STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235609	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Armada	22600 Armada Ridge Rd Armada, MI 48005

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to revise a care plan for one resident (R56) out of one reviewed for care plans. Findings Include: On 5/21/2024 at 9:46 AM, R56 was observed in their bed with a breakfast tray in front of them. R56 was observed attempting to eat some of their applesauce. R56 was noted to have pureed textured food. A review of the tray ticket stated R56 was supposed to be a 1:1 assist with feeding, no one was noted to be in the room. A review of the medical record revealed R56 admitted into the facility on [DATE] with the following diagnoses, Dysphagia following Cerebral Infarction and Aphasia. Further review of the medical record revealed a Brief Interview for Mental Status score of 2/15 indicating an impaired cognition. R56 also required assistance with bed mobility and transfers. Further review of the care plan revealed the following intervention, No straws and no fluids at bedside. On 5/21/2024 at 9:49 AM, 9:50 AM, 5/21/2023 at 12:04 PM, 12:59 PM, 5/22/2024 at 8:58 AM, 5/22/2024 at 12:59 PM, and 5/23/2024 at 9:54 AM, R56 was observed in the room with fluids at their bedside, including water with a straw. On 5/23/2024 at 10:25 AM, an interview was conducted with Registered Dietitian (RD) B. RD B stated R56 was changed to thin liquids and can have liquids at bedside. RD B states the care plan was not updated to reflect the change. A review of a facility policy titled, Comprehensive Plan of Care noted the following, 13. Re-evaluate and modify care plans: as necessary to reflect changes in care, service and treatment.

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

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

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F 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** 32220 Based on observation, interview, and record review, the facility failed to ensure meal assistance and positioning were provided for two residents (R53, R56) of five whose care needs and activities of daily living (ADLs) were reviewed. Findings include: R53 On 05/21/24 at 9:41 AM, R53 was observed to be supine in bed. Three pillows were stacked behind the shoulders and head. R53 appeared frail with decreased muscle mass and visible bony prominences in the face, shoulders and arms. R53 leaned over toward the left side of the bed. The head of the bed was up around 45 degrees. The breakfast of scrambled eggs had not been touched. R53 was asked if they needed help to eat and said yes and appeared to fall asleep. On 05/21/24 at 11:54 AM, R54 was observed to be supine in bed, the head of bed up around 45 degrees, leaned over toward the left side of the bed and appeared asleep. The breakfast tray previously observed had not been eaten. On 05/21/24 at 1:03 PM and 1:14 PM, R53 was observed to be hunched down in the bed and leaned over toward the left side. R53 appeared asleep. The lunch tray had not been eaten. Three clear plastic cups of fluids were observed with lids on them. Staff walked by the room, looked in but did not stop. A staff member was asked if R53 could eat on their own and reported R53 could, but needs encouragement. On 05/21/24 at 1:17 PM, staff picked up the uneaten food tray, R53 remained in a similar position. On 05/22/24 at 9:37 AM, R53 was observed to be in bed, the torso curved down away from head of bed so the top of head pointed toward the left side of the bed. The head of the bed was up around 30-45 degrees and R53 appeared asleep. Three clear plastic cups of orange juice, milk and a pink liquid were observed with lids off and observed full. Scrambled eggs and a bowl of oatmeal had not been touched. A large bag of hard pretzels was open next to the food tray. On 05/22/24 at 9:58 AM, R53 had been sat up slightly more upright in the bed. The meal tray and pretzels remained untouched. On 05/22/24 at 1:55 PM, R53 was observed to be in bed, leaned over toward the left, propped on pillows, eyes closed, oxygen on and appeared asleep. A pureed, food entree had been served with a piece of frosted cake. No items had been eaten. No liquids appeared to have been drank. On 05/23/24 at 8:30 AM, R53's care concerns were reviewed with the Director of Nursing (DON). The DON was asked about the diet and reported the dietitian was at the facility and they would reach out to hospice for additional interventions and would also go in to see if R53 needed assistance to eat and update the care plan as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 10:06 AM, Certified Nursing Assistant (CNA) I reported they cared for R53 two times a week, R53 was more spontaneously talking when admitted but less so lately, R53 was independent with eating and they encouraged R53 to eat and checked on R53 to see if they need help. On 05/23/24 at 10:47 AM, the Registered Dietitian (RD) reported R53 had entered the facility frail and underweight and was therefore started on health shakes. The RD reported they had been alerted that morning that R53 needed more assistance to eat. A review of the record for R53 revealed R53 was admitted into the facility on [DATE]. Diagnoses included Need for Assistance with Personal Care, Pressure Ulcer of Left Lower Back and Severe Protein Calorie Malnutrition. The diet order dated 05/03/24 documented Regular Diet, pureed texture, thin liquid consistency. An order for hospice was dated for 05/13/24. The Minimum Data Set (MDS) assessment dated [DATE] indicated intact cognition and the need for partial/moderate assistance for upper body dressing and personal hygiene, substantial/maximal assistance to roll left and right and setup for eating. A nursing care plan documented, I need assistance with my (activities of daily living) ADLS .Eating: I need '(specify what assistance)' by staff to eat . (It did not specify what assistance was needed.) The Kardex (CNA care guide) documented, .Anticipate and meet my needs .Assist me with my meals. Please assist me with my meals . A review of the task record documentation from 05/03/24 to 05/22/22 revealed 13 meals were documented as zero to 25% eaten and 13 meals 26% to 50% eaten. Three meals had been documented as refused. 44750 R56 On 5/21/2024 at 9:46 AM, R56 was observed in their bed with a breakfast tray in front of them. R56 was observed attempting to eat some of their applesauce. R56 was noted to have pureed food. A review of the tray ticket stated R56 was supposed to be a 1:1 assist with feeding, no one was noted to be in the room. A review of the medical record revealed that R56 admitted into the facility on [DATE] with the following diagnoses, Dysphagia following Cerebral Infarction and Aphasia. Further review of the medical record revealed a Brief Interview for Mental Status score of 2/15 indicating an impaired cognition. R56 also required assistance with bed mobility and transfers. Further review of the diet order noted the following: Start:5/6/2024. Directions: 1:1 feed with slow rate and small bites for diet. Status: Active. A review of a barium swallow study dated 4/1/2024 recommended 1:1 feed for R56. On 5/21/2024 at 12:59 PM and 5/22/2024 at 8:58 AM, R56 was observed in their bed with their food tray in front of them. No one was noted to be in the room assisting with feeding. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/2024 at 10:11 AM, an interview was conducted with Director of Rehabilitation (DOR) C. DOR C stated R56 refuses to allow anyone to feed them, and that Occupational Therapy has been working with R56. DOR C was queried regarding who is responsible for entering diet orders and recommendations and said, the Speech Therapist writes the order and gives it to the nurse for any changes. On 5/23/2024 at 10:18 AM, an interview was conducted with Certified Occupational Therapy Assistant (COTA) D. COTA D stated R56 can self feed and drink with cues and sometimes hand over hand (technique that physically guides someones hand movements to help develop motor skills). COTA B stated R56 is a 1:1 due to them still needing cueing and guiding. On 5/23/2024 at 10:47 AM, an interview was conducted with the Registered Dietitian (RD) B. RD B stated R56 was able to feed themselves, however the orders have not been updated yet. RD B stated that R56 refuses if someone tries to feed them. A review of the undated policy/standard operating procedure titled, Resident Assistance to Eat revealed, Purpose: To assist the resident to eat, and to provide nutrition for residents needing assistance with eating. Procedure: 1. Inform the resident that it is mealtime. 2. Obtain the resident's meal. 3. Identify the resident and verify that the diet served is correct. 4. Arrange food on the table in front of the resident. 5. Remove food covers, prepare, and arrange the food, as necessary, for the resident. 6. Protect the resident's clothing with a clothing protector or napkin if resident desires. 7. Wash your hands if you will be assisting the resident to eat. 8. Encourage the resident to feed himself/herself as much as possible, using self -help aids for eating. 9. Identify food and location on the tray for residents with visual problems. 10. Assist the resident as necessary. If the resident needs to be fed, do not stand but sit with the resident. 11. Notify charge nurse if resident refuses meal. 12. Note food and fluid intake when needed. 13. Remove protective coverings from the resident and wash resident ' s face and hands after meal if needed or requested. 14. For residents with room trays: If resident has a room tray, position resident in an upright, secure position in a chair (if applicable) or in a upright position using support pillows if unable to sit. Adjust tray table to comfortable eating position. Monitor the resident periodically to determine if assistance is needed. Remove tray from room soon after resident completes meal . A review of the undated policy/standard operating procedure titled, Baseline Interim Plan of Care revealed, Each resident will have a baseline care plan developed and implemented within 48 hours of admission to the facility which includes the instructions needed to provide effective and patient centered care that meets the professional standards of quality care. Each resident readmitted to the facility will have the previous care plans evaluated for appropriateness of goals and interventions within 48 hours of admission . A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. A review of the undated policy/standard operating procedure titled, Comprehensive Plan of Care revealed, Each resident will have a comprehensive care plan developed within 7 days after the the completion of a comprehensive or quarterly assessment .Address the resident ' s individual needs, strengths, and preferences .The comprehensive care plan must be patient centered .Be periodically reviewed and revised by the interdisciplinary team as changes in the resident ' s care and treatment occur .Care plans must be fully developed within 7 days after completing the comprehensive assessment (MDS) . (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 the undated policy/standard operating procedure titled, Skin Management Guidelines revealed, . The facility is committed to providing care and services to residents to prevent the development of skin breakdown. The following guidelines are in place to reach this goal: .Residents admitted with skin impairments will have .Appropriate interventions implemented to promote healing .

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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** 44750 Based on observation, interview and record review, the facility failed to apply heel protecters and lids to drinks per physician orders for one resident (R5) out of one reviewed for physician orders. Findings include: On 5/21/2024 at 10:00 AM, R5 was observed in bed. R5 stated they had just started to eat breakfast because they were waiting on their coffee to come. R5 stated they had just received their coffee and was now about to eat breakfast. R5's coffee cup was observed to not have a lid on it. R5 was asked if they like to get out of bed often. R5 stated that get out the bed when they feel like it. R5 was noted to not have anything on their heels and their heels were resting on the mattress. A review of the medical record revealed that R5 admitted into the facility on [DATE] with the following diagnoses, Muscle Weakness and Difficulty in Walking. Further review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 12/15 indicating an impaired cognition. R5 also required assistance with bed mobility and transfer. Further review of active physician orders revealed the following orders, Start Date: 6/22/2023. Order: Verify heel protectors are in place when pt (patient) in bed. Start Date: 6/27/2023. Directions: handled mug with lid for all drinks at all meals. On 5/21/2024 at 12:50 PM, R5 was observed in bed with two coffees with no lid, as well as a cranberry juice with no handle or lid. R5 was also observed with their heels resting on the mattress, no heel protectors in place. On 5/22/2024 at 9:06 AM and 12:54 AM, R5 was observed with a beverage (chocolate milk and cranberry juice) in a no handles cup and no lid. R5 was also noted to have their heels on the mattress, no heel protectors in place. On 5/23/2024 at 9:44 AM, R5 was observed laying in bed with their heels on the mattress, no heel protectors were in place. On 5/23/2024 at 9:49 AM, an interview was conducted with Licensed Practical Nurse (LPN) A. LPN A stated they have not tried to put on boots for R5 yet because R5 was eating breakfast when they went in there. LPN A stated R5 does refuse to wear them a lot. On 5/23/2024 at 10:25 AM, an interview was conducted with the Director of Nursing (DON). The DON stated R5 does refuse to wear the heel protectors, but it should be documented if they refuse. The DON stated the staff have been educated regarding ensuring liquids, especially coffee has lids, and they keep them on top of the cart. A request for a policy related to following physician orders was requested on 5/23/2024 at 10:23 AM, to which facility stated it was standard practice and no policy was available.

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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** 32220 Based on observation, interview, and record review, the facility failed to ensure an indwelling catheter (tube inserted into the bladder to drain urine) leg strap/band was in place and tubing positioned to allow for urine to drain for one resident (R367) of one reviewed for catheters. Findings include: On 05/21/24 at 9:59 AM, R367 was observed to be supine in bed and dressed in a hospital style gown. The connection point for the urinary catheter and drainage bag tubing was visible on the left leg and no strap was observed to prevent tension on the insertion site/urethra was in place. R367 was asked about the urinary catheter and leg strap and commented that it (the catheter) may be removed the next day. R367 reported they had been in the facility a few days. On 05/21/24 at 1:35 PM, rehab staff were in the residents room with resident. The urinary catheter drainage tubing was looped and on the floor. On 05/21/24 at 1:56 PM, rehab staff had exited the room. The urinary catheter drainage tubing remained looped and on the floor. The connection point was visible with no leg strap. On 05/21/24 at 4:50 PM, R367 was observed to be supine in bed. An incontinence brief was in place, The urinary catheter was observed to exit the left side of the brief and run under the left leg. The drainage tubing was looped down onto the floor at the left side of bed. No leg strap was visible. On 05/22/24 at 8:17 AM, R367 was observed to be supine in bed. The urinary catheter drainage tubing was looped down on the left side of bed. On 05/22/24 at 9:53 AM, R367 was observed to be supine in bed. The urinary catheter was present and the tubing was under the left leg and looped down along the left side of the bed. On 05/22/24 at 12:22 PM, R367 was asked how things were going and reported they needed to pee and have a bowel movement. The brief appeared tight and stretched at the crease between the leg and the pelvis. The tubing for the urinary catheter was under the left leg, with the connection point to the drainage tubing visible at the lateral edge of the left thigh. On 05/22/24 at 12:27 PM, Licensed Practical Nurse (LPN) H was queried about the positioning of the urinary catheter and a leg strap. LPN H confirmed no securement device was in place and the urinary catheter tubing was under R367's leg. On 05/23/24 at 8:07 AM, R367 was supine in bed, uncovered, the urinary catheter connection was visible without a leg strap in placed. A review of the progress notes indicated the urinary drainage bag had been replaced on the night shift. On 05/23/24 at 8:30 AM, the identified concerns were reviewed with the Director of Nursing (DON)and they reported they would have put on a leg strap and repositoned the catheter. The DON also noted they would have made a nurse note and reviewed the care plan and updated it as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility record for R367 revealed: R367 was admitted into the facility on [DATE]. Diagnoses included Dysfunction of the Bladder, Arthritis and Diabetes. The Minimum Data Set (MDS) assessment dated [DATE] indicated intact cognition and R367 was dependent on staff for toileting, dressing, rolling left to right/right to left, transfer and personal hygiene. The MDS also noted the presence of an indwelling urinary catheter. A review of the facility policy titled, Indwelling Catheter Care revealed, Purpose: Routine catheter care helps prevent infections and other complications, and is usually performed daily. This can be performed by a Certified Nurse Assistant (CNA) Fundamental Information. Maintenance: Inspect the catheter and tubing periodically to detect compression or kinking that could obstruct urine flow. Keep the drainage tube and collection bag lower than bladder at all times .Inspect catheter for any problems . 7. Inspect outside of catheter where it enters urinary meatus and tissue around meatus. 8. Remove leg band used to secure catheter to thigh. 9. Inspect the area for signs of irritation . 12. Reapply leg band used to secure catheter to outer thigh. 13. Remove gloves and re-tape catheter or reapply leg band to other thigh. 14. Provide enough slack before securing catheter to prevent tension on tubing .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 This citation pertains to Intakes MI00142869 and MI00143155. Based on observation, interview, and record review, the facility failed to provide timely assistance to meet the needs of residents for four residents (R367, R33, R17, R6) of five whose care needs were reviewed. Findings include: On 05/21/24 at 9:21 AM, R6 reported they have two or three times a week when staff take an hour or more to assist them when the call light is turned on. On 05/21/24 at 4:18 PM, a visitor reported they visit the facility every day and the facility staffing levels are short very often and have is a great concern. There are more staff than normal here today. Weekends are the worst. There are times when there is only one aide. I struggle with this, it is hard when you don't have family to help with visits. I sometimes wonder if they fill water cups on Saturday and Sunday. I have been thinking of moving (my family member) for this reason. On 05/22/24 at 10:08 AM, the call light for R367 was observed activated. At 10:13 AM, the call station monitor was observed and the call light had been on for 14 minutes and 48 seconds. At this time a staff member entered room [ROOM NUMBER] and noted a resident was visibly diaphoretic (sweating beaded) and reported the nurse would be in when had time. At 10:14 AM, the call light for R33 was observed to be activated. At 10:16 AM, Licensed Practical Nurse (LPN) Hpoked their head into the cracked doorway of R367 asked what R367 needed then entered the room and asked R367 number one or two. The call light was on around 18 minutes for R367. LPN G then stepped back out, left the call light on and certified nursing assistant (CNA) I walked down the hall and entered the room of R367. At 10:18 AM LPN H had returned to the medication cart. CNA I aide poked their head out of R367's room, then stepped out, went into room [ROOM NUMBER] and then to the room of R33. R33 noted they had wanted to get up in their wheelchair. On 05/22/24 at 11:05 AM, R33 was observed to be supine in bed. R33 reported they had asked staff to get up into their wheelchair around 10:00 AM. R33 was able to discern time from the clock on the wall at the foot of the bed. R33 required a mechanical lift and two persons to transfer into their wheelchair. On 05/22/24 at 12:11 PM, five call lights were observed to be activated. Staff were in room [ROOM NUMBER]. The call station kiosk indicated room [ROOM NUMBER]-1 had been activated for 23 minutes and 12 seconds, R367 had been activated for 25 minutes and 52 seconds; R17's call light had been activated for 12 minutes and 10 seconds. At 12:13 PM R367 increased to 27 minutes and 27 seconds. Room117-2 room was observed activated and answered. Staff with a sling on their arm entered 109, for a wait time of 25 minutes. At 12:16 PM, Staff entered R367's room exited and then went to R33's and R17's room and exited. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 05/22/24 at 12:22 PM, R367 reported they needed to pee and have bowel movement. The flow of a urinary catheter appeared restricted as it was under the resident's leg and tight between the brief and the thigh. Occupational Therapy Assistant (COTA) K entered R367's room noted upon exit that R367 needed a bed pan, and was not able to do it alone. R367 reported they were uncomfortable. R367 had waited over 29 minutes for assistance. R367 was dependent on staff for bed mobility and toileting. On 05/22/24 at 12:27 PM, R17's reactivated their call light and one of the staff from R367's room went to check on R17. At 12:36 PM, R17 rolled out of their room seated in their wheelchair. R17 had wanted to get up. R17 asked the nurse who helped them get up and the nurse reported it was the nurse. R17 required one person assistance for transfer into their wheelchair. On 05/22/24 at 12:37 PM, LPN H checked on R367. R367 remained on the bed pan. On 05/22/24 at 12:48 PM, CNA J was asked about they're assignment and reported they had 23 residents on their set and they were managing. At 12:52 PM, CNA I reported they had 22 residents. CNA I reported that a month ago they had three CNAs a couple times to work the set but lately there had been only two CNAs to cover all 45 patients. CNA I noted they had worked with three only a couple of times and it goes much smoother with three. On 05/22/24 at 8:19 AM, R6 was observed to be in bed and reported they hoped breakfast will be in soon and reported it was usually around 8:30 and and maybe 9 AM if the staff are busy. R6 required one person assistance. On 05/23/24 at 8:30 AM, the identified concerns were reviewed with the Director of Nursing (DON) and reported that needs should be met as soon as possible and unless there was an extenuating circumstance it should not be more than twenty minutes. A review of a complaint to the State Agency reported the weekend of 03/01/24 to 03/03/24. revealed, Today the facility had one CNA for both sides!! 46 patients on long term and also18 patients for memory care! .My mom should not have to deal with this! No care, call light on, and at least an hour wait every time we ring for assistance. A review of the schedule and time punch data documented the facility had a census of 59: -On 3/1/24 two CNA's and three nurse for the day shift. Three afternoon CNAs worked a double to cover the next 16 hours. One of the three CNA's did not clock in unitl 6:29 PM. -On 03/02/24 four CNA's worked on the day shift until 2:30 PM, a fifth until 11 AM. Three nurses were on for the day and nights shift-They worked 12 hour shifts. Four CNAs were on for the afternoon shift: two started at 2:30 PM; two started at 6:30 PM. Three of those CNAs were on for the night shifts. -On 03/03/24 three nurses were on for each shift and three CNA's covered each shift. Two of those worked the afternoon and night shift. A policy related to call light response time and timing for completion of resident request/care needs met once reported to staff were requested on 05/23/24 at 11:28 AM but not received prior to survey exit.

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	235609	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Armada	22600 Armada Ridge Rd Armada, MI 48005

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 32220 Based on observation, interview, and record review, the facility failed to ensure medications were administered per manufactures recommendations and per physician order for one resident (R54) of four observed for the medication pass, resulting in a med error rate of 7.89 percent. Findings include: On 05/22/24 at 9:07 AM, A medication pass observation was conducted with Licensed Practical Nurse (LPN) A for R54. R54 was provided cholestyramine (a cholesterol binding agent) 4 gm (gram) in liquid form with calcium acetate 667 mg (milligram) two tablets, calcitriol 0.5 mcg (microgram) one tablet, fludrocortisone 0.1 mg one tablet constipation refused, Omeprazole 20 mg one tablet, Rifaximin 550 mg one tablet, Velphoro 500 mg (sucroferric oxyhydroxide) one tablet, Lexapro 5 mg one tablet, and Norco/hydrocodone 5 mg/325 mg one tablet. LPN A was queried about the administration of the cholestyramine with the other medications and proceeded to provide R54 with the medication. R54 was also prescribed: Doptelet 20 mg (avatrombopag) Give 40 mg by mouth one time a day. This was not given and was noted to be on order as of 05/19/24. Further review indicated the medication was to be provided by family. The May 2024 medication administration record documented the medication had not been given in the month of May. R54 was also prescribed: Lidoderm Patch 5% Lidocaine apply to right knee topically in the morning for right knee pain. A 5% Menthol Patch was pulled from the medication cart and dated for 5/22 by LPN A. The order for a Lidocaine 5% patch was confirmed with LPN A. LPN A reported they did not have any Lidoderm patches and reported they believed that is what was normally given. LPN A asked the Director of Nursing (DON) and supply room staff member, and the supply staff member confrimed they only have the menthol patch in supply. The DON reported they usually interchange for the Menthol for the Lidoderm and would get an order for the change. On 05/23/24 at 8:30 AM and 1:47 PM, the idenitified medication concerns were reviewed with the DON. The orders for the cholestyramine, Lidocaine patch and Doptelet/avatrombopag were reviewed and the DON reported the doptolet was addressed and noted R54's spouse was to get it and followed a specific schedule for the administration. Clarification of the order indicated it was to be given every other week. The DON confrimed the difference in the Menthol and Lidocaine patch and reported they had called the physician and received an order to change the lidocaine patch to the menthol patch. The DON also reported the physician changed the cholestyramine to two hours before or two hours after the other medications given by mouth. A review of the URL www.drugs.com/mtm/cholestyramine.html revealed, .Cholestyramine resin may delay or reduce the absorption of concomitant oral medication .Avoid taking other medications at the same time you take cholestyramine. Wait at least 1 hour before or 4 to 6 hours after taking cholestyramine before you take any other medications. A policy or protocol from the physician and pharmacy related to the cholestyramine were requested at the time of the interview and on 05/21/24 at 11:28 AM, but not received prior to survey exit.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 This citation pertains to Intake MI00143588. Based on observation, interview, and record review, the facility failed to ensure food items were provided in a puree consistency per the diet order for one resident (R53) of two whose diets were reviewed. Findings include: On 05/22/24 at 9:37 AM, R53 was observed to be in bed, the torso curved down away from head of bed so the top of head pointed toward the left side of the bed. Three clear plastic cups of orange juice, milk and a pink liquid were observed with lids off and appeared filled. Scrambled eggs and a bowl of oatmeal had not been touched nor appeared to have been eaten. A regular size bag of hard pretzels was open next to the food tray. On 05/22/24 at 9:58 AM, R53 had been sat up slightly more upright in the bed. The meal tray and pretzels remained. On 05/22/24 at 1:55 PM, R53 was observed to be in bed. A pureed, entree had been served with a regular cubed piece of frosted cake. No items had been eaten. No liquids appeared to have been drank. On 05/23/24 at 8:30 AM, care concerns were reviewed with the Director of Nursing (DON). The DON was asked about the diet and reported the dietitian was at the facility and they would reach out to hospice for additional interventions for the diet. On 05/23/24 at 10:47 AM, the Registered Dietitician (RD) was asked about the regular cake and hard pretzels and reported they were not part of a pureed diet. A review of the record for R53 revealed R53 was admitted into the facility on [DATE]. Diagnoses included Need for Assistance with Personal Care, Pressure Ulcer of Left Lower Back and Severe Protein Calorie Malnutrition. The diet order dated 05/03/24 documented Regular Diet, pureed texture, thin liquid consistency. A review of the undated policy/standard operating procedure titled, Resident Assistance to Eat revealed, Purpose: To assist the resident to eat, and to provide nutrition for residents needing assistance with eating. Procedure: .3. Identify the resident and verify that the diet served is correct. 4. Arrange food on the table in front of the resident .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22960 Based on observation, interview, and record review, the facility failed to ensure opened food items were dated and discarded when expired, and failed to maintain the filter for the ice machine. This deficient practice had the potential to affect all residents that consume food. Findings include: On [DATE] between 8:30 AM-9:00 AM, during a tour of the kitchen with Dietary Manager (DM) L, the following items were observed: In the Blue Air reach-in cooler, there was an opened package of deli turkey dated ,d+[DATE], and an opened, undated package of salami. DM L stated both items would be discarded. In the Traulsen reach-in cooler, there was an opened 1 gallon container of Caesar dressing dated , d+[DATE], and an opened container of Enchilada sauce dated ,d+[DATE]. DML stated they should be discarded 30 days after opening. According to the 2017 FDA Food Code section ,d+[DATE].17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. In the dry storage room, there was an unlabeled bin of white powder. DM L confirmed the powder was thickener and that it should be labeled. According to the 2017 FDA Food Code ,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food, Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD. The ice machine filter was dated ,d+[DATE]-,d+[DATE]. DM L stated Maintenance was responsible for changing the filter. In the resident refrigerator located in the Activity room/Dining room, there was a container of cut pineapple with a use-by date of ,d+[DATE], and an undated container of chicken soup. Review of the undated policy Safe Storage and Handling of Outside Food noted: Any food which is not going to be consumed immediately must be covered and labeled with the resident's name and date the food was brought into the facility and placed into the unit refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The activity cabinet located next to the resident refrigerator was observed with numerous ants crawling about on the top surface. Activity staff stated she would let Maintenance know.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to wear proper personal protective equipment (PPE) for one resident (R24) out of one reviewed for Enhanced Barrier Precautions (EBP). Findings Include: On 5/21/2024 at 9:50 AM, Registered Nurse (RN) E was observed in front of R24's door grabbing gloves. RN E stated they were going into the room to finish performing care on R24. An EBP sign and cart was noted to be in front of the door. On 5/21/2024 at 9:55 AM, RN E was observed coming out of R24's room. RN E was queried as to why R24 was on EBP. RN E stated they thought that they were on EBP because R24 has chronic urinary tract infections. A review of the medical record revealed that R24 admitted into the facility on [DATE] with the following diagnoses, Personal History of Urinary Tract Infections and Muscle Weakness. Further review of the medical record revealed a Brief Interview for Mental Status score of 14/15 indicating an intact cognition. R24 also required assistance with bed mobility and transfers. Further review of the physician orders noted the following, Ordered: 4/10/2024. Order: Maintain EBP r/t (related to) urine. 4/5/2024. Status: Active. On 5/21/2024 at 2:46 PM, the Infection Control Task was completed with Infection Control Preventionist (ICP) F. ICP F stated that EBP is in place to protect the residents, as well as the staff. ICP F stated that R24 is on EBP and that all staff had been educated on what to wear when a resident is on EBP. A review of a facility policy titled, Enhanced Barrier Precautions noted the following, Policy: It is the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms.