STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235598	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riveridge Rehabilitation and Healthcare Center	1333 Wells St Niles, MI 49120

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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. 47955 Based on interview and record review the facility failed to maintain the dignity of 1 (Resident #20) of 1 reviewed for dignity resulting in feelings of anger and frustration. Findings include: Resident #20 Review of an Admission Record revealed Resident #20 had pertinent diagnoses which included: osteomyelitis (an infection in a bone) and end stage renal disease with dialysis (a condition when the kidneys no longer function, and dialysis- a procedure to filter the blood of the body when the kidneys no longer function). Review of a Minimum Data Set (MDS) assessment for Resident #20, with a reference date of 8/6/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #20 was cognitively intact. In an interview on 9/11/24 at 4:14 PM., Resident #20 reported he recently had asked to go to the hospital, and when Medical Director (MD) WW spoke with him (Resident #20) on the phone, MD 'WW's tone was short and curt when MD WW told Resident #20 he did not think he needed to go to the hospital and would not approve a transfer to the emergency room . Resident #20 reported he was angry and frustrated when MD WW told him he did not need to go to the hospital. Review of Progress Notes for Resident #20 dated 8/29/24, 11:23 PM., authored by Licensed Practical Nurse (LPN) EE revealed . I (LPN EE) spoke with him (Resident #20) about having the physician here look at it and prescribe an antibiotic if need and he (Resident #20) said no I am in so much pain and you don't have the proper pain meds (medications) to treat me here . called MD WW and he spoke with the resident as well stating this is not a life-threatening emergency and that a trip to the ER (emergency room) is not necessary . MD WW did tell resident he was not approving this transport to the emergency room as he did not feel it was an emergency . resident (#20) refused to stay here (in the facility) and insisted on being treated at the hospital .MD WW was informed of the resident (#20) insistence of going to the emergency room and stated that was fine, but that he is not in approval of him going to the emergency room . (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	In an interview on 9/12/24 at 7:09 AM., LPN EE reported Resident #20 asked to go to the hospital and she called MD WW. LPN EE reported that she informed MD WW that Resident #20 wanted to go to the ER, and that MD WW told LPN EE Resident #20 could be treated at the facility, and they have to watch their numbers. LPN EE explained that numbers refer to residents who are sent to the hospital. LPN EE reported MD WW did speak to Resident #20 via a cell phone speaker phone, and LPN EE did hear MD WW tell Resident #20 that he did not approve or support his (Resident #20) transfer to the hospital. LPN EE reported she sent Resident #20 to the emergency room that night. In a telephone interview on 9/12/24 at 11:32 AM., MD WW recalled the telephone conversation with Resident #20 regarding his wish to be transferred to the ER. MD WW reported that he had to watch his numbers with transfers to the hospital. When asked what watching his numbers means, MD WW reported too many transfers to the hospital is not good. MD WW reported he did tell Resident #20 that he did not think he needed to go to the hospital and that he did not support his (Resident #20) choice to go to the emergency room . During the telephone conversation, MD WW referred to Resident #20 as a frequent flyer. When asked what a frequent flyer was, MD WW stated someone who go to the emergency room often.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 47955 Based on observation and interview the facility failed to provide proper notification of a room change to 1 (Resident #20) of 1 resident reviewed for room change resulting in feelings of anger and frustration. Findings include: Resident #20 Review of an Admission Record revealed Resident #20 had pertinent diagnoses which included: osteomyelitis (an infection in a bone) and end stage renal disease with dialysis (a condition when the kidneys no longer function, and dialysis- a procedure to filter the blood of the body when the kidneys no longer function). Review of a Minimum Data Set (MDS) assessment for Resident #20, with a reference date of 8/6/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #20 was cognitively intact. In an interview on 9/11/24 at 4:18 PM., Resident #20 reported he had been moved rooms after he complained to administration about a confrontation he had with his former roommate. Resident #20 reported he refused to move rooms when administration asked him to move rooms, but he still was the one that was moved. Resident #20 reported he was not provided any paperwork regarding a room change. Review of Census for Resident #20 revealed a documented room change on 5/7/24. Review of Social Service Note for Resident #20 dated 4/24/24 at 16:23 PM., revealed .received a phone call . demanding that I moved his roommate .offered a room change . Res (resident) refused room change stating that he was there first . In an interview on 9/12/24 at 11:42 AM., Nursing Home Administrator (NHA) A reported there was no reported or documented confrontation between Resident #20 and his former roommate. In an interview on 9/12/24 at 11:57 AM., Social Services Director (SSD) NN reported there was no reported or documented confrontation between Resident #20 and his former roommate. SSD NN reported Resident #20 had asked for his roommate to be moved, and the roommate refused to move. SSD NN reported that she offered a room changed to Resident #20 and he refused a room change because he was there first. When asked why Resident #20 was moved rooms, SSD NN reported that Resident #20 agreed to move rooms. This surveyor asked SSD NN for documentation that supported Resident #20's agreeance to move or written notice of a room change, and SSD NN was unable to provide any documentation. SSD NN stated she documented in Resident #20's record that that he refused a room change, but she did not document when Resident #20 agreed to move rooms. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/12/24 at 12:10 PM., NHA A reported she was aware of Resident #20's room change. NHA A reported Resident #20 told her him and his former roommate did not get along. NHA A reported Resident #20 was presented with the opportunity to change rooms several times, and he refused. NHA A reported she was informed Resident #20 did finally agree to move rooms. NHA A reported SSD NN was the staff member residents discuss a room change with, and SSD NN was responsible for documentation and notification of room change. When asked for the documentation regarding Resident #20 agreeance or written notification for Resident #20's room change, NHA A stated I don't have any. Review of facility policy Change of Room or Roommate with a reviewed date of 7/2024 revealed .the notice of a change in room or roommate will be provided in writing .will include the reason (s) why the move or changed is required .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview and record review, the facility failed to ensure updated and accurate advanced directive information was in place for 2 (Resident #12 & #60) of 3 residents reviewed for advanced directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time), resulting in the potential for a resident's preferences for medical care to not be followed by the facility, or other healthcare providers. Findings include: Resident #12 Review of Resident #12's current Code Status Order in the electronic medical record indicated, Full Code, with a linked advance directive document from 2019 indicating Full Code, including CPR (cardiopulmonary resuscitation/chest compressions). Review of Code Status binder at the nurses station on [DATE] at 3:11 PM revealed Resident #12 had a green sheet of paper, indicating full code, initiate CPR, and an Advance Directive document dated [DATE] indicating that Resident #12 did not want CPR (DNR) do not resuscitate). These documents contradicted each other, and were inconsistent with the resident's medical record. In an interview on [DATE] at 11:38 AM, Director of Nursing (DON) B reported that Resident #12 had full code orders in the electronic medical record, to include CPR, based on an advanced directive from 2019. DON reported that Resident #12's advance directive that was found in the code status binder had not been recorded in the resident's medical record. DON B reported that the hospice service had been trying to reach Resident #12's POA (power of attorney) to discuss updating code status to DNR (do not resuscitate) due to her hospice status, and that DON B was not aware that the advance directive document indicating DNR had been completed in 2022 because it was not uploaded into the resident's medical record. DON B was not able to find an explanation as to why Resident #12's code status orders had not been updated to DNR. In an interview on [DATE] at 11:40 AM, Unit Manager (UM) LL was not able to explain why Resident #12's code status orders had not been updated to DNR. In an interview on [DATE] at 11:43 AM, Social Services Director (SSD) NN reported that she had completed Resident #12's DNR advance directive in 2022 with her POA, then gave it to the physician to sign. SSD NN reported that the facility policy is, after the physician signs the document, nursing staff are responsible for entering the order and to have the document scanned into the electronic medical record. Resident #12's code status should have been changed to DNR in 2022. In a subsequent review of Resident #12's record on [DATE] at 02:51 PM, indicated that the medical record had now been updated to include an advance directive indicating DNR, completed by her POA on [DATE]. It was unknown where this document was prior to the survey. 41424 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #60: Review of an Admission Record revealed Resident #60 was a male with pertinent diagnoses which included dementia, borderline personality disorder, anxiety, PTSD, high cholesterol, injury to head, and glaucoma (nerve connecting the eye to the brain is damaged, leads to vision loss). Review of current Care Plan for Resident #10, revised on [DATE], revealed the focus, .(Resident #60) and family have elected DNR (do not resuscitate) . with the intervention .Update code status if resident decided to change their preference .Ensure code status is available in electronic health record and send a copy with (Resident #60) on any trips to outside providers . Review of current Code Status on resident's profile page the resident was listed as a DNR. Review of Medical Treatment Decisions dated [DATE], revealed, the guardian designated no CPR (cardiopulmonary resuscitation) was to be performed. Review of Medical Treatment Decisions dated [DATE], revealed, the guardian had updated the resident's code status to indicate Resident #60 would have CPR performed. In an interview on [DATE] at 11:52 AM, Family Member BBB reported that his father wants CPR if something were to happen like a cardiac arrest. In an interview on [DATE] 02:49 PM, Unit manager LL reported if she witnessed the completion of an advanced directive she would make the change in the medical record, if not, the nurse who initiated the advanced directive would make the change.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake #MI00146430. Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse (corporal punishment) by staff in 1 (Resident #37) of 5 residents reviewed for abuse, when staff covered Resident #37's mouth and sprayed water in her face, to keep Resident #37 from being heard yelling during a shower. This deficient practice resulted in increased agitation and mental anguish. Findings include: Review of an Admission Record revealed Resident #37 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia and alzheimer's disease. Review of a Minimum Data Set (MDS) assessment for Resident #37, with a reference date of 7/27/24 revealed a Brief Interview for Mental Status (BIMS) score of 7, out of a total possible score of 15, which indicated Resident #37 was cognitively impaired. Review of Resident #37's Care Plan revealed, .has a behavior problem such as combativeness, refusing care, verbal aggression .r/t (related to) dementia. Date initiated: 11/23/22 .Interventions: .Assist (Resident #37) to develop more appropriate methods of coping and interacting, encourage to express feelings .Explain all procedures before starting and allow her time to adjust to changes . Review of a Facility Reported Incident (FRI) dated 8/5/24 revealed, .(Certified Nursing Assistant (CNA) XX) was showering (Resident #37). (CNA O) was assisting with shower. During the shower (Resident #37) began yelling out. Allegedly (CNA XX) then placed his hand on residents mouth. (CNA O) immediately told (CNA XX) not to do that .(CNA XX) was immediately suspended pending investigation .Per (CNA XX), he jokingly covered her mouth for a second .(CNA O) stated that (Resident #37) began screaming and yelling. He noticed that (CNA XX) was getting frustrated. When he noticed (CNA XX) put his hand briefly over (Resident #37's) mouth, he immediately told him that was not appropriate and he removed his hand. (Resident #37) then hit (CNA XX) in the face with a towel . Review of Resident #37's Physical Abuse Questionnaire dated 8/5/24 revealed, .Do you feel you have ever been handled roughly? Yes .I had a terrible shower this morning with two guys. They sprayed water all in my face and both ears. The one guy cusses me out sometimes . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/11/24 at 10:05 AM, Certified Nursing Assistant (CNA) O reported that it was typical for CNA XX to be inconsiderate and disrespectful to residents; CNA XX spoke rudely to residents, and during cares would intentionally cause residents to feel uncomfortable. CNA O reported that on 8/5/24 during Resident #37's shower, CNA XX got frustrated because Resident #37 was yelling, so he sprayed her in the face with the water and then covered her mouth with his hand. CNA O reported that this made Resident #37 more agitated and he told CNA XX to stop. CNA O reported that CNA XX stopped and they finished giving Resident #37 her shower. CNA O reported that CNA XX had done similar things in the past with other residents, and that CNA O had tried to talk to him about it, but that CNA XX got very defensive. CNA O had spoken to coworkers about the concerns, but did not report the concerns to management until 8/5/24. In an interview on 09/11/24 at 08:37 AM, CNA Y reported that on 8/5/24 she heard yelling in the shower room, and when she went to see what was going on, she saw CNA XX with his hand over Resident #37's mouth and stated, .(CNA O) was telling him to stop, but he kept doing it . CNA Y reported that CNA XX had abused several other residents, but had blackmailed coworkers, so that they would not report the abuse to management. CNA Y reported that she notified the charge nurse Licensed Practical Nurse (LPN) EE when she observed CNA XX holding his hand over Resident #37's mouth. In an interview on 09/12/24 at 09:41 AM, LPN EE reported that she was notified by CNA Y that she had witnessed CNA XX holding his hand over Resident #37's mouth because she was yelling in the shower room that morning. LPN EE reported that she immediately reported the concern to Nursing Home Administrator (NHA) A, and then found Resident #37 sitting in the hallway in her wheelchair a few minutes later. In an interview on 09/12/24 at 02:06 PM, NHA A reported that the allegation that CNA XX had abused Resident #37, was the first concern that was reported against CNA XX while employed at the facility. NHA A reported that since CNA XX's termination on 8/5/24, she had received additional allegations of past abuse by CNA XX, but could not tell this surveyor the names of the residents involved. NHA A reported that there was an all staff in-service held on 7/23/24, but it did not include education related to abuse. In an interview on 09/13/24 at 09:11 AM, CNA XX reported that he put his gloved hand over Resident #37's mouth on 8/5/24 because she was yelling while being showered. CNA XX reported that the reason he did it, was because he did not want the hot headed residents on the hall to hear Resident #37 yelling. CNA XX reported that he had been a CNA for a long time and did not think that his actions constituted abuse, because he did not hurt Resident #37.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on interview and record review, the facility failed to submit the investigation of an allegation to the State Agency for 1 resident (Resident #21) of 5 residents reviewed for abuse resulting in the potential for the allegation to not be thoroughly investigated and for the State Agency to not be notified of the status of the allegation. Findings include: Resident #21 (R21) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R21 admitted to the facility on [DATE] with diagnoses of bipolar disorder, type 2 diabetes, depression and anxiety. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R21 was cognitively intact (13 to 15 cognitively intact). Per the facility report to the State Agency on 6/20/2024, R21 alleged that someone stole a wad of ones and two fifties from his room and he called the police to file a report and notified facility staff. Nursing Home Administrator (NHA) A reported the allegation to the State Agency on 6/20/2024, the day it was discovered. During an interview on 9/10/2024 at 10:41 AM, R21 stated that he remembered calling the police on 6/20/2024 regarding his stolen money but he didn't remember exactly what happened with the investigation. Review of the Michigan Facility Reported Incident (MI FRI) website revealed that an investigation wasn't received from the facility. During an interview on 9/10/2024 at 4:49 PM NHA A stated that she went on vacation the next day after she submitted the initial report to the State Agency on 6/20/2024 and no one on her management team submitted the final investigation and report to the State Agency within the 5 working days of the incident. NHA A said that the investigation should have been submitted.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 41424 Based on interview, and record review the facility failed to ensure PASSAR (Preadmission Screening/Annual Resident Review, 3877) documentation and OBRA Level II (3878) exemption criteria were completed appropriately for 2 (Resident #39 and #60) of 3 residents, resulting in the potential for unmet behavioral health needs. Findings include: .Under the PASRR program, all persons seeking admission to a nursing facility who are seriously mentally ill and/or have an intellectual/developmental disability are required to be evaluated to determine whether the nursing facility is the most appropriate place for them to receive services and whether they require specialized behavioral/mental health services . https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/obra Resident #39: Review of an Admission Record revealed Resident #39 was a male with pertinent diagnoses which included dementia, anxiety, psychotic disorder with delusions (severe mental disorders that cause abnormal thinking and perceptions), major depressive disorder, insomnia, and traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head). Review of current Care Plan for Resident #39, revised on 6/1/23, revealed the focus, .(Resident #39) had a behavior problem of putting foreign objects in mouth and chewing on them .(Resident #39) uses antipsychotic medications r/t (related to) a history of TBI, psychotic disorder with delusions and behavior management . with the intervention .Administer medications as ordered. Observe for side effects and effectiveness .Anticipate and meet (Resident #139's) needs .Praise any indication of progress/improvement in behavior .Reward for appropriate behavior .(Resident #39) not to have paper or plastics products . Review of Resident #39's medical record revealed the last PASARR was completed on 4/28/23. Resident did not have an ARR (Annual review) from 2024 in the medical record. In an interview on 09/11/24 at 03:32 PM, Social Worker (SW) NN reported her completed portion of Resident #39's PASRR was uploaded into the PASRR system. The provider would have to log in and go to their que to complete his part of the assessment. When queried who was responsible for ensuring the completion of the PASRR, SW NN reported she was unsure who was responsible for ensuring the provider completed their portion of the PASRR. The provider would receive a notice and have to log in to the system to check. SW NN reported his had been 5 months since Resident #39's PASARR should have been completed. Resident #60: Review of an Admission Record revealed Resident # 60 was a male with pertinent diagnoses which included dementia, borderline personality disorder, anxiety, PTSD (post traumatic stress disorder), and insomnia. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of current Care Plan for Resident #60, revised on 1/16/2024, revealed the focus, .PASRR . with the intervention .Refer to OBRA and Psych service recommendations . Review of current Care Plan for Resident #60, revised on 1/16/2024, revealed the focus, .(Resident #60) has potential to be physically aggressive r/t (related to) anger, dementia, depression, history of harm to others, poor impulse control . with the intervention .Observe (Resident #60) frequently and Document observed behavior and attempted interventions in behavior log .Observe for any s/sx of (Resident #60) posing danger to self and others .Psychiatric/Psychogeriatric consult as indicated .When (Resident #60) becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away. and approach later . Review of Resident #60's medical record revealed no letter from Obra indicated exemption from continued level II assessment/review or a completed Obra level II assessment. In an interview on 09/11/24 09:57 AM, Social worker (SW) NN reported she would submit the level 2 requests as well, Obra would come and review someone and then send a copy via the electronic system and paper. When queried if Resident #60 had a level II Obra assessment completed recently SW NN reported as the resident had dementia he was exempt from a level II Obra assessment. Note: Resident #60 had a diagnosis of borderline personality disorder. In an interview on 09/11/24 at 03:30 PM, SW NN reported the original PASRR completed prior to Resident #60's admission was not in the Obra system. The referring facility had hand written the PASARR and never submitted it to Obra. SW NN reviewed the Obra system to determine if a letter was in Resident #60's Obra system to indicate he was exempt from any further level II examinations due to his dementia diagnosis. SW NN reported there was no letter currently and she had submitted a new level I PASRR into the Obra system for Resident #60 for the coordinator review.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to ensure assistance with activities of daily living (ADL) care was provided for 3 (Resident #16, #61, #178) of 4 residents reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for resident's dependent on staff for assistance. Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition.Personal hygiene affects patient's comfort, safety, and well-being. Hygiene care included cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities which as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation foster a positive self-image, promote healthy skin, and help prevent infection and disease . Resident #16: Review of an Admission Record revealed Resident #16 was a female with pertinent diagnoses which included dementia, anxiety, muscle weakness, depression, and need for assistance with personal care. Review of current Care Plan for Resident #16, revised on 3/8/2024, revealed the focus, .(Resident #16) has an ADL self-care performance deficit r/t (related to) dementia, muscle wasting and atrophy to multiple sites . with the intervention .Personal Hygiene: Requires limited to extensive assist of 1 staff member . During an observation on 09/10/24 at 04:08 PM, Resident #16 was observed in the tv room area and she had white/dark 1/2 inch long whiskers on her chin, under her chin, and on her jawline. During an observation on 09/12/24 at 10:59 AM, Resident #16 was in the tv room area and she was observed to have hairs on her chin, under her chin, and on her jaw. Resident #61: Review of an Admission Record revealed Resident #61was a female with pertinent diagnoses which included Alzheimer's disease, dementia, and stroke. Review of current Care Plan for Resident #61, revised on 12/13/2023, revealed the focus, .(Resident #61) has an ADL self-care performance deficit r/t unspecified dementia . with the intervention .PERSONAL HYGIENE: Requires limited to extensive assist of 1 staff member .Observe for facial hair, grooming as needed and per (Resident #61's) choices/preferences . During an observation on 09/10/24 at 12:23 PM, Resident #61 had walked out of her room into the hallway and she was observed to have approximately 2 inch long hairs on her chin and under her chin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 09/10/24 at 12:41 PM, Resident #61 was seated at a table in the dining room and she was observed to have approximately 2 inch long hairs on her chin and under her chin. During an observation on 09/11/24 at 02:42 PM, Resident #61 was observed in the hallway and she had approximately 2 inch long hairs on her chin, under her chin, and down the front of her neck area. During an observation on 09/12/24 at 01:41 PM, Resident #61 was seated in the dining room at a table and she was finishing up her lunch. she was observed to have approximately 2 inch long hairs on her chin, under her chin, and down the front of her neck area. Resident #178: Review of an Admission Record revealed Resident #178 was a male with pertinent diagnoses which included fracture of right humerus and dementia. Review of current Care Plan for Resident #10, revised on 8/29/2024, revealed the focus, .(Resident #178) has an ADL self-care performance deficit r/t right Humerus, Dementia, HTN, Insomnia . with the intervention PERSONAL HYGIENE: Requires extensive assist of 1 staff member . During an observation on 09/10/24 at 10:14 AM, Resident #178 was wearing an immobilizer on his right wrist and upper right arm which had a band that wrapped around his waist. Splattered dried food and splattered dried blood was observed on the wrist wrap and on the space between the wrist wrap and his waist and then on his waist wrap as well. He was wearing a dark green shirt which had dried food down the chest and stomach area. During an observation on 09/11/24 at 11:14 AM, Resident #178 was self ambulating in the hallway and he was observed to have an unshaven face, hair uncombed, and wearing the same food stained shirt and grey sweatpants from the previous day. During an observation on 09/11/24 at 02:40 PM, Resident #178 was observed in the hallway and CNA T took his hand and walked him back into the tv room. He was unshaven, hair uncombed, shirt soiled with food, and the immobilizer on his wrist, arm, and waist was soiled with splattered dried food and dried blood. During an observation on 09/11/24 09:44 AM, Resident #178 was observed attempting to pick something up off the floor, his immobilizer was covered in dried food and dried blood. He had on the same dark green shirt and grey sweat pants he had had on the day before. His facial hair was approximately 1 inch long and his hair was uncombed. In an interview on 09/12/24 at 10:40 AM, CNA X reported takes to two of us to give (Resident #178) a shower as he moves so much. During an observation and interview on 09/12/24 01:31 PM, Licensed Practical Nurse (LPN) DDD reported the staff did not have razors as they were down stairs and you have to have a code to get in to get them, She was able to get some, bunch of them were brought up to shave those who need to be shaved. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/12/24, review of the shower sheets for September 2024 showed no shower sheet completed for Resident #178. In an interview on 09/12/24 at 02:33 PM, Director of Nursing (DON) B reported the Assistant Director of Nursing (ADON) was looking into whether Resident #178 still required the use of the immobilizer as when he returned from his doctor appointment there was not mention of the immobilizer use. In an interview on 09/12/24 at 2:33 PM, Director of Nursing (DON) B reported the staff only needed to ask for more razors. and that staff should have obtained an additional immobilizer for him so we could change it out when it became soiled. Review of policy, Activities of Daily Living (ADLS) revised on 12/2023, revealed, .Care and services will be provided for the following activities of daily living: 1. Bathing, Dressing, grooming and oral care; 2. Transfer and ambulation; 3. Toileting; 4. Eating to include meals and snacks; and 5. Using speech, language or other functional communication systems .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview and record review, the facility failed to provide consistent, meaningful and person-centered activities for 4 of 7 residents (Resident #16, #56, #60, #178) reviewed for activities provided by the facility, resulting in the potential for loss of interaction, joy, self-esteem, growth, sense of wellbeing, autonomy, connectedness, identity, creativity, independence, pleasure, and comfort. This has the potential to affect all 15 residents residing on the dementia care unit. Findings include: Review of Facility assessment dated [DATE], revealed, .Activities: Assistant 4 FT .Activity Assistant- High School Diploma or GED, prior experience in a resident activities program in a health setting preferred, prior completion of a state-approved training course or willingness to complete such a course within 6 months of employment .Previous experience within a healthcare setting .Activities Management Administration 1 Experience with persons with dementia Previous experience within a healthcare setting . Review of the September 2024 activity calendar revealed, Tuesday, September 10, 24: 9:30 Roll N Stroll . 10:30 Board Games .12:00 Day in History .2:45 Pool Noodle Hockey .4:00 Ants on a log .7:15 Lucky Bingo; Wednesday, September 11, 24: 9:30 Bible Stories, 10:30 Dominoes, 12:00 BlackJack .2:30 [NAME] (music entertainer) .4:15 Men's Club; Thursday, September 12, 24: 9:30 Short Stories .10:30 Coffee Club .11:30 Book Club .12:15 YouTube Trivia .2:30 PM Movie & Popcorn . Review of the September 2024 activity calendar on the Memory Care Unit (MU), revealed, .Tuesday, September 10, 24: Room visits, Pictionary, Coffee Time, Manicures, Cooking Ants on Log, Outside/Exercise . Wednesday, September 11, 24: Room visits, Chair Exercise, Coffee Time, 2:30 [NAME], Ball toss, Word Games, Outside/Reminiscence .Thursday, September 12, 24: Room visits, Fish Bowl Game, Coffee Time, Devotional, Card game, Movie + Popcorn, Ball Toss . During an observation on 9/10/24 on the memory care unit, no activities that were posted on the scheduled activities on the board in the TV room area were observed from 10:00 am through 3:30 pm. Also noted, no individualized activities throughout initial tour, unit observations, sampled resident observations, as well as individual non-sampled residents in their rooms/hallways were observed throughout the day. During an observation on 09/10/24 at 10:34 AM, located in the TV room under the TV was the activity cart which had a radio, bible stories book, dominoes, magnet tiles and items in the cart. Next to the cart on the floor were a smaller ball and an inflatable medium beach ball. There was a basket with items to fold in it on the cart, a container with blocks under it and a bag with Lilo and stitch on it on top of it which had stuffies and babies. There were a couple books of word searches and a few magazines as well. Resident #16: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #16 was a female with pertinent diagnoses which included dementia, anxiety, stroke, and dysphagia (damage to the brain responsible for production and comprehension of speech). Review of a Minimum Data Set (MDS) assessment for Resident #16, with a reference date of 9/11/23 revealed, .Section F: Somewhat important: Books, newspapers, and magazines to read; listen to music you like; around animals, keep up with the news, get fresh air when weather is good, participate in religious services or practices, do things with groups of people, and do your favorite activities . Review of current Care Plan for Resident #16, revised on 9/13/23, revealed the focus, .Care Plan: (Resident #16) is new to healthcare facility environment little to no involvement r/t (related to) participation in therapy and or family visits .She enjoys music and singing, crafts, socializing. She used to work at the school . with the intervention .Encourage invite and assist as needed to activities of choice/interest as tolerated by (Resident #16) .Offer 1 step instruction or demonstration as needed for task related activities .(Resident #16) interests include crafts, music, socializing, church .ACTIVITIES: Invite to activity programs that encourage physical activity, physical mobility, such as exercise group, walking activities to promote mobility . Review of Activities Interview -Daily and Activity Preferences was last completed on 9/11/23. Review of Resident #16's Activity Task in the electronic medical record was conducted for a 30-day look back period. Documentation revealed R#16 had only two documented one-on-one activities. Review of Resident #16's Activity Task in the electronic medical record was conducted for a 30 day look back period. Documentation revealed R#16 did not have any group activities documented for 8/15/24, 8/21/24, 8/23/24, 8/24/24, 9/1/24, 9/4/23, 9/7/24, and 9/10/24. During an observation on 09/10/24 at 10:05 AM, Resident #16 was observed seated next to Resident #39 in the TV room in the recliners. She had her eyes closed. During an observation on 09/10/24 at 10:22 AM and 09/10/24 at 11:05 AM, Resident #16 was seated in a recliner in the tv room. During an observation on 09/10/24 at 12:27 PM, Resident #16 was observed ambulating in the hallway and went into the TV room area and was asking if she should stay right here. She took a seat in the TV room. During an observation on 09/10/24 at 12:40 PM, Resident #16 was observed exiting her room and went down the hallway towards another resident's room and closed the door and then came back down the hallway. During an observation on 09/10/24 at 01:15 PM, Resident #16 was observed seated at a table in the dining room and she had a cup of coffee. During an observation on 09/10/24 at 01:10 PM, Resident #16 was attempting to gather meal trays from the cart in the tv room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/11/24 at 11:16 AM, Resident #16 was observed seated in a recliner in the tv room area. During an observation on 09/12/24 at 10:59 AM, Resident #16 was ambulating in the tv and dining room area and appeared confused. She left the room and headed to her room. Resident #16 was not observed to be involved in church activities, crafts, singing and walking activities for the duration of the survey. Resident #56: Review of an Admission Record revealed Resident #56 was a female with pertinent diagnoses which included dementia, anxiety, major depressive disorder, lack of coordination, muscle weakness, cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language) and need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #56, with a reference date of 7/11/24, revealed Section F: Very important to the resident to: do things with groups of people; do your favorite activities, and to go outside to get fresh air when the weather is good . Review of current Care Plan for Resident #56, revised on 6/26/23, revealed the focus, .