding facility procedure related to checking food temperatures for food service, Staff K stated, We only temp (the food) once when we remove it from the oven in the kitchen. When asked what they do after the food is removed from the oven and the temperature is checked, Staff K revealed it is placed in the service carts and taken to the dining room. When asked if food temperatures are checked again, prior to servicing the food to residents, Manager J and Staff K verbalized it was not. When queried regarding documentation of food temperatures at the end of food service, Staff K stated, We don't document what temp is when done in dining room. With further inquiry, Staff K indicated they take the food temperatures when they have finished serving the food to residents but do not maintain a record of the temperature. When asked why they do not maintain a record of the food temperatures, Manager J stated, We only need to take temperatures once. When asked why they do not check the food temperature at the time of and during food service to ensure food remains at a safe temperature for consumption, Manager J reiterated they were told they only need to check the temperature once which is done when the food is removed from the oven.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37668 Based on interview and record review, the facility failed to implement an infection control program including comprehensive outcome surveillance, including monitoring of initial infection signs/symptoms and ongoing surveillance and monitoring of potential infections, resulting in a lack of accurate and comprehensive infection control tracking, surveillance and data monitoring/analysis and the likelihood for spread of microorganisms and illness for all 47 facility residents. Findings include: Upon request for facility Infection Control Surveillance Data, the facility provided handwritten Infection Control Resident Surveillance line listing documentation for November 2023 to October 2024. Review of the provided forms revealed each resident listed on the forms received a form of antimicrobial treatment. The columns on the form included Resident/admitted , Room, Unit, Onset, Category, Qualifying signs & Symptoms, Nosocomial (facility acquired) or Community, Treatment and Resolution Date. The forms provided did not include any residents with signs/symptoms of infection who did not receive treatment to identify and prevent the potential spread of contagious illnesses. An interview and review of facility Infection Control data was completed with Infection Control (IC) Licensed Practical Nurse (LPN) S on 11/20/24 at 3:15 PM. When queried regarding the provided Infection Control Resident Surveillance line listing documentation only containing residents who received antimicrobial treatment, IC LPN S confirmed all residents on the line listing received antimicrobial treatment. When asked if they had additional IC surveillance tracking documentation, IC LPN S stated they did not. When asked how they monitor and track residents who have signs/symptoms of infection to identify and prevent potential spread, IC LPN S replied, Not track on a line list. A review of the October 2024 Infection Control Resident Surveillance line listing revealed six rows detailing infections for five residents. Resident #36 was listed twice, once for an oral infection and once for a skin infection. Resident #29 was listed once for a skin infection and had three antimicrobial medications (two antibiotics and one antifungal) included on the same row. The admitted for all the residents on the list was incomplete. The Onset Date column for each listed infection included two dates. Resident #22 was listed as receiving a prophylactic antibiotic due to a Right eye abrasion. There were no carry over infections listed on the line list but a review of the September 2024 line list revealed the resolution date for a resident listed as having a nosocomial skin infection was 10/15/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview and review of facility Infection Control data was completed with Infection Control IC LPN S on 11/21/24 at 10:37 AM. The October 2024 Infection Control Resident Surveillance line listing was reviewed with IC LPN S at this time. When queried if the line listing was used to track infections or antibiotics, LPN S responded that the line listing was their infection tracking. When queried if an individual can have an infection and not require antimicrobial treatment such as Norovirus (highly contagious viral infection which causes nausea, vomiting, and diarrhea and it not treated with antimicrobial medications), LPN S confirmed they can. LPN S was then asked why there were no infections which did not require antimicrobial treatment included on any of the facility Infection Control Resident Surveillance line listing documents from November 2023 to October 2024 and stated they do not track infections which do not receive antimicrobial treatment on the Surveillance form. LPN S then revealed nursing staff implement a short term care plan when a resident has a change including a potential infection. LPN S was then asked which, if any, residents had a short-term care plan related to a potential infection during October 2024 and revealed they did not know without reviewing each resident's medical record. When asked how they are monitoring and analyzing potential infections in a timely manner to prevent potential spread if they are not tracking data related to potential infections, LPN S verbalized understanding and indicated they would add infections and potential infection which are not treated with antimicrobial's to their surveillance documentation. A detailed review of Resident #29's infection surveillance documentation for October 2024 was completed with LPN S at this time. Per the documentation on the line listing, Resident #29 had a nosocomial skin infection of their genitalia with qualifying signs/symptoms including edema, pus, red, warm . with an onset date of 10/9, 10/22. The Resident received Keflex (antibiotic), Bactrim (antibiotic), and Diflucan (antibiotic). The Resolution Date of the infection was 10/25/24. When queried why Resident #29 was listed one time on the line list with three different antimicrobial medications, LPN S replied it was because all the treatments were related to the same infection. When asked what the Onset Set meant on the line listing, LPN S replied it was the dates of treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN S was asked if all the antimicrobial medications were started on 10/9/24 and stopped on 10/22/24 and revealed they would need to review the Resident's medical record to answer. LPN S proceeded to review Resident #29's medical record and stated, Keflex from 10/9 to 10/16, Bactrim from 10/14 to 10/21, and Diflucan from 10/16 to 10/24. When asked what 10/22 meant under the onset column as none of the medications were started and/or discontinued on that date, a response was not provided. When queried what date the Resident began to display signs/symptoms of infection, LPN S revealed they would need to review the Resident's medical record as they tract the dates of antimicrobial treatment and not the date that the signs and symptoms of infection began. When queried why the Resident was started on a second antibiotic, Bactrim, on 10/14/24, LPN S indicated it was due to culture results. Resident #29's culture results were reviewed at this time. The culture results were dated as obtained on 10/9/24 at 2:00 AM, received on 10/10/24 at 11:50 AM, and reported on 10/14/24 at 9:10 AM. The culture showed Isolate One - Staphylococcus aureus (bacteria which commonly causes skin and soft tissue infections), Isolate Two - Proteus mirabilis (bacteria normally found in the gut and commonly responsible for complicated Urinary Tract Infections), Isolate Three -Yeast (fungus), and Isolate 4 - Enterococcus faecalis (bacteria normally found in the gut and eliminated in stool). Keflex was not listed on the culture and sensitivity results. The culture and sensitivity showed Isolate One - Staphylococcus aureus was sensitive to Bactrim but Isolate Two - Proteus mirabilis was resistant to Bactrim. Bactrim is not effective in treating Isolate 4 - Enterococcus faecalis. When queried why Keflex was continued when other antibiotics were identified on the culture and sensitivity as being sensitive to the organisms, LPN S replied, I guess the doctor wanted them to finish the course. LPN S was asked if they had discussed the antibiotic treatment with the physician related to rationale for continuing and indicated they would need to review the notes in the medical record. When asked why Diflucan was not started until 10/16/24, when the culture results were back on 10/14/24, LPN S was unable to provide an explanation. A review of the provided monthly summary form titled, Infection Control Summary/Analysis QAPI October 2024 revealed the form did not provide any additional data related to the onset of Resident #29's skin infection nor did it address antimicrobial treatments. The summary form did not address surveillance for potential infections and/or infections which did not receive antimicrobial treatment. The Summary did not address carry over infections and/or treatment in relation to surveillance and monitoring for prevention of spread. Review of facility provided policy/procedure entitled, Infection Prevention and Control Plan (Updated: March 2024) revealed, It is the policy of this facility to implement the Infection Prevention and Control Program utilizing a systematic, coordinated and continuous approach guided by OSHA regulations, and pertinent state, federal and local regulations pertaining to infection control. Purpose: The prevention and control program is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . 2. Surveillance includes HAI's among staff and residents. Infections are monitored when a treatment plan is ordered by a Health Care Practitioner. a. Continuously collect and screen data to identify potential outbreaks . d. The Infection Prevention Manager assumes direct accountability for the surveillance, aggregation and analysis of the data . f. Provide documentation in accordance with Antibiotic Stewardship policies . 4. Monitoring and evaluation of key performance aspects of infection control through preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents .