STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235600	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Montrose Inc	9317 W Vienna Rd Montrose, MI 48457

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to update care plan interventions for 2 residents (#74, #75) of 22 sampled residents, resulting in the potential for resident care needs being not met/missed, prolonged illness or injury. Findings include: Resident #74: Record review of Resident #74's Minimum Data Set (MDS) assessment dated [DATE] revealed an elderly male resident with a Brief Interview of Mental status (BIMs) score of 3 out of 15, severe cognitive impairment. Medical diagnosis included: Atrial fibrillation, hypertension, gastroesophageal reflux disease, obstructive uropathy, diabetes, dementia, and depression. Section H: bowel & bladder revealed there was no urinary catheter in place. Observation and interview on 12/02/24 at 11:38 AM of Resident #74 revealed the bed to be in low position. Resident #74 was speaking about a dog in the house and to get it out. The surveyor attempted more questions, with no response. Observation of urinary catheter and tubing to be laying on the floor. The catheter does have a single leaf green/blue cover on one side of the catheter, but the non-leaf catheter side is laying on the floor. Will re-observe for further issues. Observation and interview on 12/03/24 at 01:07 PM with Resident #74 were awake lying in bed and the catheter bag is on the floor. Resident #74 was not sure what the catheter was for. Observation of urinary catheter revealed the tube to run down the resident's pant leg to the bag on the floor. Observed the urinary collection bag and tubing to be touching the floor. In an interview on 12/03/24 at 01:11 PM with Resident #74 about urinary Infection and resident did not that he knew. Record review of the facility provided form CMS-802 dated 12/3/2024 identified UTI (Urinary Tract Infection) for Resident #74. Record review of Resident #74's laboratory results for urine dated 10/11/2024 revealed four pathogens: Klebsiella pneumoniae, enterococcus faecalis, actinobaculum schaalii, Providencia stuartii. Resistant (organism) genes were detected with potential for seven (7) medication classes affected. There was no recommendation of colonized organisms noted. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #74's October 2024 Medication Administration and Treatment Administration Records revealed on 10/14/2024 Macrobid antibiotic 100mg capsule by mouth every morning and at bedtime for UTI (Urinary Tract Infection) Klebsiella pneumoniae for 10 days was started. On 10/29/2024 insert Foley catheter STAT for retention was ordered. Record review of Resident #74's October physician order recap report revealed 'Insert Foley catheter STAT for retention' verbal order with started date 10/29/2024 and end date 10/29/2024. Record review on 12/5/2024 of Resident #74's December 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not have any mention or monitoring of urinary catheter, strap and/or when to change the catheter. Record review of Resident #74's care plans pages 1-42 revealed Activity of Daily living (ADL) care plan noted the resident intervention of disposable briefs and one person assist with toileting. Enhanced barrier precautions related to urinary catheter dated 10/25/2024. Review of the Risk for infection related to comorbidities, indwelling Foley catheter, and communal living and possible legionella exposure and has a history of reoccurring UTI. Initiated date 11/27/2023 and revision date 12/5/2024 last day of survey. In an interview and record review on 12/05/24 at 09:42 AM with Registered Nurse Infection Preventionist (RN/ICP) F record reviewed the Urinary Tract Infection (UTI) of Klebsiella in the identified 10/14/2024 laboratory results. RN/ICP F stated that hospice services diagnosed the infection, Hospice said that we believe he has a UTI, we sampled it, came back with klebsiella, treated with Macrobid 100mg x 10 day oral. Resident #74 has Recurrent UTI's his last UTI was in February 2024, so he is doing better than last years. There is an issue with the lab service results, we cannot tell what is colonized and then we could/will miss another infection. RN/ICP acknowledged that Urinary catheters on the floor should be placed in a basin or a barrier to keep off the floor could develop possible for MDRO's (multi-drug-resistant organisms). In an interview and record review on 12/05/24 at 01:49 PM with the Regional clinical consultant I revealed that Resident Chart reviews are done by the Interdisciplinary team (IDT), consist of Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Social Workers/Activities/Dietary/MDS/Nursing Home Administrator/Therapy, facility does daily stand up meeting at 9:00 Am and clinical DON/ADON/clinic staff only at 9:30 AM to review 24 report/admissions & discharges/ Change of conditions. The Unit managers bring in daily report from the floors and read over the 24-hour report of any changes in condition of a resident/labs/x-rays and any reaching out to the Nurse Practitioner (NP)/weight loss, any changes that's different. Record Review of Resident #74 medical record the surveyor asked for a urinary catheter order? Record review of electronic medical record for resident #74 physician orders revealed no order for urinary catheter other than the stat order 10/29/2024. Regional Clinical consultant stated acknowledged that there should have been a Foley catheter order if the catheter was to be left in place. Record review of Resident #74's Care plan? Regional clinical consultant reviewed all care plans and acknowledged that no actual catheter care plan for assess & monitor of catheter care. Resident #75: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #75's Minimum Data Set (MDS) dated [DATE] revealed a [AGE] year-old male resident with medical diagnosis of: Anemia, hypertension, renal insufficiency, diabetes, aphasia, stroke, dementia, hemiplegia, anxiety, depression, and manic depression. Observation and interview on 12/02/24 at 10:21 AM revealed Resident #75 to be in his room, seated in a wheelchair at the bedside. Surveyor attempted interview with Resident #75, and he did respond to questions when asked. Resident #75 made throat clearing noises throughout the interview and repeatedly requested more pudding. Observation on 12/04/24 at 12:24 PM of the 200 hallways noted the Resident #75 seated up in the wheelchair at the bedside in room with noon meal tray and noted to be making repetitive throat clearing noises loud enough to be heard in the hallway. Record review on 12/04/24 at 02:21 of Resident #75's medical record review noted that Clonazepam, Abilify and Lamictal medications were ordered for the resident. Record review of the medical record revealed there was No risk versus benefits and no medication education found for Clonazepam medication in the record for the resident or responsible party. Record review of Resident #75's November 2024 Medication Administration Record revealed on 11/19/2024 clonazepam 0.5 mg give one tablet every morning and at bedtime for anxiety was started on 11/19/2024 in the evening. Resident #75 was noted to still be receiving the clonazepam medication on 12/5/2024 during the annual survey. Record review of 'Nursing 2017 Drug Handbook' page 366 revealed clonazepam therapeutic class: anticonvulsant benzodiazepine. Clonazepam adverse reactions included: amnesia, coma, confusion, depression, glassy eyed appearance, hallucinations, headache, hysteria, insomnia, psychosis, aggressive behaviors, hostility, agitation, anxiety, nervousness . Record review of the facility 'Use of Psychotropic Drugs and Gradual Dose Reductions' policy dated 10/30/2023 defined psychotropic drug is defined as any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, antianxiety, and hypnotics. (1.) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. (4.b.) For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition a diagnosed by a physician (5.) Residents and/or representatives shall be educated on the risk and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions. In an interview and record review on 12/04/24 at 02:53 PM with the Director of Nursing (DON) of Resident #75's electronic medical record and the 'Use of psychotropic drug and gradual dose reductions' policy revealed that the psychotropic consents, risk versus benefits and medication education are initiated by the social services department, the unit manager should then follow up that the consent and risk forms are signed and the DON is the last stop. Reviewed of Resident #75's medical record did not find a consent/risk benefit/education of responsible party for the Clonazepam November 19, 2024, order. Record review of Resident #75's care plans revealed there were no added intervention to monitor clonazepam benzodiazepine medication or side effects found in the care plans. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #75's care plans pages 1 through 37, revealed Record review of the facility 'Comprehensive Care Plans' policy dated 6/30/2022 revealed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment (Minimum Data Set). A person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. (3.) The comprehensive care plan will describe, at a minimum the following: (a.) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being (7.D.) Any updates completed at the care plan meeting .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on record review and interview, the facility failed to follow physician's orders for monitoring blood pressure and heart rate parameters with administration of the medication Metoprolol (used to treat chest pain and hypertension (high blood pressure)) for one Resident (#34), of six reviewed for medication review, resulting in the potential for adverse drug consequences, lack of medication treatment effectiveness and medical conditions left untreated. Findings include: Resident #34: A review of Resident #34's medical record revealed an admission into the facility on [DATE] with diagnoses that included stroke, diabetes and essential (primary) hypertension. A review of Resident #34's Medication Administration Record revealed an order for Metoprolol Tartrate oral tablet 25 mg, give 0.5 tablet via PEG-Tube (Percutaneous endoscopic gastrostomy-a tube placed in the stomach to administer nutrition, fluids and medication) every morning and at bedtime for hypertension. Hold if SBP (systolic blood pressure) is less than 110 or heart rate is less than 60, with a start date on 8/21/23. A review of Resident #34's Medication Administration Record (MAR) for December 1-3, 2024, listed the following blood pressures (bp) and pulses (p) for the morning and bedtime doses given: -12/1/24 morning administration bp 113/78, p 89; bedtime administration bp 113/78, p 89. -12/2/24 morning administration bp 118/72, p 85; bedtime administration bp 118/72, p 85. -12/3/24 morning administration bp 128/68, p 70; bedtime administration bp 128/68, p 70. A review of Resident #34's Medication Administration Record for November 2024 listed the blood pressures (bp) and pulses (p) for the morning and bedtime doses given that included examples of the following: -11/2/24 morning administration bp 116/78, p 72; bedtime administration bp 116/78, p 72. -11/3/24 morning administration bp 116/700, p 72; bedtime administration bp 116/700, p 72. -11/4/24 morning administration bp 123/65, p 69; bedtime administration bp 123/65, p 69. -11/22/24 morning administration bp 114/70, p 70; bedtime administration bp 114/70, p 70. -11/23/24 morning administration bp 114/70, p 70; bedtime administration bp 114/70, p 70. -11/26/24 morning administration bp 118/780, p 72; bedtime administration bp 118/780, p 72. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the month of November 2024 there were 23 days with repeating bp and p documented for the morning administration and bedtime administration with two days with errors in transcription of the bp that were documented on the morning and bedtime administration. There were two days where the same bp and p were documented for the four consecutive medication administrations. A review of Resident #34's Medication Administration Record for October 2024 listed the blood pressures (bp) and pulses (p) for the morning and bedtime doses given that included examples of the following: -10/1/24 morning administration bp 118/72, p 70; bedtime administration bp 118/72, p 70. -10/2/24 morning administration bp 95/64, p 93 (the medication parameters were followed ad the medication was held); bedtime administration bp 95/64, p 93 (the medication was documented as given though per the bp parameter instructions, the medication would be held and not be given). -10/3/24 morning administration bp 123/65, p 69; bedtime administration bp 123/65, p 69. -10/13/24 morning administration bp 111/70 p 96; bedtime administration bp 111/70, p 96. -10/14/24 morning administration bp 111/70 p 96; bedtime administration bp 111/70, p 96. For two days the same bp and p were documented. -10/15/24 morning administration bp 123/70, p 72; bedtime administration bp 123/70, p 72. -10/16/24 morning administration bp 123/70, p 72; bedtime administration bp 123/70, p 72. For two days the same bp and p were documented. -10/18/24 morning administration bp 108/70, p 88 (the medication was documented as given though per the bp parameter instructions, the medication would be held and not given); bedtime administration bp 108/70, p 88 (the medication was documented as given though per the bp parameter instructions, the medication would be held and not given). In the month of October 2024, there were 23 days with repeating bp and p documented for the morning administration and bedtime administration with three administrations where the bp documented were not within the prescribed parameter to give the medication, but the medication was documented as given. There were four days where the same bp and p were documented for the four consecutive medication administrations. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 3:46 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #34's Metoprolol medication administration. The MARS for October, November, and December were reviewed with the DON. The DON agreed that of the unlikelihood of having consecutive blood pressures as what was documented and that the errors in the bp should not be carried over from one administration to the next. The DON reported the possibility of the nurses having the option to pull and chart the last recorded blood pressure and pulse. A review of the medication administration record revealed there was an option to document the last recorded blood pressure. The DON indicated that the nurse was to take the blood pressure at or near the time of administration and record the vitals taken in the medication administration record when there were parameters for the medication and should not be using the previous blood pressure and pulse. The DON reported that the CNAs (certified nursing assistants) do the vitals for anything that does not require a medication, and the nurse were to do the vitals for medications and the nurse was to follow the instructions of the parameters. A review of facility policy titled, Medication Administration, reviewed/revised 1/17/2023, revealed, .Policy Explanation and Compliance Guidelines: .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to assist with denture care and nail care for two Residents (#11 and 51) of seven residents reviewed for activities of daily living, resulting in fingernails long and jagged, denture cup with debris inside and the potential for embarrassment, skin injury and infection. Findings include: Resident #11: A review of Resident #11's medical record revealed an admission into the facility on [DATE] and readmission on 12/28/21 with diagnoses that included stroke, hemiplegia and hemiparesis following stroke affecting right dominant side, dementia, anxiety disorder, depression and dysphagia following stroke. A review of the Minimum Data Set assessment dated [DATE] revealed the Resident had intact cognition and needed substantial/maximal assistance with activities of daily living. On 12/4/24 at 9:40 AM, an observation was made of Resident #11 in their room. The Resident was dressed and had on her personal jewelry and many bracelets on her wrists. The Resident was asked about nail care and an observation was made of fingernails long, some jagged or cracked. An observation was made of scant amount of old nail polish on a couple nails. The Resident was asked if she liked long nails and indicated they were too long. The Resident was asked if she would allow staff to trim or file their nails and the resident nodded in confirmation. The Resident was unsure when she had her nails painted. On 12/4/24 at 3:05 PM, an observation was made with Unit Manager, Nurse K of Resident #11's fingernails on her left hand. The Unit Manager asked the Resident if she would consent to have her nails trimmed and the Resident confirmed. The Unit Manager reported that the Resident liked to have longer nails and stated, They definitely need to be filed, and reported it should be offered during showers and the Resident was to get two showers a week. The Unit Manager reported it's a beauty thing with her, she will let some one file them, and she will probably let me trim them, but she has refused nailcare at times. When asked about the old nail polish, when that was to be removed, the Unit Manager reported that the Activities department will paint the nails and they take it off before done again. On 12/4/24 at 3:36 PM, an interview with the Activities Director S was conducted regarding painting of Resident nails. The Activities Director reported the Activities Department has not been doing nails, and that families can do them if Residents want them done. On 12/4/34 at 3:58 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #11's nail care. The DON indicated nail care was to be done with bathing and as needed. A review of Resident #11's care plan revealed no interventions regarding refusal of nail care nor interventions in place to address refusals. The DON indicated that was one thing they were working on, getting refusals on the care plans. It was discussed how the Resident may not want them clipped but the staff can offer to file the nails instead. Resident #51: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident $51's medical record revealed an admission into the facility on [DATE] with diagnoses that included epilepsy, weakness, and adjustment disorder with mixed anxiety and depressed mood. A review of the Minimum Data Set assessment revealed that the Resident had intact cognition and the Resident was independent of activities of daily living. On 12/3/24 at 11:55 AM, an interview was conducted with Resident #51 who answered questions and engaged in conversation. The Resident was dressed and propelling self in the room. An observation was made of Resident #51's denture cup on the counter by the sink. The denture cup was half full of water, there was debris floating in the water and debris on the sides of the cup above the water. There appeared to be small round cream-colored dots on the sides of the plastic cup at the water line. The denture cup was open and in the vicinity of the sink. The Resident reported putting her own dentures into her mouth. On 12/3/24 at 1:00 PM, an observation was made with Infection Control (IC) Nurse F of Resident #51's denture cup on the counter of the sink area. The cup was not clean with debris in the water and on the sides of the cup. With gloves on, the IC Nurse swiped the sides of the cup where the cream colored dots were observed earlier and reported a possibility it was food debris and stated, It needs to be changed none the less. A review of facility policy titled, Activities of Daily Living (ADL), reviewed/revised 12/28/23, revealed, .Policy Explanation and Compliance Guidelines: .3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . A review of facility policy titled, Nail Care, reviewed/revised 8/20/24, revealed, Policy: The purpose of this procedure is to provide guidelines for the care of a resident's nails for god grooming and health. Policy Explanation and Compliance Guidelines: .3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular basis and as the need arises. 5. Principles of nail care: a. Nails should be kept smooth to avoid skin injury .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to 1. Coordinate and collaborate hospice service for Resident #83 to ensure comprehensive care and 2. Complete timely assessment and monitoring of skin and change bandages and sheets when visibly soiled for Resident #403. Findings Include: Resident #403: On 12/3/2024 during initial tour, Resident #403 was observed in bed resting, she stated she recently admitted to the facility after being septic and coding. She reported her fingers are black which is why they are bandaged and were last changed last night by facility staff. Resident #403's bilateral hands were bandaged but were completely saturated with brown colored drainage. There was a dressing on the right side of her neck dated 11/25 11:00 and another dressing on her right arm with no date. On 12/4/2024 at 9:15 AM, Resident #403 was observed visiting with her husband. When asking about the dressings that were on her right arm and chest the day prior. He expressed facility staff voiced he was able to take off the dressings as they had been here since she was in the hospital. Bruising was noted to the right brachium, small pea size scab to catheter insertion site to neck. Resident #403's bilateral hands were wrapped with brown/tan drainage seeping through. The sheets underneath her feet were soiled with betadine and serosanguinous drainage. The resident's husband asked about a dressing that was completed at the hospital but had not been done since his wife's admission. The resident reported she was ok with completing a skin observation of the area. On 12/4/2024 at 10:07 AM, an observation of Resident #403's skin was completed in the presence of CNA (Certified Nursing Assistant) N. Resident's bed was observed to have a moderate amount of old drainage on it. Her coccyx was observed to have a pink, spongy, occlusive dressing dated 11/29 with initials gm on it. Resident did complain of pain with be mobility and per her husband she had not received her pain medications this morning. Record review was completed with the ADON (Assistant Director of Nursing) and there was no order located regarding her coccyx dressings. The ADON reported their wound nurse took pictures of Resident #403's hands and feet but not her coccyx area. The DON (Director of Nursing) entered the room at 10:27 AM, and Resident #403's husband asked when the bedding is changed, and she reported on shower days and as needed. The DON removed the coccyx dressing and the resident's skin was slightly reddened to the upper right area. Her husband stated the dressing was put on at the hospital. The ADON stated this area was no listed on the initial skin assessment. On 12/4/2024 at approximately 11:30 AM, a review was completed of Resident #403's medical records and it indicated the resident admitted to the facility on [DATE] with diagnoses that included, Diabetes, Kidney failure, Bacteremia, Sepsis, Gangrene, Pleural Effusion. Further review yielded the following: Admission Skin Assessment 11/29/2024: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Right hand/left hand. Bilateral feet gangrene Necrotic bue (bilateral upper extremities) and ble (bilateral lower extremities) Progress Notes: 11/29/2024 at 22:21: Pt(patient) admitted on ,d+[DATE]. I was not present during admitted . This admission was completed today 12/2/24 during my scheduled shift .pt has wounds noted to BLE and BLE. Pt c/o (complaints of) intermittent pain . Review was completed of the facility policy entitled, Wound Treatment Management revised 10/26/2023 .The policy stated, .In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. Dressing changes may be provided outside the frequency parameters in certain situations: a. Feces has seeped underneath the dressing. b. The dressing has dislodged. C. The dressing is soiled otherwise, or is wet . 37666 Resident #83: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #83 was admitted to the facility on [DATE] with diagnoses: history of a stroke, Chronic respiratory failure, tracheostomy, Cushing's syndrome, chronic kidney disease, diabetes, dysphagia, feeding tube, blindness, chronic pain and depression. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status score of 0/15 and the resident needed assist with all care. On 12/03/2024 at 10:04 AM, during a review of the physician orders, the following was identified: Please have Hospice evaluate and treat, dated 3/5/2024. A review of the Care Plans for Resident #83 provided, (Resident #83) has a terminal prognosis with (Hospice Care) related to end of life diagnosis: apraxia (a movement disorder) following cerebral infarct (stroke). Start of service was 3/11/24 ., date initiated 3/27/2024 and revised 5/15/2024 with Interventions including: Hospice to supply binder and calendar that has schedule of when the nurse, can, social work and clergy will visit, date initiated 5/15/2024. A review of the electronic medical record/emr for Resident #83 revealed the last Hospice note in the chart was input on 11/4/2024. On 12/05/2024 at 9:26 AM, Social Worker H and Social Services G were interviewed about the Hospice documentation for Resident #83. They said each resident had a Hospice book near the nurses desk. Social Services G showed the book for Resident #83; there were no Nurses or nurse aide notes identifying services or visits provided to the resident. There were only Care plans and documents dated 3/14/24. Social Worker H said she would call the Hospice company and have the documents sent over. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/2024 at 9:36 AM, Assistant Director of Nursing M was interviewed and she said the Hospice notes for Resident #83 should be in the binder at the nurses desk. The ADON M stated, They are not in the book. I will contact Hospice and have her send them over. A review of the facility policy titled, Hospice, dated 10/30/2020 and revised 10/26/2023 revealed, Policy: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff . The facility maintains written agreement with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on interview and record review the facility failed to ensure thorough initial therapy assessment documentation, prevent a reduction in range of motion and the development of contracture for one resident (Resident #10) of one resident reviewed for limited range of motion. Findings Include: Resident #10: On 12/4/2024 at 11:05 AM, Resident #10 was observed resting in this in his room. He reported he has been at the facility for one year and therapy has not attempted to stand him up. He stated they informed him he would not be able to stand due to the outwardness of his feet. He reported he was walking at one point with a cane and now is not able too. On 12/4/2024 at approximately 11:45 AM, a review was conducted of Resident 10's medical records and it indicated he admitted to the facility on [DATE] with diagnoses that included, Peripheral Vascular Disease, Heart Disease, Kidney Disease, Adjustment Disorder, Hypertension and Mood Disorder. Further review of the records yielded the following: Progress Notes: 10/15/2024 at 02:42 PM: .Negative: Decreased muscle tone, Contractures . 10/14/2024 at 02:35 PM: .He is a long term resident at the facility that was recently placed back on therapy services due to a functional decline. He was placed with Services to work on increased ROM, bed mobility and help with his contractures. He did well with a brief bedside assessment and some passive and active ROM. He denies any acute pain or unmet needs at this time . Stretching to BLE's including hip . knee and ankles to increase ROM, positioning and contracture management BLE AROM to AAROM/PROM in all planes of movement to increase strength to assist with bed mobility and positioning for pressure reduction . 11/04/2024 at 08:34 AM: .Mobility and ADL dysfunction secondary to weakness and debility ROM: AROM in BUE and limited in BLE. Patient has a decorticate position with contractures noted . 11/14/2024 at 06:38 PM: . He states therapy is going well and he continues to work on his hand contractures and extension and his b/l leg strength. He continues to work on his core strength and his posture while sitting in his chair . He continues to have difficulty with grip strength and grasping objects and poor extension if his hands . 11/19/2024 at 10:47: .ROM: AROM in BUE except bilateral hand contractures and limited in BLE . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/2024 at approximately 12:15 PM, an interview was held with Therapy Director Q regarding Resident #10's level of functioning in addition to reviewing his therapy evaluation. The Director explained upon admission they evaluate the residents for their presenting reason. When reviewing his initial PT (physical therapy) and OT (occupational therapy) assessment from 11/10/2023. It was found his baseline ROM (range of motion) was not comprehensively assessed as many sections were denoted NA, and under contractures it indicated, No. Therapy Director Q reported they picked him back up to maintain his prior level of functioning and due to contractures. When reviewing his records it was asked how they would assess if his ROM had declined if they had no baseline assessments. It was explained they utilize the discharge paperwork and resident interview to do so. Resident #10's measurements were reviewed, and the Director Q stated the documentation points to a decline in functional abilities since admission and new onset of contractures. Review was conducted of Resident #10's therapy discharge summaries and plan which indicated there was decline in his overall mobility since his admission to the facility and development of contractures, which per his therapy assessments were not present upon admission. PT (Physical Therapy) Evaluation & Plan of Treatment 11/10/2023 -12/9/2023: RLE ROM=Impaired; LLE ROM= Impaired Right Hip= Impaired; Knee= impaired; Ankle= WFL Left Hip= Impaired; Knee =Impaired; Ankle- WFL AROM- R Hip: Flexion= NA; Extension=NA AROM- R Knee; Flexion= NA; Extension=NA AROM L Hip; Flexion= NA; Extension=NA AROM L Knee; Flexion= NA; Extension=NA Contracture: Functional limitations present due to contracture= no Reason for therapy: Therapy session was conducted using telehealth services for today's session . The assessment indicated the resident did not have contractures. Occupational Therapy Evaluation & Plan of Treatment 5/16/2024-6/14/2024: .Contracture; Functional limitations present due to contracture= no . PT Discharge Summary 9/25/2024-11/22/2024: PROM (passive range of motion) BLE (bilateral lower extremities) hip flexion to 55 degrees PLOF (Prior Level of Functioning): 60 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/25/2024 Baseline: 50 PROM left knee extension PLOF: -15 9/25/24 Baseline: -30 Anatomical alignment while in bed: Not assessed until 10//16/2024- 2 hours PROM Right Ankle Dorsiflexion PLOF: 4 Baseline 09/25/24: -5 PROM BLE Ankle Inversion PLOF: WNL (within normal limits) Baseline 09/25/24: -15 PROM BLE Hip Flexion: PLOF: 60 Baseline 09/25/24: 50 PROM Right Knee Flexion: PLOF: 60 Baseline 09/25/24: 45 PROM Left Knee Extension: PLOF: -15 Baseline 09/25/24: -30 On 12/5/2024 at 1:30 PM, an interview was conducted with Physical Therapist R regarding Resident #10. She reported he does have some range of motion and not enough to be to be functional and is fully dependent on staff for his care. When he was evaluated earlier this year, Therapist R completed a restorative plan so he could at least maintain that level of functioning but there was a decline between the most recent two times he was on therapy. Resident #10 now has bilateral hip, knee and ankle contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/2024 at approximately 2:00 PM, the DON (Director of Nursing) reported Resident #10 has never been on a restorative program at the facility. Review was completed of the facility policy entitled, Range of Motion, revised 10/21/2024. The policy stated, Residents who enter the facility without limited range of motion will not experience a reduction in range of motion. The resident's range of motion (such as current extent of movement of his/her joints and the identification of limitations) shall assess on admission/readmission, quarterly, and upon a significant change .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to provide necessary management and care of an indwelling urinary catheter for 2 residents (Resident #24, and Resident #74) and management of recurrent Urinary tract infection/UTI for one resident (Resident # 73) of 3 residents reviewed for urinary catheters, resulting in the potential for complications including infection and a decline in condition. Findings Include: Resident #24: Urinary Catheter or UTI On 12/03/2024 at 10:23 AM, Resident #24 was observed sleeping in bed. An indwelling urinary catheter (Foley catheter) bag was sitting on the floor bent over, not hanging freely; the catheter tubing had thick yellow urine with sediment and biofilm (a sticky grouping of bacteria) on the inside of the catheter walls. A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: history of a stroke, diabetes, chronic kidney disease, Crohn's disease, gastrostomy tube, respiratory failure, hypertension, arthritis, anxiety and depression. The MDS assessment dated [DATE] revealed the resident had moderate cognitive loss and needed total assistance with all care. The MDS Section H Bowel and Bladder did not indicate the resident had an indwelling urinary catheter. A review of the physician orders on 12/4/2024 at 3:30 PM, revealed there was no order for a urinary catheter for Resident #24. A review of the Medication Administration Record and Treatment Administration Records (MAR/TAR) for December 2024 indicated there was no documentation for the presence of an indwelling urinary catheter for Resident #24. A review of the progress notes revealed the following: A Provider note dated 11/29/2024, . Genitourinary: Positive- Urinary catheter, Foley . A Provider note dated 11/13/2024, . On 11/10/24, nurse reports patient with anuria for approximately 12 hours. Nurse performed bladder scanned and shows 801 ml. The on-call provider was notified and new orders given to insert indwelling Foley catheter . A review of the November 2024 MAR/TAR's for Resident #24 indicated there was no documentation for the presence of an indwelling urinary catheter (Foley catheter). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/2024 at 3:45 PM, a review of the Care Plans for Resident #24 indicated there was no mention of a urinary catheter. On 12/5/2024 a urinary catheter Care Plan was initiated, after the resident had the urinary catheter for approximately 3 weeks. On 12/05/2024 at 9:47 AM, the Assistant Director of Nursing/ADON M was interviewed about the Foley catheter for Resident #24. She looked in the electronic medical record/emr for a physician's order for the catheter and stated, I do not see one. During the interview, the ADON was accompanied to Resident #24's room. The resident's Foley catheter bag was observed sitting in a wash basin and the basin was on the floor. The ADON said the residents with a low bed usually had the catheter bag in a basin so it did not touch the floor. Reviewed with the ADON that on 12/3/2024 the resident's catheter bag was on the floor bent over and was not in a basin. She said they were trying to keep them off the floor Resident #73: Urinary Catheter or UTI 12/3/2024 at 11:04 AM Resident #73 was observed lying in bed, awake, alert and answered questions by shaking his head yes or no. The resident was observed to have a Foley catheter, draining yellow urine. A record review of the Face sheet and MDS assessment indicated Resident #73 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Osteomyelitis (wound/bone infection) of vertebra, sacral and sacrococcygeal region, history or infection with multiple different microorganisms, peripheral vascular disease (PVD), history of a stroke with left sided weakness, chronic pain, right above the knee amputation, diabetes. The MDS assessment dated [DATE] revealed the resident had moderate cognitive loss with a BIMS score of 7/15 and needed some assistance with all care. A review of the progress notes and assessments for Resident #73 identified a document titled, SBAR Communication Form and progress note, dated 12/4/2024 at 9:38 AM, . Pelvic pain and pressure . Treatment for last episode: October 2024 . Primary diagnoses: Osteomyelitis of Vertebra, sacral and sacrococcygeal . abdominal pain . pelvic pain . painful urination . Other new requested/suggested orders: UTI (urinary tract infection), Cefdinir 300 mg (antibiotic) . monitor for increased s/s of infection . A review of the physician orders identified an order for Cefdinir Capsule 300 mg dated 12/3/2024 to begin 12/3/2024 at 8:00 PM. There was an additional order dated 12/4/2024 Okay to take Cefdinir with a history of penicillin allergy. The order was pending confirmation. On 12/4/2024 at 2:15 PM, Infection Control Practitioner/ICP F was interviewed about Resident #73's UTI. She said a urine had been collected for the resident on 11/27/2024, sent to the laboratory/lab on 11/27/2024 and was resulted on 12/2/2024 and identified 2 organisms: Proteus Mirabilis and Enterococcus faecium. There was no antibiotic sensitivity provided with the urine culture. The laboratory provided Pharmacy Guidance and Medication Review, but did not show the results of the urine culture and sensitivity for provider and nursing review. The resident was ordered Cefdinir antibiotic on 12/3/2024. The ICP said the resident had also had another UTI in November 2024: urine collected 10/30/2024, sent to the lab 10/31/2024 and resulted on 11/5/2024. It also identified Proteus mirabilis in the urine with no antibiotic sensitivity. The laboratory provided Pharmacy Guidance for antibiotics. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview with the ICP on 12/4/2024 at 2:15 PM, the antibiotic treatment for Resident #73 was reviewed. She said the resident had several prior UTI's and the organism was identified as Proteus Mirabilis in both instances. A review of the lab results indicated there were antibiotic recommendations from the lab, but no antibiotic sensitivity provided to the facility. Reviewed the resident also had a chronic sacral wound with osteomyelitis and had been on long term antibiotic therapy for several months prior to the UTI diagnoses and now had recurrent UTI's. The ICP said the UTI rate had been high at the facility and they were attempting to identify the cause. On 12/05/2024 at 2:30 PM, the Corporate Clinical Nurse I was interviewed about. The facilities use of laboratory urine results with no antibiotic sensitivity. She said the facility was reviewing the lab results for UTI's to ensure the resident received necessary care and antibiotic use was appropriate. 22927 Resident #74: Observation and interview on 12/02/24 at 11:38 AM of Resident #74 revealed the bed to be in low position. Resident #74 was speaking about a dog in the house and to get it out. The surveyor attempted more questions, with no response. Observation of urinary catheter and tubing to be laying on the floor. The catheter does have a single leaf green/blue cover on one side of the catheter, but the non-leaf catheter side is laying on the floor. Will re-observe for further issues. Observation and interview on 12/03/24 at 01:07 PM with Resident #74 were awake lying in bed and the catheter bag is on the floor. Resident #74 was not sure what the catheter was for. Observation of urinary catheter revealed the tube to run down the resident's pant leg to the bag on the floor. Observed the urinary collection bag and tubing to be touching the floor. In an interview on 12/03/24 at 01:11 PM with Resident #74 about urinary Infection and resident did not that he knew. Record review of the facility provided form CMS-802 dated 12/3/2024 identified UTI (Urinary Tract Infection) for Resident #74. Record review of Resident #74's laboratory results for urine dated 10/11/2024 revealed four pathogens: Klebsiella oxytoca pneumoniae, enterococcus faecalis, actinobaculum schaalii, Providencia stuartii. Resistant (organism) genes were detected with potential for seven (7) medication classes affected. There was no recommendation of colonized organisms noted. Record review of Resident #74's October 2024 Medication Administration and Treatment Administration Records revealed on 10/14/2024 Macrobid antibiotic 100mg capsule by mouth every morning and at bedtime for UTI (Urinary Tract Infection) Klebsiella pneumoniae for 10 days was started. On 10/29/2024 insert Foley catheter STAT for retention was ordered. Record review of Resident #74's October physician order recap report revealed 'Insert Foley catheter STAT for retention' verbal order with started date 10/29/2024 and end date 10/29/2024. 12/04/24 09:17 AM Observed up in reclining chair with catheter bag hanging on arm of chair above the bladder level. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 12/05/24 at 09:42 AM with Registered Nurse Infection Preventionist (RN/ICP) F record reviewed the Urinary Tract Infection (UTI) of Klebsiella in the identified 10/14/2024 laboratory results. RN/ICP F stated that hospice services diagnosed the infection, Hospice said that we believe he has a UTI, we sampled it VIKOR, came back with klebsiella, treated with Macrobid 100mg x 10 day oral. Resident #74 has Recurrent UTI's his last UTI was in February 2024, so he is doing better than last years. There is an issue with the lab service results, we cannot tell what is colonized and then we could/will miss another infection. RN/ICP acknowledged that Urinary catheters on the floor should be placed in a basin or a barrier to keep off the floor could develop possible for MDRO's (multi-drug-resistant organisms). In an interview and record review on 12/05/24 at 01:49 PM with the Regional clinical consultant I revealed that Resident Chart reviews are done by the Interdisciplinary team (IDT), consist of Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Social Workers/Activities/Dietary/MDS/Nursing Home Administrator/Therapy, facility does daily stand up meeting at 9:00 Am and clinical DON/ADON/clinic staff only at 9:30 AM to review 24 report/admissions & discharges/ Change of conditions. The Unit managers bring in daily report from the floors and read over the 24-hour report of any changes in condition of a resident/labs/x-rays and any reaching out to the Nurse Practitioner (NP)/weight loss, any changes that's different. (laboratory Name)- we only use them for culture items such as urine/sputum/wound cultures, this building is still using that lab. The labs don't give a sensitivity, makes the facility call the lab pharmacy for recommendations of antibiotic treatments. The sensitive or colonization is not on the results. Record Review of Resident #74 medical record the surveyor asked for a urinary catheter order? Record review of electronic medical record for resident #74 physician orders revealed no order for urinary catheter other than the stat order 10/29/2024. Regional Clinical consultant stated acknowledged that there should have been a Foley catheter order if the catheter was to be left in place. Record review of Resident #74's Care plan? Regional clinical consultant reviewed all care plans and acknowledged that no actual catheter care plan for assess & monitor of catheter care. Record review on 12/5/2024 of Resident #74's December 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not have any mention or monitoring of urinary catheter, strap and/or when to change the catheter.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on observation, interview and record review, the facility failed to ensure tube feeding equipment was maintained, tube feeding supplies were labeled and dated, and enteral nutrition and care per physicians' orders were provided for four residents (#34, #35, #53, #90) out of five residents reviewed for enteral nutrition, resulting in undated solutions, unassessed skin, inaccurate volumes infused and dirty equipment. Findings include: Resident #90: On 12/04/24, at 8:35 AM, an observation along with Nurse J of Resident #90's alarming tube feeding pump and Glucerna 1.5 solution was conducted. Nurse J was asked if there was a date or time on the solution bottle and/or tubing and Nurse J shook their head no. Nurse J was asked what the total volume fed for solution and total volume fed for water flush was. Nurse J manipulated the pump to reveal total volume fed to be 1915 ml (milliliters) and the total flush to be 960 ml. The water flush bag was a liter volume capacity and appeared to be 100 % full. There was nothing written on the label of the solution bottle nor the water flush. On 12/04/24, at 8:40 AM, an observation along with the Director of Nursing (DON) of Resident #90's tube feeding equipment was conducted. The DON was asked if they seen a date, time or rate on the solution bottle and the DON stated, I did not. The DON was asked if the water flush bag appeared full and the DON stated, yes. The DON was asked how they could ensure the water flush was working as the total flush revealed 960 ml but the bag appeared 100% full and the DON stated, I cannot. On 12/04/24, at 12:56 PM, an observation of Resident #90's tube feeding insertion site was conducted with Unit Manager (UM) K. The insertion site had dried crusty build up under the securement device with no dressing. There was an abdominal securement device that was stuck to Resident #90's abdomen. The dressing appeared old, was undated and was discolored. UM K was asked what the dressing was for and UM K offered, it's a duoderm and that the hospital often placed that type of dressing. UM K offered, they planned to take it off. UM K unhooked the feeding tube from the dressing securement device and removed the dressing. The abdominal wall had a shiny appearance. UM K was asked to clarify why the dressing was in place and UM K stated, the hospital put it on and that the facility doesn't use that type of dressing. UM K further offered, normally we take them off but it got missed. On 12/04/24, at 2:30 PM, a record review of Resident #90's electronic medical record revealed an admission on 6/13/2024 with a readmission on 7/10/2024 with diagnoses that included severe malnutrition, gastrostomy and jaw necrosis with maxillofacial surgery. Resident #90 required assistance with Activities of Daily Living and had intact cognition. A review of the physician orders revealed no order for the duoderm securement dressing. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Order Details . Order Date 9/12/2024 . Enteral Feed . Everyday . Hang: Via Peg feeding tube Glucerna 1.5 CONTINUOUS at goal rate of 80 ml/hr (hour) x 12 hrs (7pm -7am) or until 960 ml infused . A review of the Nutrition Data Collection . Quarterly 9/16/2024 . revealed . Flush order Via Peg feeding tube continuous water flush of 60 ml/hr for 12 hrs (7pm-7am), total of 720 ml water flush/24 hrs . A review of the Treatment Administration Record for the November and December 2024 revealed no order and no assessment for the abdominal securement dressing that was found on Resident #90's abdomen. On 12/04/24, at 2:39 pm, a record review of Resident #90's electronic medical record along with the DON was attempted but failed due to Internet connectivity issues within the building. The DON was asked to provide the time and date the abdominal securement dressing was applied and the most recent hospitalization . The DON was asked why the dressing or Resident #90's abdominal wall was not assessed, and the DON offered that they would follow up. The DON did not offer any follow up information prior to exiting the survey. On 12/05/24, at 839 AM, Resident # 90's call light was activated. The tube feeding machine was alarming. Nurse O entered Resident #90's room and turned off the alarm. Nurse O was asked to obtain the total volume fed for the solution which revealed 2815 ml. Nurse O was asked to obtain the total water flush which revealed 2251 ml. Nurse O was asked if the total volume of solution and flush was accurate and Nurse O stated, it looks like they didn't clear the total volumes from yesterday. On 12/05/24, at 9:35 AM, Registered Dietician (RD) L was interviewed regarding Resident #90's tube feeding orders and how often they spot check the tube feeding volumes and RD L offered, they would look into it. A review of the facility provided policy Feeding Tubes Revised: 10/15/2024 revealed . Feeding tubes will be utilized according to physician orders . The facility will utilize the Registered Dietician in estimating and calculating a resident's daily nutritional and hydration needs . Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders . Direction for staff regarding how to manage and monitor the rate of flow will be provided . use of a pump . Periodic evaluation of the amount of feeding being administered for consistency with practitioner's orders . 37666 Resident #35: Tube Feeding A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #35 was admitted to the facility on [DATE] with diagnoses: recent abdominal surgery, history of intestinal obstruction, diabetes, heart failure, COPD, respiratory failure, tracheostomy, pneumonia, Bipolar disorder, dysphagia, gastrostomy tube, and kidney failure. The MDS assessment dated [DATE] revealed the resident had mild cognitive loss with a Brief Interview for Mental Status/BIMS score of 12/15 and needed some assistance with all care. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/03/2024 at 10:59 AM , Resident #35 was observed sitting up in bed, awake. He was observed to have an enteral nutrition/tube feeing bottle hanging on an IV pole near the bed. The label on the bottle said the enteral nutrition formula was Glucerna 1.5 and was to be administered at 90 ml hour. The label was dated 12/3/2024 6:00 AM. The bottle was full and it was not infusing/running. A bag with water was also hanging on the pole with a label that said it was to be administered at 50 ml hour and was dated 12/3/2024. The resident was asked if he had a feeding tube and nodded his head yes and pointed to his abdomen. On 12/04/2024 at 12:32 PM, the physician orders were reviewed for Resident #35: Enteral feed order one time a day Hang: Via PEG (feeding tube) Jevity, Continuous nocturnal at goal rate of 120 ml/hour x 12 hours (7 PM to 7 AM) or until 1440 ml infused, to provide 2160 kcal, 92 gm protein, start date 12/2/2024. Enteral Feed Order one time a day Via Peg feeding tube, continuous water flush of 83 ml/hour for 12 hours (7 PM to 7 AM), total of 996 ml water flush/24 hours, start date 12/3/2024. A review of the weights for Resident #35 revealed the following: 6/7/2024 180.6 lbs. and 11/29/2024 162.9 lbs. A review of a dietary note dated 11/26/2024 identified the resident had weight loss and a Dietary assessment dated [DATE] recommended to increase the tube feeding and water amount provided to Resident #35. An order was written for both on 12/2/2024. On 12/5/2024 at 9:45 AM, during an interview with Assistant Director of Nursing M, the tube feeding orders were reviewed for Resident #35, she confirmed the orders were changed and said the resident's tube feeding bottle of formula and water should have had the correct information on them when the bottle was viewed on 12/3/2024. On 12/05/2024 at 10:52 AM, during a interview with Registered Dietitian/RD L she said Resident #35 had experienced weight loss during the time he was recently in the hospital. The RD said she recommended for increased tube feeding and water and the orders were updated with the recommendations and that was what he should have been getting. 37771 Resident #34: A review of Resident #34's medical record revealed an admission into the facility on [DATE] and readmission on 12/22/22 with diagnoses that included stroke, dysphagia following stroke, diabetes, muscle weakness, dementia and dysarthria following a stroke. The Minimum Data Set (MDS) assessment revealed the resident had intact cognition and needed setup or clean-up assistance with eating, dependent with toileting hygiene, bathing, and lower body dressing, and needed substantial/maximal assistance with most mobility. Further review of the medical record revealed the Resident had a PEG tube (percutaneous endoscopic gastrostomy tube-a tube placed in the stomach for nutrition, hydration and/or medication administration). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/3/24 at 11:37 AM, an observation was made in Resident #34's room of the enteral feeding attached to tubing and hanging next to the Resident's bedside. The Resident was not in the room. The tube feeding was not running but was ready for infusion. There was not a time of when the bag was hung, the date was 12/3/24. The tubing was not dated and there was no date or time when the water flush was hung. The enteral feeding was partially used. The tubing had enteral feeding in the tube and the end of the tubing was open to air with no cap on the end. On 12/4/24 at 9:58 AM, an observation was made with the Director of Nursing (DON) of Resident #34's tube feeding that had the enteral nutrition up on the pole with tubing connected. The label had a date on it but there was not time. When asked if the label needed to be dated with a time, the DON pointed to the label and indicated it should be dated with a time of when it was hung. The tube feed was partially used, and the end of the tubing was draped over the pump and was not capped. When asked, the DON reported the tubing should be cap and not left open to air. Resident #53: A review of Resident #53's medical record revealed an admission into the facility on [DATE] and readmission on 11/14/24 with diagnoses that included respiratory failure with hypoxia, dysphagia, need for assistance with personal care, surgical aftercare following surgery on the digestive system, and gastrostomy status. A review of the MDS assessment revealed the Resident was cognitively intact and needed partial/moderate assistance with toileting, bathing and upper body dressing. Further review of Resident #53's medical record revealed the Resident had a PEG tube. On 12/3/24 at 12:39 PM, an observation was made of Resident #53 lying in bed with the head of the bed elevated. The Resident had a tube feeding bag with tubing that was connected to a pump but was not infusing at this time. The Resident indicated that they took it off this morning. The bottle of enteral solution was dated 12/2/24 at 1430 (2:30 PM), the tubing and water flush were not dated/timed. The enteral solution was partially used. The end of the tubing hung over the tube feeding pump and was not capped but left open to air. On 12/4/24 at 9:28 AM, an observation was made of Resident #53 lying in bed with the head of the bed elevated. The tube feeding was infusing, and the pump was on. The date on the enteral feeding was 12/2/24 and time was 1430. The enteral nutrition was mostly used. On 12/4/24 at 9:44 AM, Nurse C who was assigned care of Resident #53 was asked about the tube feeding. The Nurse indicated that the tube feed was due to be taken down at 10 AM. The Nurse was asked when the Resident was started on the tube feeding. The Nurse responded that she had left at 6:30 PM the day before and that the nightshift nurse had started it. The Nurse reported that when she came in, that was the bottle that was hanging. On 12/4/24 at 9:50 AM, an observation was made with the Director of Nursing (DON) of Resident #53's tube feeding infusing. The date of the bottle of enteral solution was 12/2/24 and time was 1430. The enteral nutrition had been infusing past 24 hours. The DON was queried regarding how long tube feeding should be hung. The DON reported tube feeding should be changed every 24 hours. When asked about labeling the tubing, the DON reported that with every bottle that goes up, a new administration set was put on. The DON indicated that Resident #53's tube feeding should have been changed the day before and should not be infusing over 24 hours.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to: 1) Ensure that residents received oxygen as ordered for 4 residents (#'s 21, 24, 30 and 83) of 6 residents reviewed for oxygen use and; 2) Ensure proper management of oxygen and trach supplies for 2 residents (#'s 24 and 83) of 5 residents reviewed for Trachs, resulting in the potential for the lack of necessary oxygen therapy and contamination of supplies. Findings Include: Resident #21: On 12/05/2204 at 9:54 AM, Resident #21 was observed wheeling herself rapidly in her wheelchair past the nurses table near the 300 hall. Her face was red and she was breathing heavily. A staff member was walking with her and said she was looking for a nurse, because the resident's oxygen tank was empty. The resident was asked if she was having difficulty breathing and she shook her head Yes and stated, I need a new oxygen tank. The Assistant Director of Nursing/ADON, said she would get the resident a new oxygen tank. The resident said she was on the other side of the building in the dining room. The Assistant Director of Nursing/ADON, stated, That's a long way to go, and said she would get the resident a new oxygen tank. The resident continued to breathe heavily. At 9:59 AM, on 12/5/2024, the ADON returned with a new portable oxygen tank and said the tank the resident had was empty. The indicator on the oxygen valve was red. The ADON connected the new tank and at 10:03 AM the resident began to wheel herself to her room. The ADON was asked about the resident's oxygen saturation level and she asked Nurse DD to assess the resident. The ADON was asked about the empty oxygen tank and she said it should have been checked. A review of the electronic medical record and Minimum Data Set/MDS assessment, indicated Resident #21 was admitted to the facility on [DATE] with diagnoses: Diabetes, hypertension and depression. The MDS assessment dated [DATE] revealed the resident had moderate cognitive loss and needed partial assist with care. The MDS Section O identified the resident as receiving oxygen therapy. Resident #24: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: history of a stroke, diabetes, chronic kidney disease, Crohn's disease, gastrostomy tube, respiratory failure, tracheostomy, hypertension, arthritis, anxiety and depression. The MDS assessment dated [DATE] revealed the resident had moderate cognitive loss and needed total assistance with all care. On 12/03/2024 at 10:18 AM, Resident #24 was observed sleeping in bed. She had a tracheostomy tube/trach, a congested cough, and slight dark dried secretions on the tip of the trach and trach ties. She had an air compressor on the bedside table set at 20 and oxygen via trach mask at 2 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the physician orders for Resident #24 identified an order for oxygen therapy: Oxygen: Run at 8 l/min via trach, continuous, date started 8/1/2024. There was no order for the compressor rate. A review of the Medication Administration Record and Treatment Administration Record/MARTAR for December 2024 provided, Oxygen: Run @ 8 l/min via trach continuous, start date 8/1/2024. The entries for day evening and night were all initialed by a nurse as completed as required, including 12/3/2024 when the oxygen was observed to be set at 2 l/min. On 12/05/2024 at 8:52 AM, Resident #24 was observed to have an open 100 ml bottle of normal saline 100ml with approximately 25% remaining. The bottle was not dated when opened. The resident's oxygen was observed set at 2 l/min. On 12/05/2024 at 9:46 AM, ADON M was interviewed about the oxygen for Resident #24. The ADON reviewed the order for the resident's oxygen and stated, It says 8 l/min. Reviewed with the ADON the oxygen was set at 2 liters a minute. She said she would have the nurse address it. A review of the Care Plans for Resident #24 identified the following: (Resident #24) has an impaired pulmonary/respiratory status related to acute and chronic respiratory failure, recent malfunction of trach . dated initiated and revised 6/26/2024 with Interventions including: Oxygen as ordered: Oxygen: Run @ 8 l/min via trach continuous, date initiated 6/26/2024 and revised 10/9/2024. Resident #83: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #83 was admitted to the facility on [DATE] with diagnoses: history of a stroke, Chronic respiratory failure, tracheostomy, Cushing's syndrome, chronic kidney disease, diabetes, dysphagia, feeding tube, blindness, chronic pain and depression. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status score of 0/15 and the resident needed assist with all care. On 12/03/2024 at 10:05 AM, Resident #83 was observed lying in bed. She had a trach, with thick secretions, dark yellow and light brown, with some blood flecks in it. She had oxygen delivered via a trach mask at 4 liters/minute and an air compressor set at 20. A suction canister was sitting on a table by the wall and was approximately 60% full, with thick secretions: dark yellow/brown, and slight green tinted in the fluid. A record review of a Provider note dated 12/2/2024 indicated the resident had a cough with green mucous. Several provider notes indicated Resident #83 had been treated for prior respiratory infections 10/18/2024 to 10/25/2024 and 6/19/2024 to 6/26/2024. The notes said Hospice was to manage. A review of the physician orders identified the following order: Oxygen: Run @ 2 l/min via trach, continuous, as tolerated by lodger, keep spO2 (oxygen saturation) greater than 88%, dated 11/11/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/2024 at 8:57 AM, Resident #83 was observed lying in bed sleeping. The trach was observed to have a large amount of thick tan secretions around the outside of it. The suction canister was greater than 80% full with tan secretions. The oxygen was set at 4 l/min. On 12/05/2024 at 9:39 AM, the ADON M was interviewed about Resident #83's oxygen settings, as they did not match the orders. She said she would check the orders. Reviewed the MAR/TAR for December 2024 for Resident #83, it had an intervention for Oxygen: Run @ 2l/min via trach 24 hours per day, continuous, as tolerated by lodger, keep spO2 greater than 88% every shift, start date 11/11/2024. The nurses were initially they completed this intervention for oxygen at 2 l/min, when it was set at 4 l/min. Also reviewed with the ADON there was no order for the air compressor settings. She said she would check on that. During the interview, also reviewed with the ADON, that the resident was observed to have a large amount of very thick tan secretions around the outside of the trach. She said trach care was completed 3 times a day and one nurse was assigned to the unit and probably had not completed the care yet. Discussed the suction canister in the resident's room, it was very full with secretions. She said someone would change it. A review of the Care Plan for Resident #83 revealed, (Resident #83) has an impaired pulmonary/respiratory status . date initiated 12/8/2023 and revised 3/8/2024 with Interventions including: Oxygen as ordered: Oxygen: Run @ 2 l/min via trach 24 hours per day continuous . dated 12/8/2024 and revised 11/11/2024. A review of the facility policy titled, Tracheostomy Care, dated 10/30/2020 and reviewed/revised 10/26/2023 provided, The facility will ensure that residents who need respiratory care including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice . The facility will provide necessary respiratory care and services, such as oxygen therapy . make sure oxygen is administered as ordered . 39059 Resident #30: On 12/03/24, at 11:32 AM, Resident #30 was lying in their bed resting with their eyes closed. Their oxygen was on 5 liters via a nasal cannula. The nasal cannula was not in both nostrils correctly. Their nebulizer mask was lying face up on their nightstand uncovered. There was a CPAP (continuous positive air pressure) mask hanging inside a plastic bag on the wall out of reach. The CPAP machine was dry of hydration. On 12/03/24, at 4:37 PM, Resident #30 was lying in bed resting with an audible snore. Resident #30 did not have on their CPAP mask and their oxygen remained dialed to 5 liters. On 12/04/24, at 8:52 AM, Resident #30 was in bed on their back resting with their eyes closed. Their CPAP mask remained in a plastic bag hanging on the wall out of reach. Their oxygen rate remained dialed to 5 liters. Their nebulizer mask was face down on the nightstand uncovered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/04/24, at 8:55 AM, an observation along with the Director of Nursing (DON) of Resident #30 was conducted. Their nebulizer mask was face down on their nightstand. The DON was asked if the nebulizer mask should be face down uncovered and the DON stated, No and then discarded the nebulizer mask and tubing. The DON fixed the nasal cannula and was asked what liter of oxygen Resident #30's concentrator was dialed to, and the DON offered, 5 liters. The DON was asked if the resident required hydration with the high dose of 5 liters and the DON offered, they would look into it. Resident #30 woke up and was asked is they use their CPAP mask, and the resident responded, I'm supposed to. Upon exiting the room, the DON was alerted of Resident #30's observations the day prior. The DON offered they would follow up. On 12/04/24, at 2:30 PM, a record review of Resident #30's electronic medical record revealed an admission on 05/19/2023 with diagnoses that included Chronic Obstructive Pulmonary Disease, (COPD) Dementia and Age-related physical debility. Resident #30 required extensive assistance with Activities of Daily Living and had impaired cognition. A review of the physician orders revealed Order Date: 8/9/2023 . Oxygen: RUN @ (2) L/MIN VIA N/C CONTINUOUS . every shift for Hypoxia . A review of the Focus (the resident) has an impaired pulmonary/respiratory status related to CHF, COPD . Interventions . Uses CPAP at night as tolerated . Revision on: 12/15/2023 . Oxygen as ordered Date Initiated: 10/03/2023 . Clean nebulizer with warm water and mild soap, after each usage, dismantle, place on paper towel to dry, after drying place in plastic bag. Revision on: 12/06/2023 . On 12/04/24, at 2:48 PM, the DON was further interviewed regarding Resident #30's oxygen rate and the DON offered, yes, it was on 5 liters. The DON was alerted the physician order was for only 2 liters. The DON planned to call the nurse practitioner. A review of the facility provided policy Nebulizer Therapy Revised 05/15/2024 revealed . Clean after each use . Disassemble parts after every treatment. d. Rinse the nebulizer cup and mouthpiece with water . Air dry on an absorbent towel. g. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37771 Based on interview and record review, the facility failed to ensure that Licensed Nurses (RNs-Registered Nurses and LPNs-Licensed Practical Nurses) and Certified Nursing Assistants (CNA) received yearly competency evaluations to ensure competent and trained nursing staff to perform their duties to attain or maintain the wellbeing of residents, for six Nurses and CNAs of seven staff reviewed for evaluations, education and competencies, resulting in the potential nursing staff lacking necessary training and skills to adequately care for the needs of the residents residing in the facility of a census of 105. Findings include: On 12/5/24 at 12:43 PM, an interview was conducted with Human Resources (HR) Personnel U during the Sufficient and Competent Nurse Staffing task of the survey. The HR was asked for documentation for staff competency and evaluations with training/education based on the evaluation outcomes. LPN W's evaluations were reviewed with one completed in 2022. When asked for a more current competency evaluation, HR Personnel indicated she did not have one available for 2023 or 2024 and that the only one in there was from orientation. A review of LPN X, RN Z, CNA AA, CNA BB and CNA CC competencies were reviewed with HR Personnel U, all of which lacked a current evaluation. RN Z had a yearly evaluation dated 4/12/23 but did not have one for 2024. HR Personnel was asked about the facility policy for completing evaluations, indicated they should have one in their folder yearly, reported she would have the evaluation if they had been completed and that they were not done by the previous administration. When asked how long the new Director of Nursing had been at the facility, the HR Personnel indicated about 2 months. On 12/5/24 at 2:01 PM, an interview was conducted with the Director of Nursing (DON) regarding how often nursing staff are evaluated to assess their competency, skills and knowledge and the process to evaluate staff skill levels to develop individualized competency-based training. The DON reported that she was made aware of the lack of yearly evaluation that were not completed when she had started and reported that evaluations were in progress with the Unit Managers. The DON indicated that the Unit Managers work closely with the nursing staff and that yearly evaluations will be completed with the Unit Managers for CNAs and Nurses both. The DON reported the past administration had not completed the yearly evaluations and stated, I have a plan to accomplish the task.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 37771 Based on observation, interview and record review, the facility failed to post required, accurate, updated nurse staffing records and retain accurate data of the nurse staffing hours, resulting in the potential to affect all Residents residing in the facility of a census of 105, Resident representatives and visitors to be unable to determine nursing staff on duty. Findings include: On 12/5/24 at 11:51 AM, an interview was conducted with Scheduling Coordinator (SC) T to review nursing staffing hour postings. An observation of the posting for 12/5/24 did not have the RN (registered nurse) hours posted. The SC indicated that the posting must have been cut off when it printed and reported she will reprint the posting. The RN hours were confirmed. The posting for November 23, 2024, did not have RN posted hours. The DON confirmed that there was a RN on for the day. The SC was questioned about the daily posting of nursing staffing hours. The SC indicated that every day when she comes in, she would retrieve the posting and correct it if there were any changes during the night. When asked about weekends, the SC indicated that the posting was to be completed and posted for every day and the receptionist would print them and post them for the weekends. The binder presented for retained nursing staffing posted hours documents used by the facility titled BIPA (Benefits Improvement and Protection Act), revealed multiple days not available. The DON had been notified to determine access to the missing nursing staffing posted hours. A review of the binder for July 2024 had one BIPA for July 30th. The SC was able to find another file that had postings for July and other months, but with review with the SC, the retained postings were not complete. A review of the month of July postings with the SC revealed multiple postings for the same day that had different hours posted resulting in conflicting data. The SC indicated that could have been where a posting had been updated and the old or inaccurate posting had not been disposed of. The SC was unsure which posting was the accurate document. The staffing schedules were compared with the BIPA's for accuracy of the posted nursing staffing hours with the SC. The SC compared the day of November 24, 2024. The total number of CNAs on the schedule indicated 16 but the daily staffing indicated 13 were on. The SC indicated there could have been some call offs but with review of the schedule for call offs, the assignment and the posted staffing hours did not match. The 11/9/24 assignment and BIPA were compared. The SC reported they had 18 CNAs on, one was a one to one and another was training which the SC reported would not count for the posting. The SC reviewed the BIPA with 14 listed CNAs and reported the schedule and the BIPA did not match. The SC confirmed that the schedule had 18 listed CNAs, but the BIPA listed 14. A review of the LPNs scheduled for the day on 11/9/24 revealed 10 LPNs with one training. The SC indicated the BIPA should have 9 listed. The review of the BIPA revealed 6 documented. The BIPA document that was used for posting of the nursing g staffing hours were not accurate with the documentation of the staff scheduling. A review of the August 2024 Daily Staffing documents revealed the days of the 8/3, 8/4, 8/7, 8/9, 8/10, 8/11, 8/12, 8/15, 8/17, 8/22, 8/24, 8/25 were not presented as available for review by the facility. (continued on next page)

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	235600	A. Building B. Wing	12/05/2024

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Medilodge of Montrose Inc	9317 W Vienna Rd Montrose, MI 48457

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of March 2024 Daily Staffing documents revealed March 1, 2 and 3rd were available to review. A review of the Daily Staffing document used by the facility titled, BIPA with the date, revealed, on the bottom of the document, Section 941 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) requires nursing homes participating in Medicare and Medicaid to post this information daily.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to respond to pharmacy recommendations for two (#8 and #9) residents of five residents reviewed for unnecessary medications. Findings Include: Resident #8: On 12/4/2024 at 10:45 AM, a review was completed of Resident #8's medical records and it revealed he admitted to the facility on [DATE] with diagnoses that included, Traumatic Brain Injury, Depression, Insomnia and Adjustment Disorder. On 12/05/24 at 12:15 PM, review was conducted of Resident #8's Medication Regime Review's (MRR) from November 2023- November 2024. It was found there were three recommendations from the pharmacist that the facility failed to respond too. The recommendations were requested from the facility (as they were not accessible in the medical record) and, the DON (Director of Nursing) stated they do not have the physical pharmacy recommendations prior to October 2024. She further explained she would have to call pharmacy to obtain them, and they would not have a response by the provider. Resident #8 had the following recommendations: 10/7/2024 at: 15:00: Pharmacy Medication Review Progress Note Note Text: Medication regimen review: 1 note to prescriber 6/11/2024 at 12:19: Pharmacy Medication Review Progress Note Note Text: Medication regimen review: 1 note to prescriber 4/7/2024 at 18:10: Pharmacy Medication Review Progress Note Note Text: Medication regimen review: 1 note to nursing 3/8/2024 at 16:54: Pharmacy Medication Review Progress Note Note Text: Medication regimen review: 1 note to prescriber On 12/5/2024 at 12:50 PM, the DON expressed they contacted the pharmacy and received communication on what the specific recommendations were and reviewed them to verify if they were completed. It was found of the four recommendations within the lookback period, three were not responded too. They are as follows: 10/7/2024: Recommended A1C, TSH, CMP and lipid panel. Upon chart review it was not completed (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/7/2024: Recommendation to correct the route of oral antibiotic as it was ordered to instill 1 tablet in left ear every 12 hours when it should be via mouth. This antibiotic order was not corrected during the course of administration 3/8/2024: Recommended lipid panel, A1c and TSH for antipsychotic monitoring. Labs were not completed. Review was conducted of the facility policy entitled, Addressing Medication Regimen Review Irregularities, reviewed 12/28/2023. The policy stated, .The report will be sent to the attending physician, the facility's medical director and director of nursing and lists, at minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. d. The attending physician must document in the resident' medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. If the pharmacist should identify an irregularity that requires urgent action to protect a resident, the DON or designee is informed verbally. a. The facility shall immediately act upon the recommendation, contacting the physician no later than midnight of the next calendar day. b. The response shall be documented in the resident's medical record or on a form designated by the facility . 37771 Resident #9: A review of Resident #9's medical record revealed an admission into the facility on [DATE] with diagnoses that included hypertensive heart and chronic kidney disease, dementia, chronic pain, psychotic disorder with delusions, mood disorder and major depressive disorder. A review was conducted of Resident #9's Pharmacy Medication Review Progress Notes from 12/7/23 to 11/11/24. In the progress notes, there were pharmacy notes to prescriber identified for the dates of 12/7/23, 7/9/24, 8/6/24, 10/7/24 and 11/11/24. The recommendations were not accessible in the medical record and were requested from the facility. The following pharmacy recommendations were received by the facility: -Date 8/6/24: Please consider discontinuing this monitoring order as she is no longer on an antipsychotic (GDRed to end date 5/1/24). The Physician/Prescriber Response was not documented or signed by the Provider. -Date 7/9/24: Loratadine Tablet 10 MG (milligrams) Give 1 tablet by mouth every 24 hours as needed for Seasonal Allergy. Please consider discontinuation for non-use in 2024 per eMAR. The Physician/Prescriber Response was not documented or signed by the Provider. -Date 10/7/24 and 11/11/24: The recommendations were addressed and signed by the Provider. The Pharmacy Recommendations for the date of 12/7/24 were not received by the facility. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 4:05 PM, an interview was conducted with the Director of Nursing (DON) regarding the MRR for Resident #9. The DON indicated that they did not have the recommendations and had the pharmacy send a copy, but they were not signed off on. The DON indicated that before October 2024, they did not have copies of the pharmacy recommendations.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview, and record review the facility failed to provide risk versus benefits and/or medication education to one resident (Resident #75) or resident/responsible party, resulting in Resident #75 to be administered a benzodiazepine medication without appropriate risk versus benefit analysis of the medication explained to the resident/responsible party and the increased potential for serious side effects and adverse reactions. Findings include: Resident #75: Record review of Resident #75's Minimum Data Set (MDS) dated [DATE] revealed a [AGE] year-old male resident with medical diagnosis of: Anemia, hypertension, renal insufficiency, diabetes, aphasia, stroke, dementia, hemiplegia, anxiety, depression, and manic depression. Resident #75 Brief Interview of Mental status (BIMs) score of 7 out of 15 cognitively impaired Observation and interview on 12/02/24 at 10:21 AM revealed Resident #75 to be in his room, seated in a wheelchair at the bedside. Surveyor attempted interview with Resident #75, and he did respond to questions when asked. Resident #75 made throat clearing noises throughout the interview and repeatedly requested more pudding. Observation on 12/04/24 at 12:24 PM of the 200 hallways noted the Resident #75 seated up in the wheelchair at the bedside in room with noon meal tray and noted to be making repetitive throat clearing noises loud enough to be heard in the hallway. Record review on 12/04/24 at 02:21 of Resident #75's medical record review noted that Clonazepam, Abilify and Lamictal medications were ordered for the resident. Record review of the medical record revealed there was No risk versus benefits and no medication education found for Clonazepam medication in the record for the resident or responsible party of legal guardian. Record review of Resident #75's November 2024 Medication Administration Record revealed on 11/19/2024 clonazepam 0.5 mg give one tablet every morning and at bedtime for anxiety was started on 11/19/2024 in the evening. Record review of 'Nursing 2017 Drug Handbook' page 366 revealed clonazepam therapeutic class: anticonvulsant benzodiazepine. Clonazepam adverse reactions included: amnesia, coma, confusion, depression, glassy eyed appearance, hallucinations, headache, hysteria, insomnia, psychosis, aggressive behaviors, hostility, agitation, anxiety, nervousness . In an interview and record review on 12/04/24 at 02:35 PM with social worker G in her office of Resident #75's electronic medical record for medication risk versus benefits and resident/responsible party/legal guardian education of medication clonazepam. There was no risk versus benefits or education found in the medical record or presented to the surveyor upon request. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility 'Use of Psychotropic Drugs and Gradual Dose Reductions' policy dated 10/30/2023 defined psychotropic drug is defined as any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, antianxiety, and hypnotics. (1.) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. (4.b.) For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition a diagnosed by a physician (5.) Residents and/or representatives shall be educated on the risk and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions. In an interview and record review on 12/04/24 at 02:53 PM with the Director of Nursing (DON) of Resident #75's electronic medical record and the 'Use of psychotropic drug and gradual dose reductions' policy revealed that the psychotropic consents, risk versus benefits and medication education are initiated by the social services department, the unit manager should then follow up that the consent and risk forms are signed and the DON is the last stop. Reviewed of Resident #75's medical record did not find a consent/risk benefit/education of responsible party for the Clonazepam November 19, 2024, order. In an interview and record review 12/04/24 at 02:57 PM with social services staff H reviewed Resident #75's Clonazepam 0.5 mg oral twice daily order for anxiety stated that the medication did start in November 2024. Record review of paper file in social services office revealed that no consent/no risk versus benefits/ and no responsible party/legal guardian education was found for the clonazepam. Social services staff H stated that Resident #75 was started on 11/19/2024 clonazepam, and the facility had plenty of time to get a consent/risk versus benefits/responsible party education. Hallways are split by: Social worker G has hallways 200, 400, 600, and the front half of 700 hallway. Social services staff H had hallways of 100, 300, 500, and the back half of 700 hallway. Social services staff H stated that she did call the wife, and she did not answer, just since surveyor asked about the clonazepam, left a voice message to return the call and will email the consent today to her yahoo account. But currently we have nothing for a consent/risk versus benefits/responsible party education was found.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview, and record review the facility failed to ensure proper storage of medications in 4 of 4 medication carts reviewed, and ensure appropriate narcotic reconciliation, resulting in opened and undated multi-dose medications, the potential for unaccounted controlled substances and altered medication efficiency. Findings include: Medication Storage and Labeling: Observation and interview on 12/03/24 at 11:10 AM with Licensed Practical Nurse (LPN) A of the 300-hall medication cart review noted medication punch cards in the second drawer, the surveyor found 2 loose white tablets, marked with TV 2204 on back side of tables. LPN A stated that the night shift was to clean out the medication carts last night and placed the loose tablets in a drug buster located within the medication cart. Review of third drawer of the medication cart revealed nasal spray Fluticasone Propionate 50 mcg for the resident in room [ROOM NUMBER] was opened/used and not dated for when the multi-dose bottle was opened. Observation of a Valproic acid 250mg/ml bottle opened/used and not dated with 15ml left in bottle of a 30ml bottle for the resident residing in room [ROOM NUMBER]. LPN A stated that both multi-dose bottles should have had an open date on the bottles. Observation of the 300-hall medication cart narcotic drawer reviewed noted Morphine 20mg/ml for Resident #83 noted the bottle was opened and not dated, surveyor observed 14.75 ml left in bottle. Observation and interview on 12/04/24 at 08:31 AM with Licensed Practical Nurse (LPN) B of the single medication room revealed a medication machine with fingerprint access for each nurse. Observation and interview on 12/04/24 at 08:34 AM with Licensed Practical Nurse (LPN) B 400 hall medication cart revealed Budesonide 0.25mg/2ml nebulizer vial solution not dated and not in container in third drawer of med cart and with no resident identification. Observation and interview on 12/04/24 at 08:43 AM with Licensed Practical Nurse (LPN) A of the 100-hall medication cart revealed discharge Resident #44's had albuterol 0.083% nebulizer solution foil pack opened and not dated three left in the 5 pack. Observation of Resident #5's Albuterol 0.083% nebulizer solution vial not dated with only one vial out 5 left in the package. Observation of the 100-hall narcotic drawer reviewed Ativan gel with 18mg left in the tube with no open date on the tube. LPN A stated that again the night shift nurses were to clean out the medication carts and date all open medications before surveyors got to the facility. Observation and interview on 12/04/24 at 08:53 AM with Licensed Practical Nurse (LPN) C of the 600-hall medication cart review revealed Resident #30 had Albuterol 83% nebulizer solution foil package of 4 vials not dated out of 5 packages. Observation of Resident in room [ROOM NUMBER] had Ipratropium and albuterol 0.5/ 2.5 nebulizer solution 3ml solution foil packet opened and not dated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility 'medication Storage' policy dated 1/30/2024 revealed it is the policy of the facility to ensure all medications housed on the premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Record review of the pharmacy services 'Storage of Medications' policy dated 8/2024 revealed (5.) When the manufacturer has specified a usable duration after opening (i.e. beyond use date), the nurse shall place a date-opened sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacture recommends another date or regulations/guidelines require different dating. (b.) I a vial or container is found without a stated date opened, the date opened will automatically default to the date dispensed and the expiration date will be calculated accordingly, unless otherwise indicated in a facility-specific policy. No specific policy was provided by the facility. 39059 On 12/05/24, at 8:05 AM, an observation of the pharmacy delivery to medication cart on the 600 hall was conducted. Nurse O received narcotics and placed them in the narcotic drawer for the 500 hall medication cart. After medication pass task was finished on the 600 medication cart. Nurse O went back to the 500 hall medication cart. Nurse O added +1 F.A. to the narcotic count sheet. A record review of the Unit 500 narcotic count sheet with Nurse O was conducted. For the date of 12-3-24 the Final # 18 was scribbled dark over number 17. Nurse O was asked if they reconciled that morning and Nurse O stated, yes but was unsure who the other nurse signature was. Nurse O signature was in the On Coming Nurse column for the date of 12/4. Nurse O was asked why the signed the 12/4 column when the date was 12/5/24 and Nurse O offered, Honestly, I didn't check the date. A further record review of the Unit 500 narcotic count sheet revealed a Final # 21 for the date of 12/4 600 (6:00 AM). For 12/4 8p (8:00 PM) revealed Starting # 21 . Empty -1 JF . Final # 20 There were two nurse signatures for the Off Going Nurse column. The signature in the On Coming Nurse was Nurse O's signature. The next line was blank. Nurse O was observed documenting the date of 12/5 . Starting # 20 and documented a +1 F.A. in the Received from pharmacy column. Nurse O did not subtract the -1 from the total and left the Final # at 20 when it should have been 19. On 12/05/24, at 9:17 AM, a record review of the Unit 600 narcotic count sheet revealed 12-3-24 6pm Starting # 5 Received from pharmacy +3 Empty 0 Removed by DON 0 Final #8 . There was a signature in the Off Going Nurse column but no signature in the On Coming Nurse column. The next line down was crossed off with +2 DJ written in the Received from pharmacy column. There were initials in the On Coming Nurse column with a date written of 12-3-24 but no time and the +2 was not added to the Final # column. The second narcotic drawer count sheet for the 600 medication cart was not labeled with the Unit number and revealed on 12-4-24 Starting # 14 which was scribbled over with number 15 and the Final # column was the same. The 12/5/24 Starting # also had a scribbled number 15 over the 14. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/24, at 10:04 AM, the Director of Nursing (DON) was asked why Nurse O signed the narcotic count sheet for the date of 12/4 when she wasn't in the building and why the actual off going nurse didn't sign that they reconciled the narcotics and the DON offered, it should have been Nurse P. The DON was alerted of the scribbled numbers and was asked if that was ok and the DON offered, no. The DON offered, they spot check the narcotic count sheets about once a week and did do a nurse education about 2 months ago when they took over to not scribble and ensure narcotic count sheets were completed correctly.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 39059 Based on observation, interview and record review, the facility failed to provide food preferences for a lunch for one resident (Resident #22) of fifteen residents reviewed during the dining task, resulting in consumption of food not liked with the likelihood of decreased nutritional intake. Findings include: Resident #22: On 12/03/24, at 12:15 PM, Resident #22 was sitting at a dining table with their lunch meal in front of them. Resident #22's meal ticket revealed dislikes that were on the plate. Resident #22 had mashed potatoes and gravy and what appeared to be carrots. The resident was asked if they liked masked potatoes and the resident stated, no, but I'll take what I can get. On 12/3/2024, at 3:30 PM, a record review of Resident #22's electronic medical record revealed an admission on 09/08/2022 with diagnoses that included Dementia, Mood Disturbance and Anxiety. Resident #22 required extensive assistance with Activities of Daily Living (ADL's) and had severely impaired cognition. A review of the Focus (the resident) has potential for alterations in nutrition/hydration status . Revision on 07/30/2024 . Interventions . Obtain and honor food preferences within dietary parameters. Date Initiated: 09/26/2023 . On 12/05/24, at 10:03 AM, Registered Dietician (RD) L was asked for Resident #22's meal tickets for all meals that day. On 12/05/24, at 10:30 AM, a record review along with RD L of Resident #22's meal tickets revealed Notes: . Mashed Potatoes/Gravy . Alerts: . Gravy on all meats . Dislikes . Other . Vegetables. RD L was asked why dislikes of gravy are listed and then in the alert section it says gravy on all meats and RD L offered that Speech therapy will often add alerts to the meal tickets . RD L offered that they would follow up and update the meal tickets to reflect Resident #22's preferences.

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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. 39059 Based on observation, interview and record review, the facility failed to ensure proper medication administration and clean reusable medical equipment for one resident (Resident #10) of six residents reviewed for medication administration task, resulting in the use of unsanitary equipment and the administration of dirty pills. Findings include: Resident #10: On 12/05/24, at 8:31 AM, During medication administration task, Nurse O prepared Resident #10's medications. Nurse O offered they needed to cut 2 of the larger pills for the resident. Nurse O placed a large tablet in the pill cutter which was soiled with a moderate amount of white residue. Nurse O placed the cut tablet in the medication cup with their bare hands. Nurse O then cut the second tablet and placed into the medication cup with their bare hands. Nurse O entered Resident #10's room and administered the medications to the resident. On 12/05/24, at 9:43 AM, Infection Control (IC) Nurse F was asked if residents oral medications should be touched with bare hands and IC Nurse F stated, no. IC Nurse F was alerted of the soiled pill cutter. IC Nurse F was asked what the nurses are to do with a soiled pill cutter and IC Nurse F stated, they're expect to clean them off. A record review of the facility provided Medication Administration Revised:1/17/2023 revealed . Remove medication from source, taking care not to touch medication with bare hand .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235600	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Montrose Inc	9317 W Vienna Rd Montrose, MI 48457

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on interview and record review the facility failed to: 1.) obtain laboratory results for the use of antibiotics prior to starting antibiotic therapy for two residents (#6 and #73); of three residents reviewed for antibiotic stewardship and initiate interventions to reduce antibiotic use, potentially effecting all residents, resulting in the potential for unnecessary medications, additional infections and resistant organisms. Findings Include: Resident #6: On 12/4/2024 at 11:00 AM, review was completed of Resident #6's medical record and it revealed he admitted to the facility on [DATE] with diagnoses that included, Parkinson's, Atrial Fibrillation, Major Depression and Kidney Disease. Further review of Resident #6's record revealed the following: November 2024 MAR (Medication Administration Record): Cephalexin Tablet 500 MG (milligram)- Given one tablet by mouth every morning and at bedtime for infection for 5 days per hospice. Possible UTI (urinary tract infection). Resident #6 received nine doses of the antibiotic from 11/16/2024-11/20/2024 Progress Notes: 11/15/2024 at 16:18: hallucinating more frequently and stating he cant move his body. assessed lodger. lodger can move body. hospice nurse here. per hospice dr wrote order for kelfex for possible UTI. lodger in bed with call light in reach. There was no record of laboratory results obtained for the usage Cephalexin nor were there any other symptoms noted by the facility. Review was completed of November 2024 Infection Control Line Listing and Resident #6 was not listed and inevitably not being monitored for his usage of a possible UTI. On 12/4/2024 at 2:04 PM, Infection Control Nurse F was asked about Resident #6's antibiotic order from November 2024. Nurse F reported the hospice physician ordered it and there was a risk vs benefits and labs completed. Review was conducted of the resident chart with Nurse F and there were no labs obtained nor was a risk vs benefit located. On 12/5/2024 at 9:40 AM, Infection Control Nurse F stated after reviewing their records she was not able to locate the risk vs benefits for his antibiotic usage. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review was completed of the facility policy entitled, Antibiotic Stewardship Program, revised 12/13/2023. The policy stated, .Nursing staff shall evaluate residents who are suspected to have an infection. Laboratory testing shall be in accordance with current standards or practice .Monitor response to antibiotics and laboratory results .Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness . 37666 Resident #73: On 12/4/2024 at 2:15 PM, Infection Control Practitioner/ICP F was interviewed about Resident #73's UTI. She said a urine had been collected for the resident on 11/27/2024, sent to the laboratory/lab on 11/27/2024, was resulted on 12/2/2024 and identified 2 organisms: Proteus Mirabilis and Enterococcus faecium. There was no antibiotic sensitivity provided with the urine culture to determine the most appropriate antibiotic to give the resident. The laboratory provided Pharmacy Guidance and Medication Review, but did not show the results of a urine sensitivity for provider and nursing review. The resident was ordered Cefdinir antibiotic on 12/3/2024. The ICP said the resident had also had another UTI in November 2024: urine collected 10/30/2024, sent to the lab 10/31/2024, resulted on 11/5/2024 and antibiotic treatment with Bactrim DS was initiated on 11/8/2024. Proteus mirabilis was identified in the urine with no antibiotic sensitivity. The laboratory provided Pharmacy Guidance for antibiotics and listed pharmacy recommendations for which antibiotics to give, but there was no antibiotic sensitivity to compare to for determination of the most appropriate antibiotic for Resident #73. Per the National Library of Medicine: A Medline Plus article dated August 21, 2024 identified the following: Antibiotic Sensitivity Test: . Antibiotics are medicines used to fight bacterial and certain fungal infections. They are not effective for viral infections. There are different antibiotics, and each one only works well against certain types of bacteria and fungi. An antibiotic sensitivity test can help find out which antibiotic will be most effective . The test can also help find a treatment for antibiotic resistant infections . During the interview with the ICP on 12/4/2024 at 2:15 PM, the antibiotic treatment for Resident #73 was further reviewed. She said the resident had several prior UTI's and the organism was identified as Proteus Mirabilis in both instances. A review of the lab results indicated there were antibiotic recommendations from the lab, but no antibiotic sensitivity provided to the facility. Reviewed the resident also had a chronic sacral wound with osteomyelitis and had been on long term antibiotic therapy for several months prior to the UTI diagnoses and now had recurrent UTI's. The ICP said the UTI rate had been high at the facility, and they were attempting to identify the cause. During a review of the Infection Surveillance Line Listings for June 2024- November 2024 with the ICP, it was noted that there were several months that the facility had many Healthcare associated Urinary Tract Infections/UTI's: June 9 , July 5, and October 7. There were 4 Escherichia coli/E. coli, 3 Klebsiella oxytoca in June and 2 E. coli in July. In October 2024 each UTI had a different microorganism. The ICP said she had provided education to the staff on the proper procedure for providing perineal care and catheter care for the residents and reviewed proper hand hygiene. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the continued review of the Infection Surveillance Line Listings and antibiotic treatment with the ICP, it was identified that many residents were receiving antibiotics mainly for UTI, and skin/soft tissue infections (the resident census during the survey was 105): June - 31 residents received antibiotics; July -21 residents received antibiotics; August -37 residents received antibiotics; September -20 residents received antibiotics; October - 21 residents received antibiotics; November - 27 residents received antibiotics. Several of the residents receiving antibiotic treatment for UTI's were treated multiple times until the infections resolved and some residents had no urine testing and were receiving antibiotics either stating Risk vs. Benefit or Hospice. During the review, it was also noted that many residents were being treated for fungal infections: June- 14 residents with fungal infections; July- 4 residents with fungal infections; August- 9 residents with fungal infections; September - 8 residents with fungal infections; October- 17 residents with fungal infections and November- 14 residents with fungal infections. The ICP said the fungal infections and other skin/soft tissue infections had increased. The ICP was asked about the large volume of antibiotics being administered to the residents and the lack of antibiotic sensitivity testing to ensure the residents were receiving the appropriate antibiotic for their infection, so they did not receive prolonged antibiotic treatment or treatment with a less effective antibiotic, which could lead to fungal infections. The ICP said this was something the facility was talking about. She said they were provided a report from the lab that had a list of all organisms identified in all infections for all of the residents put together and antibiotic sensitivity was compared as a whole, but not specific for each resident. On 12/05/2024 at 2:30 PM, the Corporate Clinical Nurse I was interviewed about the facilities use of laboratory urine results with no antibiotic sensitivity. She said the facility was reviewing the lab results for UTI's to ensure the residents received necessary care and antibiotic use was appropriate. She said they were looking at the overall number of infections including fungal infections and the large amount of antibiotics being used, but had not yet identified what they would do about it.