(Resident #56) is dependent on staff for activities, cognitive stimulation, social interaction r/t cognitive deficits. She had stated her interests as being reading, music, going outside, church, games, puzzles, crafts . with the intervention . All staff to converse with (Resident #56) while providing care .Assure the activities (Resident #56) is attending are: compatible with physical and mental capabilities; compatible with known interests and preferences; Adapted as needed (such as large print, holders if (Resident #56) lacks hand strength, task segmentation, Compatible with individual needs and abilities, and age appropriate .Invite and escort as needed to activities of choice. Target music, religious groups, outdoor groups crafts, games and social groups .Offer (Resident #56) materials for independent use. (Resident #56) likes mysteries, word search and stated she knits and crochets . Review of Resident #56's Activity Task in the electronic medical record was conducted for a 30 day look back period. Documentation revealed Resident #56 did not have any group activities documented for 8/15/24, 8/21/24, 8/23/24, 8/24/24, 9/1/24, 9/4/23, and 9/7/24. Review of Resident #56's Activity Task in the electronic medical record was conducted for a 30-day look back period. Documentation revealed Resident #56 only had 6 days of documented one-on-one activities. Note Resident #56 had only one Activities Interview - Daily and Activity Preferences completed on 6/28/23. Resident #56 was not observed to be reading, completed word searches, knitting, or crocheting during the duration of the survey. Resident #60: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #60 was a male with pertinent diagnoses which included dementia, borderline personality disorder, anxiety, PTSD, and glaucoma. Review of a Minimum Data Set (MDS) assessment for Resident #60, with a reference date of 11/16/23 revealed, .Section F: Preferences for Routine & Activities revealed, Somewhat important - to have books, newspapers, and magazines to read, to do things with groups of people, to do your favorite activities, to go outside to get fresh air when the weather is good, participate in religious services and practices .Very important - have music you like . Review of current Care Plan for Resident #60, revised on 7/10/2018, revealed the focus, .(Resident #60) is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t cognitive deficits . with the intervention .(Resident #60) needs assistance/escort to activity functions .Prefers to socialize with staff and other residents .Invite to scheduled activities .Provide a program of activities that is of interest and empowers (Resident #60) by encouraging/allowing choice, self-expression, and responsibility .Ensure that the activities (Resident #60) is attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Compatible with individual needs and abilities . Review of Activities Initial assessment dated [DATE], revealed, .(Resident #60) likes to talk about life experiences. His conversation is disorganized. During this interview he did not answer any questions .Try to phrase questions so they can be answered with yes or no . Note: this was the only assessment completed for Activities. During an observation on 09/10/24 at 11:05 AM, Resident #60 was seated in his wheelchair next to a recliner in the doorway to the dining room area. He was not participating in an activity. During an observation on 09/11/24 at 11:16 AM, Resident #60 was observed seated in his wheelchair next to the sink in the tv room area, he appeared between sleepiness and awake. During an observation on 09/12/24 at 10:59 AM, Resident #60 was observed in the tv room area and he was asleep in his wheelchair. During an observation on 09/12/24 at 01:28 PM, Resident #60 was observed asleep in his wheelchair, had his chin resting on his chest area while seated in the dining room. Review of Resident #60's Activity Task in the electronic medical record was conducted for a 30 day look back period. Documentation revealed Resident #60 did not have any group activities documented for 8/15/24, 8/21/24, 8/23/24, 8/24/24, 9/1/24, and 9/7/24 and only had 3 days of documented one-on-one activities other than watching television Resident #60 was not observed to have books, newspapers, and magazines to read, to do things with groups of people, to do his favorite activities, participate in religious services and practices and listened to music he liked. Resident #178: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #178 was a male with pertinent diagnoses which included fracture of right humerus, restlessness and agitation, anxiety, dementia, and fall on same level from slipping, tripping, and stumbling. Review of a Minimum Data Set (MDS) assessment for Resident #178, with a reference date of 9/3/24 revealed, .Section F: Staff Assessment: snacks between meals, listening to music, doing things with groups of people, participating in favorite activities, and spending time outdoors . Review of current Care Plan for Resident #178, revised on 9/2/24, revealed the focus, .(Resident #178) is dependent on staff for activities, cognitive stimulation, social interaction r/t dementia. (Resident #178) was a computer technician, he loves trains, and train models. (Resident #178) likes camping and going for walks. He likes pets, kids and is friendly. (Resident #178) does not watch TV with the intervention .All staff to converse with resident while providing care .(Resident #178) needs assistance/escort activity functions . Encourage ongoing family involvement. Invite (Resident #178's) family to attend special events, activities, meals .Introduce (Resident #178) to residents with similar background, interests and encourage/facilitate interaction .Invite (Resident #178) to scheduled activities .Thank resident for attendance at activity function . When (Resident #178) chooses not to participate in organized activities, respect his decision and allow him to just observe, to provide sensory stimulation . Review of Resident #178's Activity Task in the electronic medical record was conducted for a 30 day look back period. Documentation revealed R#178 did not have any group activities documented for 8/27/24, 8/29/24, 8/30/24, 9/1/24, 9/2/24, 9/4/24, 9/6/24, 9/7/24, 9/8/24, 9/9/24, 9/10/24, and 9/11/24. Resident #178 was not observed to have any activities which dealt with computers, trains or model trains. (Resident #178) liked camping and going for walks. There were no pet visits for the duration of the survey. During an observation on 09/10/24 at 10:14 AM, Resident #178 got up from the recliner and headed to the sink area and looked at items around the sink. He headed out of the tv room area and went to the hallway to self ambulate. During an observation on 09/10/24 at 10:22 AM, Resident #178 was observed pushing on the back door and set off the alarm. During an observation 09/10/24 at 11:05 AM, Resident #178 was observed seated in a recliner in the corner in the tv room area. During an observation 09/10/24 at 12:23 PM, Resident #178 was observed ambulating by the door on the hallway where you enter the unit. During an observation on 09/10/24 at 12:27 PM, Resident #178 continued to self ambulate up and down the hallway. During an observation on 09/11/24 at 11:16 AM, Resident #178 was self ambulating in the dining room area, walked around, left and walked back out to the tv room area. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/12/24 at 10:59 AM, Activities Director (AD) D came to the memory care unit and gathered residents to go to the coffee time in the main dining room. Only 3 residents were brought out of the unit to the main dining room. In an interview on 09/10/24 10:55 AM, Activities Director (AD) D reported she was going around and checking to ensure the activity calendars were still up as they tend to get taken down. She reported Activity Aide (AA) E was the only AA today as the other person called in sick, and the other AA was out on personal time off. In an interview on 09/12/24 10:26 AM, Activity Aide (AA) E reported she would go around and ask everybody, document the refusals, and for those residents who were bed bound we would do a sensory group every morning for those who were impaired. AA E reported she had time between each activity and she would take that time to document in the records of those residents who participated in the activity. In an interview on 09/12/24 01:20 PM, AD D reported she was an assistant last fall and when the previous director left she was placed in that position. AD D reported then she was out the end of April 24 for a few months and she was new to the position really, still trying to catch up on the assessments, training of the activity aides as there were two new ones. AD D reported the residents should have had an activities assessment completed yearly and quarterly. AD D reported she would look at the likes and dislikes of each resident, talk to family about the resident's interests, and confer with staff as they would pick up on things the residents like or dislike. AD D reported she had been training the AAs to complete the documentation in the electronic medical record for each resident as prior it had been done on paper. AD D reported there were processes which needed tweaked and there needs to be some improvement. Review of policy, Dementia revised on 7/2024, revealed, .Our focus in the care of the resident with Dementia is on functioning, not etiology or pathology. Activities: Activities should be available around the clock. There are meaningful activities that can be done if the resident cannot sleep, that would not disturb other residents. Group activities should not have more than 10-15 in a group. Mentally stimulating activities should occur early in the day when cognitive function is at its highest . Review of Activity Involvement and Quality of Life of People at Different Stages of Dementia in Long Term Care Facilities, [NAME] & Twist (2015), published in Aging Mental Health, revealed Despite a Resident's cognitive status, their activity involvement was significantly related to better scores on care relationships, positive affect, restless tense behavior, social relations and having something to do. Review of The Needs of Older People with Dementia in Residential Care, Woods & [NAME] (2006), published in the International Journal of Geriatric Psychiatry revealed Determining which activities have high degree of meaningfulness can aide recreation staff in creating programs more likely to promote health and wellness for persons with dementia.

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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** 41027 Based on observation, interview and record review, the facility failed to ensure residents received the necessary care and services to prevent the development of pressure ulcers in 1 (Resident #54) of 4 residents reviewed for pressure ulcers, resulting in not receiving preventative interventions and protective skin treatments per physician orders, based on a history of multiple pressure wounds, and the potential for the development of new pressure injuries. Findings include: Review of an Admission Record revealed Resident #54 was originally admitted to the facility on [DATE]. Review of Resident #54's Care Plan revealed, .has actual skin issues r/t (related to) impaired physical mobility, spinal stenosis (immobility, generalized weakness. Open area to R (right) upper thigh and L (left) lower inner leg. Resolved. Date initiated: 09/15/23. Revision on: 09/05/24 .Interventions: .administer treatments as ordered and monitor effectiveness. Date initiated: 09/15/23 .Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date initiated: 09/15/23 . Review of Resident #54's most recent Braden Assessment (to determine risk of developing pressure injuries) dated 10/6/23 indicated that the resident was at risk. During an observation on 09/10/24 at 11:58 AM Resident #54 was sitting in his broda (specialized chair to provide comfort) wheelchair, across from the nurses station. During a subsequent observation on 09/10/24 at 01:53 PM Resident #54 was sitting in his broda wheelchair, across from the nurses station. During an observation on 09/11/24 at 08:06 AM Resident #54 was sitting in his broda wheelchair, across from the nurses station. During an observation on 09/11/24 at 09:54 AM Resident #54 was sitting in his broda wheelchair, in the TV room. During an observation on 09/11/24 at 10:57 AM Resident #54 was sitting in his broda wheelchair, in the TV room. During an observation and interview on 09/11/24 at 02:38 PM in Resident #54's room, Certified Nursing Assistant (CNA) O had transferred Resident #54 to bed, and was providing incontinence care. Resident #54 did not have any wound dressings on his buttocks and/or hips. Resident #54's right hip was observed with discolored lighter skin, and CNA O reported that the resident previously had bad wounds in that area, but that he had not seen a bandage on the area in about a month. CNA O reported that Resident #54 had been up in his chair since 6:30 AM that morning (8 hours ago), and had not been transferred to bed after breakfast, that he typically stays up in his chair until after lunch. CNA O reported that Resident #54 was completely dependent on staff for all cares. (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 Resident #54's Physician Orders/Treatment Administration Record (TAR) revealed, .Right hip. Cleanse area with NS (normal saline) or wound wash, and apply hydrocolloid (waterproof bandage that promotes healing) dressing for prevention, change q (every) 7 days and PRN (as needed). Every day shift every 7 days for wound care. May change PRN for soilage or dislodgement. Start date 06/05/24 at 7:00 AM . According to the TAR documentation, Resident #54 missed 10 of 13 opportunities for treatment administration since the order was placed on 6/5/24. In an interview on 09/11/24 at 02:45 PM, Licensed Practical Nurse (LPN) CC reported that Resident #54's wound dressing was ordered as a protection due to previous wounds, but that she did not do any treatments for the resident yesterday or this day, so she was not sure if the dressing was still in place. In an interview on 09/12/24 at 09:51 AM, LPN EE reported that Resident #54 had admitted to the facility with 11 wounds, and all of them have healed. LPN EE reported that there were no orders for a protective dressing that she was aware of, and that the only treatment at this time was barrier cream. LPN EE reported that Resident #54's skin was extremely fragile, and it was very important to frequently reposition the resident to offload pressure. In an interview on 09/12/24 at 01:25 PM, Registered Nurse (RN) FF reported that Resident #54 does not currently have a treatment ordered for his right hip, and that the CNA's just apply cream. In an interview on 09/12/24 at 02:20 PM, Unit Manager (UM) LL reported that Resident #54 should be getting a once a week protective dressing applied to his right hip, where he previously had a pressure wound. UM LL reported that she had spoken to the wound doctor about it last week, and he wanted the treatment in place. UM LL reported that Resident #54 is at risk for developing pressure wounds due to him not being able to reposition himself, and history of pressure wounds. UM LL reported that Resident #54 should be up in his chair for meal, and laid down between meals to offload pressure. UM LL reported that Resident #54 should be assessed for his risk of developing pressure wounds quarterly, but was last assessed in October of 2023 (11 months ago). Review of Resident #54's Wound Visit dated 5/28/24 revealed, .Right hip is a Stage 2 pressure injury pressure ulcer and has received a status of not healed .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47955 Based on observation, interview, and record review the facility failed to ensure 1. facility staff followed the care plan for transfer techniques for 1 (Resident #29) of 5 residents reviewed for falls, resulting in the potential for a fall, and/or an injury. Findings include: Resident #29 Review of an Admission Record revealed Resident #29 had pertinent diagnoses which included: Dementia, abnormalities of gait (walking) and mobility, and lack of coordination. Review of a Minimum Data Set (MDS) assessment for Resident #29, with a reference date of 6/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated Resident #29 was severely cognitively impaired. On 9/10/24 at 10:27 AM., Certified Nurse Assistant (CNA) R was observed positioning Resident #29 into a seated position on the side of his bed, reaching under both of his arms, picking Resident #29 up and transferring him into his wheelchair that was positioned to the right of CNA R, next to Resident #29's bed, parked on top of the fall mat on the floor. CNA D did not use a gait belt for the transfer. In an interview on 9/10/24 at 10:30 AM., CNA R reported she had a gait belt in her possession but did not use it to transfer Resident #29. CNA R reported that she should have used the gait belt during the transfer. CNA R reported that she had worked 6 other shifts, and this was the first time she cared for Resident #29. CNA R reported she thought Resident #29 was a one-person transfer and that the Kardex (a form with resident specific information related to their care needs) was printed by the nurse. Review of Care plan for Resident #29 revealed .Focus .self-care performance deficit r/t (related to) . abnormal gait, dementia .Interventions .Transfers requires limited to extensive assistance of 2 staff members . In an interview on 9/12/24 between 7:02 AM and 2:55PM., CNA Z, CNA Q, Licensed Practical Nurse (LPN) EE, CNA V, and Registered Nurse (RN) F all reported Resident #29 was a two person transfer with a gait belt for transfers. In an interview on 9/12/24 at 5:55 PM., Director of Nursing (DON) B reported her expectation was a gait belt should be used for every transfer, except a mechanical lift.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on interview and record review, the facility failed to ensure annual performance evaluations for certified nursing assistants were completed, resulting in the potential for the delivery of nursing and related services that does not support or maintain the residents highest practicable physical, mental, and psychosocial well-being. Findings include: Review of The Essentials Guide to Healthcare Performance Reviews, www.hrforhealth.com. 2024, revealed The benefits of healthcare performance reviews go beyond creating a better experience for your team .the most important [benefit) is performance reviews lead to improved performance .greater productivity and better overall experience for your patients. Review of the Facility assessment dated ,d+[DATE], revealed, .CNA: 31 FT (full time), 8 PT (part time) and 8 PRN (As needed) . Total of 47 CNAs employed by the facility. Review of Employee Personnel Files on 09/11/24 at 03:12 PM, revealed, Certified Nursing Assistant (CNA) V, CNA W and CNA T had not received their annual performance evaluations. In an interview on 09/11/24 at 11:06 AM, Certified Nursing Assistant (CNA) V reported she had not received an annual performance evaluation since she worked at the facility and she had worked for the facility for 4 years. CNA V reported she worked 3 days a week one week and 4 days a week the next week. In an interview on 09/12/24 at 12:51 PM, CNA U reported she worked on Thursday, Friday, and Saturdays at the facility. CNA U reported she had not received an annual performance evaluation since she had been employed with the facility. In an interview on 09/11/24 at 03:15 PM, Receptionist EEE reported she had not received any annual performance evaluations for the facilities CNAs for a while. Receptionist EEE reported the document was paper before and wasn't sure if they were electronic now. She reported she was not the generator of the annual performance evaluations for the CNAs to be completed by the nursing department. In an interview on 09/11/24 at 03:16 PM, Director of Nursing (DON) B reported the annual performance evaluation for the CNAs would get generated by human resources for the nursing department to complete. DON B reported Receptionist EEE and Business Office Manager (BOM) K were the employees who covered the duties of human resources. In an interview on 09/11/24 10:35 AM, Administrator A reported the nursing department would be responsible for generating and completing the annual performance evaluations for the CNAs and they have not been done.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the 1. facility failed to develop person centered interventions and approaches for dementia care and implement a plan of care to engage and enrich the quality of life, 2. failed to provide qualified staff for dementia care for 1 (Resident #56) of 4 residents reviewed for dementia care, resulting in the potential for negatively affecting the residents' highest practicable physical, mental, and psychosocial well-being. Findings include: Review of an Admission Record revealed Resident #56 was a female with pertinent diagnoses which included dementia, anxiety, major depressive disorder, lack of coordination, muscle weakness, cognitive communication deficit ((progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language) and need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #56, with a reference date of 7/11/24, revealed Section F: Very important to the resident to: do things with groups of people; do your favorite activities, and to go outside to get fresh air when the weather is good . Review of current Care Plan for Resident #56, revised on 6/26/23, revealed the focus, .(Resident #56) has impaired cognitive function/dementia or impaired thought processes r/t vascular dementia . with the intervention .Administer medications as ordered. Monitor/document for side effects and effectiveness .Ask yes/no questions to determine what (Resident #56) needs .Communicate with family/caregivers regarding capabilities and needs . Review of current Care Plan for Resident #56, revised on 3/27/24, revealed the focus, .(Resident #56) has depression r/t dementia, disease process, and major depressive disorder. (Resident #56) becomes tearful every afternoon about different subjects . with the intervention .Administer medications as ordered. Monitor/document for side effects and effectiveness .Arrange for psych consult, follow up as indicated .Assist the resident in developing/Provide (Resident #56) with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise, physical activity .Monitor/document/report PRN (as needed) an s/sx (signs and symptoms) of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness . Review of Behavior/Mood Symptom Tracking Tool was reviewed for the dates 7/1/24 - 8/31/24 revealed the following: 8/17/24: 2:00 PM, TV room .Multiple stimuli .Tried to direct her attention by going out of room . Unable to redirect .2. Behavior got worse . Note: There was not other documentation on the behavior log. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Care Conference Note dated 7/16/2024 at 1:50 PM, revealed, .Quarterly Care Conference held today with res daughter/POA (First Name) via phone and IDT team to review res plan of care. Activities preferences reviewed with no changes reported. Dietary preferences and nutritional status reviewed with no changes reported. (Daughter) brought new glasses and New Balance shoes that are labeled. Res conts to ambulate with a wheelchair. Nursing care reviewed with no concerns noted. Res mood and behavior are stable at this time . Review of Nursing Progress Note dated 7/18/2024 at 4:02 PM, revealed, .Resident crying and mildly agitated before before/at lunchtime, wanting to see husband. Not easily distracted. Improved after routine lorazepam given, some weepy moments but more easily distracted/redirected. Review of Nursing Progress Note dated 7/29/2024 at 10:52 PM, revealed, .Resident very distraught this shift, believes her house is on fire and she has to get home to save her kids, unable to redirect, staff doing 1:1 with her, she is trying to get out of the door, when in bed she tries to get up and walk . Review of Social Service Progress Note dated 7/31/2024 at 11:32 PM, revealed, .Nursing report res having increased behaviors that include hallucinations, delusions, anxiety, and crying. Resident has dx (diagnosis) of Generalized Anxiety, Vascular dementia, major depressive disorder, and cognitive communication deficit and has (Psychiatric Services Provider) Services. IDT discussed resident's behaviors with plans to complete UA and consult with (Psychiatric Services Provider) on 8/5/24 regarding behaviors. Will document as needed . Review of Nursing Note dated 8/5/2024 at 02:56 AM, revealed, .Resident removed her brief while in her bed, Bed linens had to be changed 3 x. Resident up walking in her room x2. She is brought to the tv room. Resident continues to attempt to stand. Yelling and fighting with staff for most of the last 2 hours, unable to be consoled. Brief is dry, Tylenol given with no change in behavior . Review of Progress Note dated 8/9/24, revealed, .Chief complaint: Crying and Delusional .Patient was seen crying and delusional. Patient says that the onset of the problem was acute .Plan: Refer to psyche services . Ensure proper administration of prescribed medication .Monitor patient B.S (blood sugar) closely for 24 hrs . Review medications .Address patient concerns .Continue management for other chronic conditions .Assess for possible complications .Patient education . Review of Nursing Note dated 8/19/24 at 6:42 AM, revealed, .Note Text: resident not feeling well when she got up 6:15am was crying and carrying on unable to console her. T 99.7 Coughing and congested, given tylenol and cough syrup, put in Doctors book to be seen . (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Encounter dated 8/19/24 at 1:00 PM, revealed, .Session Summary: Resident is a [AGE] year old caucasian woman who was sitting in the common areas in her wheelchair when clinician arrived and agreed to participate in a session. During session resident was tearful, crying, however answered all inquiries and was cooperative with congruent affect. She responded to all inquiries and made good eye contact. She stated she has did know what was wrong. She asked for a shirt (had a long sleeve on) and CNA got her a sweater as well. They noted she had a fever. She stated she felt better. Got her a graham cracker and this pacified her and she stopped crying. She stated she has a good appetite and is eating well yeah. She reported she is sleeping well Yes. She denied depression. She denied anxiety. Clinician provided supportive therapy, reorientation, reassurance, behavioral therapy and neurocognitive stimulation to help explore and promote adaptive management of negative affect and behaviors. Communication with staff completed. Staff report she is still crying daily . Review of Nursing Progress Note dated 8/22/24 at 8:31 AM, revealed, .Resident crying, stating I need my glasses, she was told they were on her face she felt them and stated no there (sic) not, and continued to cry. Stated she had no clothes on, I need clothes, when she was told she was dressed, she stated no I'm not. Very hard to redirect . Review of Encounter dated 9/4/24 at 01:00 PM, revealed, .Chief Complaint / Nature of Presenting Problem: Follow up visit with (Psychiatric Services provider) NP for ongoing management of psychotropic medications and neuropsychiatric conditions .History Of Present Illness: (Resident #56) is a [AGE] year-old woman who admitted to (Facility) on 06/22/2023 .She was under (Psychiatric Services provider) services at that SNF as well. Clinical Update 9/4/2024: Behavior and mood remain at baseline per SSD/staff. (Resident #56) continues to have intermittent periods of crying. Today, she is seen in common area as she is sitting with peers. She is calm at this time. No acute distress observed .Mood Symptoms: Intermittent tearfulness and anxiety as reported by staff .7/29/2024: 34/132, moderate neuropsychiatric symptoms (21-50 pts); w/ clinically significant elevations in domain(s):delusions, hallucinations, dysphoria (Feeling uneasy, unhappy or unwell), anxiety and irritability/lability=6s' agitation=4 .Follow Up: Nursing staff to monitor and document any new or worsening moods/behaviors and notify (Psychiatric Services provider). Resident to continue with behavioral health services .Assess and monitor severity of mood symptoms. During an observation on 09/10/24 at 01:18 PM, Licensed Practical Nurse (LPN) DD reported she wants to go and see her husband but he had passed away. LPN DD reported the husband had been a resident at the facility as well and he used to come and visit her every day. Resident #56 was unconsolable and was loud and tearful disrupting the rest of the residents seated in the dining room. During an observation on 09/10/24 at 01:26 PM, Resident #56 was noted to be in the dining room. She was very tearful, her face expressed sadness. Certified Nursing Assistant (CNA) W went to her to speak to her to calm her down but no change in her expression of sadness/tearfulness. LPN DD spoke to Resident #56 and was unable to calm her down. Review of Behavior/Mood Symptom Tracking Tool was reviewed for the dates 9/1/24 - 9/13/24 revealed the following: No documentation. Review of Behavior/Mood Symptom Tracking Tool revealed, .Symptom/Behavior: 1. Combative .2. Tearful . 3. Wandering .Interventions: A. Reassure/comfort .B. Redirect .C. Reapproach .D. Assess needs . (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/11/24 09:33 AM, Psychologist FFF reported (Resident #56) had always been tearful, she needs to be reminded to take a deep breath and that works to calm her down. Psychologist FFF reported staff have to mirror the breathing for her to do it, it helps to calm her down, her tearfulness. Psychologist FFF reported has been so much turnover with the staff over here not sure how many know this with her. In an interview on 09/12/24 at 10:18 AM, Social Worker (SW) NN reported the psychologist would stop in to discuss if there were any residents with concerns, if anyone, will go and see them. Also, if she noted immediate concerns or issues on the floor, she would stop and tell SW NN.: SW NN reported the provider for the psychiatric services were able to go into the electronic medical record to enter their notes in the system. SW NN reported she would also review the provider notes after visits to verify if there were any changes and diagnosis changes. SW NN reported she and the MDS nurse would review the notes, but the provider was pretty good at stopping and express who they were concerned about, if there were any changes in interventions to be entered in the care plan for dementia care and behaviors. SW NN reported the care plan was updated between her and nursing department. SW NN reported she would review the notes for morning meeting and enter IDT notes as well. SW NN reported she was just not placing the behavior monitoring tracking tools in the binder for September as she had been on vacation and it was not done by another staff member. Social worker (SW) NN reported she pulled the behavior tracking toll every day and review them. The CNAs and Nurses were able to update them and they were to document on the tracking tool and enter a note into the medical record in the task section. SW NN reported we encourage the CNAs to document in the medical record. In an interview on 09/12/24 at 02:16 PM, Director of Nursing (DON) B reported the nurse would document the residents' behaviors in a progress note as well as complete a the referral form located in the behavior log book. DON B reported the Interventions were on the behavior sheet, not inclusive to those as sometimes interventions work and sometimes they do not. DON B reported and if the staff determine an intervention which works with the resident, they would notify the social worker and she would update the tracking tool sheet. Review of Resident #56's clinical record revealed there was not a person-centered plan, that staff were not consistently implementing a person-centered plan that reflects the resident's goals and maximizes the resident's dignity, autonomy, socialization, independence, and choice. The care plan provided was not comprehensive person-centered plan of care and services. Review of the facility's Employee training records, revealed the facility was unable to provide evidence that 39 out of 104 employees received dementia care training prior to the beginning of the survey on 09/10/24.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 48637 Based on interview and record review, the facility failed to employ a dietary manager with appropriate training and certifications to provide oversight of the kitchen increasing the potential for food service sanitation failures and food borne illness for all residents that consume food from the kitchen. Findings include: During the initial tour of the kitchen on 9/10/2024 at 9:30 AM, Dietary [NAME] (DC) H stated that they haven't had a dietary manager in the kitchen for over a month since the last dietary manager left. DC H said she wasn't sure when the Registered Dietitian (RD) comes in and if she monitors the kitchen when she is there. During an interview on 9/10/2024 at 4:58 PM, Nursing Home Administrator (NHA) A stated that she was aware that there isn't a manager in the kitchen and she tries to go back there to help but she is busy with her own job. During another interview on 9/11/2024 at 9:26 AM, NHA A stated that the RD comes in about 8 hours a month and doesn't monitor the kitchen when she is there.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48637 Based on observation, interview and record review, the facility failed to ensure proper label and dating of foods in the kitchen resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings include: During the initial tour of the main kitchen on 9/10/2024 at 9:30 AM, the cook's reach in refrigerator was observed to have the following: bag of open cheese slices in a ziploc bag with no label and date shredded pork thawing on the middle rack on a cookie sheet with ready to eat food below it The dietary aide's reach in refrigerator was observed to have the following: 1 gallon open Vit D milk jug with no label and date 1 gallon open 2% milk jug with no label and date 1 8-ounce milk in cup, covered with plastic wrap on tray with no label or date During another tour of the kitchen on 9/11/2024 at 9:26 AM, the dietary aide's reach in refrigerator was observed to have the following: cranberry concentrate in a plastic container which was open and had a use by date of 8/14/2024 The main kitchen was observed to have the following: bread crumbs stored in big plastic container which had a preparation date of 6/20/2024 with no use by date thickener stored in big plastic container which had a preparation date of 7/25/2024 with no use by date sugar stored in big plastic container with no label or date The reach in freezer was observed to have the following: open bacon bits in a package with no label and date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 2017 FDA Food Code revealed: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Review of the Date Marking for Food Safety Policy with an implementation date of 12/2023 and a review date of 5/2024 revealed Policy Explanation and Compliance Guidelines for Staffing: 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall consist of the day/date of opening, and the day/date the item must be consumed or discarded. 5. The discard day or date may not exceed the manufacturer's use-by date, or three days, whichever is earliest. The date of opening or preparation counts as day 1. (For example, food prepared on Tuesday shall be discarded on or by Friday). 6. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. 7. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47955 Based on observation, interview, and record review failed to maintain complete and accurate medical records in 3 (Resident #13, Resident #69, and Resident #21) of 19 residents reviewed for complete and accurate medical records resulting in an incomplete and inaccurate documented information in the medical records. Findings include: Resident #13 Review of an Admission Record revealed Resident #13 had pertinent diagnoses which included: Type 2 diabetes (a condition that occurs when the body cannot regulate blood sugar). Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 6/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #13 was cognitively intact. On 9/11/24 at 9:31 AM., Registered Nurse (RN) JJ was observed administering Humalog (insulin) 20 units to Resident #13. In an interview on 9/11/24 at 9:35 AM., RN JJ reported that Resident #13 had an order for Novolog and had Humalog insulin available in the medication cart. RN JJ reported that the two insulins could be interchanged. Review of Physician Order Summary for Resident #13 revealed .Novolog flex pen 100 unit/mL, solution pen-injector (insulin, medication to decrease blood sugar in the body) inject 20 units subcutaneously (under the skin) with meals related to Type 2 diabetes . ordered on 8/13/2024 . No order noted for Humalog. In an interview on 9/11/24 at 2:40 PM., Director of Nursing (DON) B reported the pharmacy will send whatever insulin was available, either Humalog or Novolog for Resident #13. DON B reported the pharmacy will complete a therapeutic interchange with Humalog and Novolog. In a telephone interview on 9/11/24 at 2:58 PM., Pharmacist (P) UU reported that Humalog and Novolog can be therapeutically interchanged. P UU reported there should be a physician order in place for the insulin that was available in the facility for the resident. P UU reported that Resident #13 had an order for Novolog insulin and Resident #13 should be administered Novolog insulin, not Humalog. In an interview on 9/11/24 at 3:09 PM., RN JJ reported the pharmacy would do therapeutic interchanges for insulin according to what the pharmacy had in stock. RN JJ reported the nurses administer to the residents the insulin that was available in the facility. RN JJ reported they did not change the order in the computer record to match what insulin was available in the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/11/24 at 3:24 PM., Unit Manager/Licensed Practical Nurse (UM/LPN) LL reported the pharmacy will input orders into the computer record when they therapeutically change an insulin to match what was sent to the facility for a resident. UM/LPM LL reported the nurse had to confirm the new order for the therapeutically interchanged insulin. In an interview on 9/11/24 at 3:29 PM., DON B reported her expectations were, the physician order must match the medication that was being administered to the resident. If they order did not match, the nurse should update the order before administration of the medication. On 9/12/24 at 1:08 PM., RN II was observed administering 20 units of Humalog to Resident #13. In an interview on 9/12/24 at 1:15 PM., RN II reported she obtained a telephone order from MD WW to administer Humalog until the ordered Novolog was delivered by the pharmacy. When asked if she administered the ordered insulin RN II replied we use what was on hand, we do not change the order in the computer record. In an interview on 9/12/24 at 1:25 PM., DON B reported Resident #13's insulin order should have been corrected yesterday to the insulin that was available in the facility. Review of Medication Administration Record for Resident #13 for the month of September revealed . documentation of administration of Novolog insulin on 9/11/24 by RN JJ at 8:00 AM and 9/12/24 by RN II at 12:00 PM . Resident #69 Review of an Admission Record revealed Resident #69 had pertinent diagnoses which included: asthma (a lung disorder, causing narrowing and constriction of the airway, and shortness of breath) and systolic (congestive) heart failure (a condition where the heart muscle is not able to pump enough blood throughout the body). Review of a Minimum Data Set (MDS) assessment for Resident #69, with a reference date of 8/6/24 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated Resident #69 was severely cognitively impaired. In an observation on 9/10/24 at 10:33 AM., on the bedside stand next to Resident #69's bed was a nebulizer machine (Medical equipment that uses air through tubing into a mask with a liquid medication in it to make a mist that is breathable into the lungs) the with tubing and a mask laying out in the open. The tubing had tape on it with the date of 8/19 written in black ink. Review of Physician Order Summary for Resident #69 revealed .Albuterol Sulfate inhalation nebulization solution 2.5MG/3ML) 0.083% 3 ml inhale orally via nebulizer every 6 hours related to systolic (congestive) heart failure .ordered on 6/11/2024 . In observations on 9/10/24 at 4:00 PM., 9/11/24 at 8:00 AM., 9/11/24 at 2:00 PM., 9/12/24 at 6:55 AM., and 9/12/24 at 1:12 PM., in Resident #69's room, on top of the bedside table next to his bed was a nebulizer machine wrapped in a plastic bag. No tubing or mask noted. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/11/24 RN HH reported Resident #69 has nebulizer treatments scheduled four times a day and they are given. RN HH reported Resident #69 does refuse to take them, and the nurse could chart when he refused. In an interview on 9/12/24 at 7:18 AM., LPN EE reported that Resident #69 has refused his nebulizer treatments. RN EE reported Resident #69 refused his nebulizer treatment that was scheduled for 12:00 AM (Midnight) but that she had not been in to offer him his 6 am dose. Review of Medication Administration Record (MAR) for Resident #69's order for Albuterol Sulfate inhalation nebulization solution indicated by a check mark and LPN EEs initials that the doses on 9/12/24 at 12:00 am and 6:00 am were both administered by LPN EE. In an interview on 9/12/24 at 7:52 AM., when shown Resident #69's MAR, LPN EE confirmed that the documentation entered for Albuterol Sulfate inhalation nebulization solution indicated that the nebulizer treatments had been administered to Resident #69. LPN EE verbally agreed that she had previously told this surveyor that Resident #69 had refused his 12:00 am dose, and she had not administered his 6:00 am dose. 48637 Resident #21 (R21) During an interview on 9/10/2024 at 10:28 AM, R21 stated that he has a pressure ulcer on his bottom and it's been there for a while. R21 said he wants it cleaned every day and it wasn't being done every day. Review of R21's physician order with a start date of 7/18/2024 revealed, Cleanse L (left) and R (right) buttocks with NS (normal saline) pat dry and apply Xeroform to open/excoriated area and cover with ABD (wound dressing) q (every) night shift for wound care; change PRN (as needed) for soilage or dislodgement at bedtime for wound. Review of R21's September 2024 Treatment Administration Record (TAR) revealed that R21 didn't receive treatment to his wound on 9/3, 9/4, 9/5, 9/6, 9/7, 9/9 and 9/11. Review of R21's August 2024 TAR revealed R21 didn't receive treatment to his wound on 8/2, 8/3, 8/5, 8/6, 8/7, 8/8, 8/9, 8/10, 8/14, 8/22, 8/23, 8/24, 8/26, 8/27 and 8/31. Review of R21's July 2024 TAR revealed R21 didn't receive treatment to his wound on 7/18, 7/23, 7/24, 7/28 and 7/29. During an interview on 9/11/2024 at 12:05 PM, Licensed Practical Nurse (LPN) CC verified that R21's wound treatments should be done at night and daily. During an interview on 9/12/2024 at 9:52 AM, Unit Manager (UM) LL stated that she didn't know why R21's wound treatments weren't done every day and she said she can't speak to what happened with that. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/12/2024 at 1:56 PM, Director of Nursing (DON) B stated that R21 refuses treatments quite often but the nurses should have documented that in the TAR if this was the case.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48637 Based on interview and record review, the facility failed to ensure that Quality Assessment and Assurance (QAA) meetings were held at least quarterly and the required individuals attended the meetings resulting in the potential for quality deficiencies not being identified or corrected. Findings include: Review of the Quality Assurance and Performance Improvement (QAPI) meeting sign in sheets revealed that the facility had QAPI meetings on 10/20/2023, 12/21/2023, 1/25/2024 and 8/29/2024. The Medical Director did not attend the QAPI meeting on 1/25/2024 and on 8/29/2024. There were no QAPI meetings from 1/25/2024 to 8/29/2024. During an interview on 9/12/2024 at 11:08 PM, Nursing Home Administrator (NHA) A stated that there wasn't a QAPI meeting since 1/25/2024 until 8/29/2024 but she had been meeting with each department head individually and goes over information for the month. Review of the Quality Assurance and Performance Improvement (QAPI) Policy with an implementation date of 3/2023 and a review date of 2/2024 revealed Policy Explanation and Compliance Guidelines: 1. The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI Plan. 2. The QAA Committee shall be interdisciplinary and shall: a. Consist at a minimum of: i. The Director of Nursing Services; ii. The Medical Director or his/her designee; iii. At least three other members of the facility's staff, at least one of which must be the Administrator, Owner, a Board Member or other Individual in a leadership role; and iv. The Infection Preventionist. b. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary.

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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. 47955 Based on observation, interview, and record review the facility failed to ensure proper use of personal protective equipment during care was used for residents in enhanced barrier precautions (EBP) in 2 (Resident #29 and Resident #41) of 2 reviewed for enhanced barrier precautions care resulting in the potential for the introduction of and/or the spread of infection. Findings include: Resident #29 Review of Physician Order Summary for Resident #29 revealed .Enhanced barrier Precautions due to open wound . started 7/17/2024 . Review of Care plan for Resident #29 revealed .Focus .wound management .date initiated on 7/17/24 . Interventions .enhanced barrier precautions due to open area toe . On 9/10/24 at 10:27 AM., observed signage on the door to Resident #29's room indicated that the room including a resident in enhanced barrier precautions. Certified Nurse Assistant (CNA) R was observed assisting Resident #29 to complete a transfer from his bed to his wheelchair. CNA R was not wearing a gown during care. In an interview on 9/10/24 at 10:30 AM., CNA R reported she had worked at the facility for 7 days, and she did not know what the sign on the door indicated. CNA R stated It's on every door in the building, I don't know what it means. On 9/12/24 at 7:02 AM., CNA Z was observed in Resident #29's room assisting him with dressing for the day. CNA Z was not wearing a gown. On 9/12/24 at 7:08 AM., CNA Q and CNA Z were observed in Resident #29's room assisting him with dressing for the day and transferring Resident #29 into his wheelchair. Neither CNA Q nor CNA Z were wearing a gown during care. In an interview on 9/12/24 at 7:10 AM CNA Z reported the signage on Resident #29's door indicated a resident in the room was in enhanced barrier precautions. CNA Z reported staff should wear PPE (gown and gloves). CNA Z reported Resident #29 was not the resident in the room that was on enhanced barrier precautions. In an interview on 9/12/24 at 7:28 AM., Licensed Practical Nurse (LPN) EE reported Resident #29 was not in enhanced barrier precautions. LPN EE reported that staff should wear PPE during high contact care like bathing, dressing and wound care. In an interview on 9/12/24 at 1:51 PM., CNA V reported Resident #29 was in enhanced barrier precautions and staff should wear a gown and gloves when providing care, including transfers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/12/24 at 2:55 PM., Registered Nurse (RN) FF reported enhanced barrier precautions were used for residents who had wounds, catheters, and IV and staff should wear a gown and gloves during close contact care. In an interview on 9/12/24 at 5:55 PM., Director of Nursing (DON) B reported her expectation was PPE was used during high contact care activities for residents who were in enhanced barrier precautions. DON B reported that transfers were included in the high contact care activities. DON B reported that Resident #29 was in enhanced barrier precautions. 41027 Resident #41 During an observation on 09/10/24 at 09:59 AM Resident #41's room was observed with EBP signage. Review of Resident #41's Physician Orders revealed, Enhanced barrier precautions due to open malignant (cancerous) lesion on back. Active 5/8/24. During an observation on 09/10/24 at 10:16 AM Hospice Nurse (HN) HHH visiting Resident #41 at the bedside, reported that the resident had a very large, open, draining wound on her back. HN HHH was touching the resident and the resident's bedding, and was not wearing a gown. During an observation on 09/11/24 at 11:06 AM in Resident #41's room, Certified Nursing Assistant (CNA) W was providing incontinence care, washing the residents private area and changing her soiled brief. CNA W was wearing gloves, but was not wearing a gown. In a subsequent interview on 09/11/24 at 11:13 AM, CNA W reported that EBP are in place due to Resident #41's wound, and would require a gown to be worn when changing the wound bandage, but not with incontinence care. Review of Resident #41's Nursing Progress Note dated 9/9/2024 revealed, Dressing changed to upper back, large amount of serosanguinous (blood and watery fluid) drainage noted, the top of her right shoulder is red and non-blanchable (redness does not disappear when pressed on), and the right side of her face is deep purble dark red in color, non-blanchable. In an interview on 09/12/24 at 10:09 AM, Director of Nursing (DON) B reported that when a resident has orders for EBP, the expectation would be to wear a gown and gloves with any direct, hands on care of the resident.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 41027 Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) completed specialized training in infection prevention and control, resulting in the potential for knowledge deficits pertaining to current infection prevention and control standards. Findings include: In an interview on 09/12/24 at 10:09 AM, Director of Nursing (DON) B reported that she was the facilities IP, and ran the infection control program for the facility, with the assistance of Unit Manager (UM) LL. DON B reported that she had completed all of the modules from the CDC (Center for Disease Control and Prevention) IP certification training program, but did not complete the post test. DON B reported that she did not have an IP certificate. DON B reported that the facility does not have anyone from corporate overseeing their infection control program, and that it had been DON B's sole responsibility. In an interview on 09/12/24 at 10:10 AM, UM LL reported that she had not completed the IP certification training, therefore was not a certified IP. In an interview on 09/12/24 at 02:13 PM , Nursing Home Administrator (NHA) A reported that she was not aware that DON B had not completed the IP certification training.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41027 Based on interview and record review, the facility failed to ensure residents who were eligible for recommended Pneumococcal vaccines were offered the vaccinations in a timely manner for 2 residents (Resident #5& #14) out of 5 residents reviewed for immunizations resulting in the potential for developing vaccine preventable disease. Findings include: Resident #5 Review of Resident #5's Immunization Record revealed historical vaccines prior to admission including, Pneumococcal PPSV23 received on 3/2/23, and PCV (Prevnar) 13 received on 11/9/15. In an interview on 09/12/24 at 10:09 AM, Director of Nursing (DON) B reported that Resident #5 was over the age of 65, admitted to the facility in February 2024, and was eligible for additional doses of Pneumococcal vaccination (PCV15 or PCV20). DON B reported that the facility would order the vaccine to be administered. DON B reported that there was not education, consent, and/or declination documentation in the resident's record. Resident #14 Review of Resident #14's Immunization Record revealed one historical dose of Pneumococcal PPSV23 given on 9/22/17. In an interview on 09/12/24 at 10:09 AM, Director of Nursing (DON) B reported that Resident #14 was eligible for additional doses of Pneumococcal vaccination (PCV15 or PCV20). DON B reported that there was no record of Resident #14 being educated, offered or declining the vaccination.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 41027 Based on interview and record review, the facility failed to maintain documentation related to staff COVID-19 vaccination to include, that staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine, that staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine, and maintain a record of current vaccination status of facility staff. Findings include: In an interview on 09/12/24 at 10:09 AM, Director of Nursing (DON) B reported regarding facility staff COVID-19 vaccinations, that the vaccination is available for staff to receive. DON B reported that she did not maintain documentation of the vaccination being offered, and/or declined by facility staff. In an interview on 09/12/24 at 02:13 PM, Nursing Home Administrator (NHA) A reported that she was not aware that they needed to keep records of educating, offering, or track status of the facility staff's COVID-19 vaccination status.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 41424 Based on interview and record review, the facility failed to provide annual required abuse prevention education for all employees. This has the potential to affect all 79 residents residing in the facility at the time of the survey. Findings include: Review of Preventing The Abuse of Residents with Dementia or Alzheimer's Disease In The Long-Term Care Setting: A Systematic Review, Published by The National library of Medicine, 2019, revealed . there is an increasing rate of abuse in the long-term care setting, specifically for those individuals with either dementia or Alzheimer's. Common causes and risk factors leading to this abuse include poor training . In an interview on 09/11/24 at 11:06 AM, Certified Nursing Assistant (CNA) V reported (Vendor) training application was on a schedule to be completed. CNA V reported there was not much time at work to complete the trainings as would get pulled to the floor to work and/or they have their charting to do for the residents and it doesn't leave much time to complete the assigned trainings. CNA V reported they were able to access the application at home and could complete the training at home and would submit a slip to the timekeeper to get paid for completion of the training. In an interview on 09/11/24 at 12:34 PM, Receptionist EEE reported she would run reports, employees needed certain classes to start work on the floor for any department. Receptionist EEE reported she would during orientation, checked completed the classes to ensure they were finished prior to the staff working on the floor. Receptionist EEE reported the staff have different due dates for the training to be finished based on their hire dates. Receptionist EEE reported she would send reminders to each employee to complete the trainings, a report would be generated by department each month and sent to the supervisor to remind the employees. In an interview on 09/11/24 at 12:29 PM, Administrator A reported nursing would complete any trainings when needed as well as the training required for completion in the (Vendor) program. The electronic training in (Vendor) program was tracked by Receptionist EEE. Review of the facility's Employee training records, revealed the facility was unable to provide evidence 33 out of 104 staff members received annual abuse prevention training prior to the beginning of the survey on 9/10/24. Review of (Vendor) Training Plans received on 9/11/24, revealed, .New Hire Orientation: All courses marked with an asterick (*) must be completed prior to working independently .All Staff: Preventing, Recognizing, and Reporting Abuse . (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of policy Abuse, Neglect, and Exploitation revised on 10/20/22, revealed, .11. Employee Training .A. New employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation .B. Existing staff will receive annual education through planned in-services and as needed .C. Training topics will include: 1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation; 2. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property; 3. Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators; 4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources; 5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as: a. Aggressive and/or catastrophic reactions of residents; b. Wandering or elopement-type behaviors; c. Resistance to care; d. Outbursts or yelling out; and e. Difficulty in adjusting to new routines or staff .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235598	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riveridge Rehabilitation and Healthcare Center	1333 Wells St Niles, MI 49120

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 41424 Based on interview and record review, the facility failed to ensure the provision of training for behavioral health care and services for 104 staff reviewed for behavioral health care training. This deficient practice had the potential to result in unmet behavioral health care needs and services for residents. Findings include: In an interview on 09/11/24 at 11:06 AM, Certified Nursing Assistant (CNA) V reported (Vendor) training application was on a schedule to be completed. CNA V reported there was not much time at work to complete the trainings as would get pulled to the floor to work and/or they have their charting to do for the residents and it doesn't leave much time to complete the assigned trainings. CNA V reported they were able to access the application at home and could complete the training at home and would submit a slip to the timekeeper to get paid for completion of the training. In an interview on 09/11/24 at 12:34 PM, Receptionist EEE reported she would run reports, employees needed certain classes to start work on the floor for any department. Receptionist EEE reported she would during orientation, checked completed the classes to ensure they were finished prior to the staff working on the floor. Receptionist EEE reported the staff have different due dates for the training to be finished based on their hire dates. Receptionist EEE reported she would send reminders to each employee to complete the trainings, a report would be generated by department each month and sent to the supervisor to remind the employees. In an interview on 09/11/24 at 12:29 PM, Administrator A reported nursing would complete any trainings when needed as well as the training required for completion in the (Vendor) program. The electronic training in (Vendor) program was tracked by Receptionist EEE. Review of the facility's Employee training records, revealed the facility was unable to provide evidence 78 out of 104 staff members received annual abuse prevention training prior to the beginning of the survey on 9/10/24.