STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235618	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Canton	7025 Lilley Road Canton, MI 48187

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview, and record review the facility failed to ensure dignity was maintained for one resident (R21) of three residents reviewed for dignity, resulting in the resident expressing feelings of embarrassment and humiliation. Findings include: In an interview on 7/9/24 at 12:40 P.M., R21 explained that on Friday 6/21/24 he had been taken to physical therapy wet. R21 reported he told the PTA (Physical Therapy assistant) G he had an accident and his sheets and briefs needed to be changed. According to R21 PTA G did not assist or request staff assistance in changing the resident's brief, but did ask the two nurse aides at the desk to change the resident's linen on the bed before the resident returned to the unit. During the interview R21 began to cry uncontrollably stating he was taken to therapy and had to wear a wet brief for 45 minutes or more and he felt embarrassed and humiliated. The resident continued and repeatedly commented, I am a human being, well respected in my church and community, and no one should be treated like that. When I returned back to my room around 1:00 P.M., (COTA I) can tell you I was wet and the bed still had the same soiled linen that PTA G had requested the staff to changed before leaving. Witnessing how upset I was PTA G requested staff to assist me with a brief change and she changed the linen on the bed. Review of the Admission Face Sheet indicated R21 was admitted to the facility on [DATE] with pertinent diagnoses of: Heart Failure, Chronic Kidney Disease, stage 4, Hypertension, Atrial fibrillation, Chronic Pulmonary Disease and Diabetes Mellitus. According to the minimum Data Set (MDS) dated [DATE], R21 had a BIMS (Brief Intellectual Mental Score) of 14/15 for cognition and required two person assist with transferring and hygiene. Review of the Physician Order's for R21 indicated Physical therapy and discharge home. On 7/10/24 at 2:26 P.M. PTA G was interviewed concerning taking R21 to therapy wet. PTA G denied R21 told her he was wet, but did confirm requesting the two nurse Aides (one being CNAB) on the unit to change the linen on the bed. PTAG reported being removed from R21's workload for therapy after returning to work on 7/8/24, but was unsure why. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:30 P.M. interview with CNA B concerning R21 being taken to therapy wet on 6/21/24. CNA B indicated when R21 returned from therapy (1:00 P.M.) escorted by COTA I the resident was wet and assistance was provided in changing the resident's brief. The aide indicated remembering the day very well because staffing was short on the unit on that date and R21 reported to COTA I and herself how he felt and stated, he had informed PTA G of being wet before going to physical therapy. On 7/11/24 at 2:44 P.M. UMH was interviewed concerning the incident on 6/21/24 with R21. UMH reported being made aware of the details returning to the unit on 7/7/24, stating a Concern Form was formulated and sent to the Administrator and Physical Therapy Manager. No reason was provided why there was a delay in reporting the incident and correcting the concern. In a follow up interview at 3:00 P.M. the Director of Nursing could not provide any reason there was a delay in addressing R21 concern and indicated she had no knowledge of the incident. The DON was informed of the resident's uncontrollable crying while reporting the incident on 7/9/24, even though the incident occurred 6/21/24. On 7/12/24 at 9:00 A.M. Therapy manager (PT) J was interviewed concerning the incident. The manager stated something appeared to have happened between R21 and PTA G so we changed staff. I recently received the Concerned Form (unsure of date). Review of the submitted Concern Form, indicated the incident was referred to the Administrator and PT Manager on 7/7//24 and follow up date of 7/9/24. Review of the facility's policy dated 9/21/2023, Titled: Dignity . It is the policy of this facility that each resident will be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 Based on interview and record review the facility failed to provide accurate and complete information for Advance Medical Directives (AMD), legal documents that allow a person to identify decisions about end-of-life care ahead of time, for eight residents (R12, R15, R16, R17, R19, R21, R40, and R55) of 12 residents reviewed for AMDs resulting in the resident or their Legal Guardian (LG) not being fully informed of how to formulate an AMD and their preferences for medical care not to be followed by the facility. Findings include: R12 According to R12's Electronic Health Record (EHR), the resident admitted to the facility with multiple diagnoses that included history of a stroke and chronic obstructive pulmonary disease. The EHR's header (top of page) indicated R12 was a full code. (All medical measures will be take to maintain and resuscitate life including Cardio Pulmonary Resuscitation if the resident has no heartbeat and not breathing.) R12 had a Legal Guardian (LG) with valid paperwork and contact information in the EHR. The Minimum Data Set (MDS) dated [DATE], indicated the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of ,d+[DATE]. A care conference on [DATE] indicated that the resident's LG was not present, did not attend by phone, and the resident was 'unable to participate due to cognitive limitations'. R12's code status was marked as Full Code with no additional documentation. There was no AMD form or progress note that indicated information had been provided to R12 or the LG regarding code status or the formulation of an AMD. On [DATE] at approximately 10:30 AM during an interview with R12 he said he had no recall of anyone asking him about AMDs. A phone call to R12's LG was made and a voice message left. On [DATE] at 1:00 PM Social Worker (SW) L reviewed R12's EHR and said, The resident is a full code. That is his code status. All residents are full codes unless there is a medical directive stating otherwise and a 'Do Not Resuscitate' order (Do not attempt resuscitation efforts in the event of not heartbeat or breathing) has been written. SW L could not locate any documentation to support R12 or the LG had been provided with information regarding code status or AMD formulation. R15 According to R15's EHR the resident admitted to the facility on [DATE] with multiple diagnoses that included vascular dementia with severe agitation, psychotic disorder with delusions, and failure to thrive. The EHR header indicated R15 was afull code. R15's admission orders from the hospital indicated that R15 was a Do Not Resuscitate (DNR). There was no AMD form or progress note that indicated information had been provided to R15 or the family regarding code status or the formulation of an AMD. A MDS dated [DATE], indicated R15 had severely impaired cognition with a BIMS score of ,d+[DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care conference dated [DATE] documented R15's family was present. There was no documentation to support AMD information was provided or discussed. R15 was marked as a 'Full Code'. On [DATE], a Physician's progress note documented that R15's family wants the resident to be a DNR. A psychiatric consultation was ordered for mental competency evaluation. A Psychiatric assessment was conducted on [DATE] that did not include a competency evaluation. There was no additional documentation to indicate R15 or his family had been provided with information regarding the formulation of an AMD for the resident. On [DATE] at 12:36 PM during an interview with SW K it was acknowledged that R15 did not have an AMD form or any documentation to support that AMD information had been given to the resident or the family. SW K was aware that R15's family members had requested the resident to be made a DNR and said, They were going through the process to obtain Legal Guardian status to make medical decisions for the resident. The psych consult was to determine the resident's mental capacity. I don't know why that process had not happened yet. According to the facility's policy for 'Advance Directive - Code Status' last revised [DATE] in part reads; Upon admission, the facility will inquire if the resident has executed a written advance directive related to their code status. If they have not, the facility will provide information in a manner easy to understand to the resident related to their right to formulate advanced directives related to their code status. -If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative -If the resident and/or their legal representative has chosen for the resident's code status to be Do-Not-Resuscitate: - The facility will accept a Michigan Do-Not-Resuscitate (DNR) form that has been completed prior to admission to the facility under the following circumstances: - The form is fully filled out and includes the resident signature or the resident's legal representative signature, two witness signatures, and physician signature. 15194 R17 On [DATE] at 1:37 P.M. Review of the Admission Face Sheet indicated R17 was admitted to the facility on [DATE], with pertinent diagnoses of spinal stenosis, anemia, morbid obesity, and osteoarthritis. Review of the Admission assessment dated [DATE] indicated the resident had (BIM'S) Brief Intellectual Mental Score of 15 for cognition. The resident was his own responsible person. Review of the resident's clinical record revealed no Advanced Directive, and no written evidence that the resident had a discussion concerning formulation of an Advanced Directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R21 On [DATE] at 1:51 P.M. review of the Admission Face Sheet indicated R21 was admitted to the facility on [DATE] with pertinent diagnoses of Heart failure, Diabetes mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, and shortness of breath. According to the Minimum Data Set (MDS) dated [DATE] R21 had a BIM'S of 14 of 15 for cognition, required substantial/maximum assistance for toileting and ambulation. In an interview on [DATE] at 3:00 P.M. R21 was queried if the facility had discussed or provided him any information concerning and Advanced Directive. R21 responded NO. They have not talked to me about my wishes. Documented under Advanced Directive: Full Cardiopulmonary Resuscitation (CPR) from the Hospital. R40 On [DATE] at 2:24 P.M. review of the Admission Face Sheet indicated R40 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm of the mandible According to MDS dated [DATE], R40 had a BIM'S of 15 of 15 for cognition required supervision for most activities of daily living (ADL'S). R40 was her own responsible person. The Face Sheet documented Full code by default. There was no evidence or written discussion related to Advanced Directive. R55 On [DATE] at 2:14 P.M. review of the Admission Face Sheet indicated R55 was admitted to the facility on [DATE] with diagnoses of sepsis, adjustment disorder, insomnia, peripheral vascular disease, and acute kidney failure. According to the Admission MDS dated [DATE] R55 had a BIMS of 13 of 15 for cognition and his brother was his responsible party. According to the Clinical Record documented under Advanced directive indicated: Full Cardiopulmonary Resuscitation (CPR) from the hospital. There was no documentation or evidence the resident's brother had been contacted to formulate or discuss and Advanced Directive. 38230 R16 On [DATE] at 1:38 p.m. R16 was observed in room sitting on the bed watching television. The resident presented as alert, oriented to person and place and able to make needs known. R16 had some knowledge of desired code status when explained what it was, All I know is I want everything done to me to keep me alive as long as possible. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:03 p.m. review of the clinical record documented the R16 was initially admitted into the facility on [DATE] and readmitted from the hospital on [DATE] with diagnoses that included major depressive disorder, vascular dementia, and cerebral infarction. According to the quarterly MDS assessment dated [DATE], R16 had moderate impaired cognition and required set-up and supervision with most ADLs. Review of the resident profile in the electronic medical record document: Advance directive: Full Cardiac Pulmonary Resuscitation. Review of the R16's face sheet documented there was a legal guardian effective as of [DATE]. Review of the physician's orders dated [DATE] documented: Adv Directive: Full Cardiopulmonary Resuscitation (CPR). Further record review did not reveal a written Advance Directive formulated by the resident/ legal guardian in the electronic medical record. R19 On [DATE] at 11:31 a.m. R19 was observed in bed asleep. The resident did not respond to name when called. Per the attending nurse, R19 was non-verbal. On [DATE] at 2:20 p.m. review of the clinical record documented R19 was initially admitted into the facility on [DATE] with diagnoses that included Alzheimer's disease, peripheral vascular disease, and dementia. According to the annual MDS assessment R19 had severe cognitive impairment and required dependent total assistance with all ADLs. Review of the resident profile in the electronic medical record document: Advance directive: Full Cardiac Pulmonary Resuscitation. Review of the R19's face sheet documented there was a DPOA (Durable Power of Attorney) for healthcare effective [DATE]. Review of the physician's orders dated [DATE] documented: Adv Directive: Full Cardiopulmonary Resuscitation (CPR). On [DATE] an email correspondence with the Nursing Home Administrator read as follows: Good morning our policy states that a form will only be required for Do-Not-Resuscitate (DNR) . This was submitted after requesting to review written Advance Directives for multiple residents that had Full Code statuses. According to the Michigan Physician's Orders for Scope of Treatment (MI-POST) and Michigan Public Health Code Act 368 of 1978: An advance directive is a written document in which you specify what type of medical care you want in the future, or who you want to make decisions for you, should you lose the ability to make decisions for yourself . MI-POST General Rules:1 Are for adults with advanced illness/frailty. 2 Should use standard form. 3 Should be retained in medical record .

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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** 15194 Based on observation, interview, and record review the facility failed to provide showers for one (R21) of five residents reviewed for Activities of Daily Living (ADL'S), resulting in the resident not receiving scheduled showers. Findings include: In an interview on 7/9/24 at 12:40 P.M., R21 stated, he was admitted to the facility on [DATE] and for 2 and half weeks after admission had not received a shower. R21 stated he got so frustrated his wife came to the facility and gave him a shower because the staff was ignoring his requests for a shower. The resident was queried, if he told anyone about his showers, R21 responded yes, it was reported to the concierge (corporate liaison from outside who take concerns in the facility 2-3 times a week) and R21 did not receive the shower promised on that Saturday night. R21 indicated the staff continued to give me a bucket bath (meaning bed bath). Review of the Admission Face Sheet indicated R21 was admitted to the facility on [DATE] with pertinent diagnoses of: Heart Failure, Chronic Kidney Disease, Stage 4, Hypertension, Atrial fibrillation, Chronic Obstructive Pulmonary Disease and Diabetes Mellitus. According to the Minimum Data Set (MDS) dated [DATE], R21 had a BIMS (Brief Intellectual Mental Score) of 14 of 15 for cognition and required two person assist with transferring and hygiene. On 7/10/24 at 9:00 A.M., review of the Care Plan dated 5/30/24, Focused ADL Self Care and mobility deficit indicated the Nurse Aide was responsible for Assisting and bathe/showers as needed, assist with daily hygiene, grooming, dressing, oral care and eating. Review of the Nurse Aide's Task Assignment for R21 did not identify showers as a task that the Aide was to perform or identify any shower days for the resident. At 2:30 P.M. Nurse Aide (CNA) B was quired concerning documentation for resident's showers. CNA B stated, showers were documented on the Assignment Sheets and once the task was completed a shower Sheet was to be put in the shower Logbook on the unit. CNA B stated during the observation of the Shower Book, when we are short of help, or someone calls in residents don't always receive showers like they are supposed to. We are not robots; we take care of the residents the best we can, and we let them know. Review of the Shower Logbook revealed an unorganized binder with multiple loose-leaf sheets. Shower sheets found for R21 documented the resident did not receive a shower on the following days: (Tuesdays, Fridays). 5/31/24, 6/4/24, 6/7/24, 6/11/24, 6/18/24, 6/21/24, 6/25/24, 6/28/24, 7/2/24, and 7/5/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was documentation R21 received a shower by his family 6/14/24 and on 7/9/24 after the entry of the survey team. On 7/10/24 at 4:00 P.M. interview with R21's wife revealed R21 complained staff only gave him bucket bathes. On 6/14/24 R21's wife gave her husband a shower after the resident requested to be transferred to a different facility and his attitude changed. The resident's wife explained prior to admission R21 always showered daily and was very prideful concerning his appearance. During the interview R21's wife reported the resident lost hope in progressing especially after not receiving the promised Saturday night shower from the Concierge. We then decided to report our concern to Unit Manager (UM) H who assisted in completing a Concern Form. On 7/11/24 at 2:44 P.M. Unit Manager (UM) H was interviewed and denied knowledge of the missing showers. The manager reported he became aware of the resident's concern during interviewing R21 and his wife for another incident over the weekend and during the conversation R21 reported his concern related to not receiving scheduled showers. A request was made to review the Concern Forms for R21. At 3:00 P.M. The Director of Nursing was interviewed concerning R21 not receiving scheduled showers. The DON reported R21 had some Concern Forms, but she had not received anything related to him not receiving scheduled showers. The DON acknowledged she had reviewed the shower Book, and it was incomplete, in disarray, and missing evidence of current shower sheets for residents. The DON stated, I was not aware of that concern, R21 and all residents show receive two showers a week on their scheduled days. All showers should be documented and not providing that service for the residents was unacceptable. No reason was provided why R21 did not receive showers after reporting the concern to the Concierge.

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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** 22349 This citation contains two Deficient Practice Statements. Deficient Practice Statement #1. Based on observation, interview, and record review the facility failed to effectively communicate and collaborate care with hospice staff for one resident (R28) reviewed for hospice services resulting in R28 not receiving an Alternating Pressure Relief Mattress (APM). Findings include On 7/10/24 at approximately 4:00 PM, R28's family member said the resident was supposed to receive a pressure relieving mattress (APM) from hospice for comfort care about a month ago and had not received it. R28 was observed in a bariatric sized bed (a wider bed) with a regular bariatric mattress in place, not an APM. It was noted that an APM was outside the resident's room, leaning against the wall. Review of R28's Electronic Health Record (EHR) indicated R28 had multiple diagnoses that included adult failure to thrive, dementia, and was receiving hospice services. A care plan for 'hospice' was initiated on 3/19/24 included the following intervention; Collaborate care with hospice to meet resident's needs. A progress note on 6/13/24 documented that an APM was ordered by hospice. There were no corresponding progress notes from hospice in the resident's EHR. The last hospice note was dated 5/28/24. A care conference dated 6/14/24 did not document hospice orders for the APM or include hospice reports or staff participation. A review of R28's skin assessments indicated R28 was free from pressure ulcers. On 7/11/24 at 9:47 AM the Director of Nursing (DON) said that Hospice staff documents their communications in a physical paper binder kept at the nurse's station. Review of R28's binder revealed a schedule for hospice staff's on-site visits. The sign-in sheets were blank. The notes, special instructions and supplies forms were blank. The DON said since the company had switched over to a new software application the hospice staff did not have access to resident's EHR. On 7/11/24 at 1:15 PM Maintenance Director (MD) Y was asked about the APM outside R28's room. MD Y confirmed the APM was delivered by hospice for R28 about one month ago. MD Y said, The mattress was too small for the resident's bariatric-sized bed. The resident's bed is 42 inches wide and this mattress is only 36 inches wide. It isn't going to fit properly and we didn't put it on the resident's bed. MD Y said since the mattress was not the facility's equipment and he could not move it back into facility storage. MD Y was unaware of how to communicate to the hospice company and said, I thought nursing would be communicating with them to get a new mattress. On 7/11/24 at approximately 2:00 PM, the Hospice Registered Nurse (RN) P was interviewed about the APM. RN P confirmed the APM was delivered to the facility on [DATE]. RN P said she was unaware the APM was the wrong size and had not been placed on R28's bed. RN P said there had been difficulty communicating with the facility staff since they could not access the resident's EHR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's policy titled: Hospice issued on 3/20/24 in part reads; In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident ' s needs. These include: . - Administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care. - Notifying the hospice about the following: - Clinical complications that suggest a need to alter the plan of care. - Communicating with the hospice provider and documenting such communication to ensure that the needs of the resident are addressed and met 24 hours per day . The facility has designated a member of their clinical leadership team such as their Director of Nursing or Unit Managers) to coordinate care provided to the resident by our facility staff and the hospice staff. They will be responsible for: - Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving their services. - Ensuring the facility is communicating with hospice representatives including the hospice medical director, the resident's attending physician, and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions to ensure quality of care for the resident and family, - The facility and hospice will collaborate to ensure the resident's coordinated care plans maintain the resident's highest practicable physical, mental, and psychosocial well-being while reflecting the resident's goals and wishes. 38208 Deficient Practice Statement #2 Based on observation, interview, and record review the facility failed to accurately obtain and document weights for two residents (R46 and R60) out of four residents reviewed for nutrition, resulting in R46 have a documented 127.4 lbs.(pound) weight loss in a one-month period. Findings include: R46 During an observation and interview on 7/9/24 at 12:44 PM, R46 was observed alert and oriented and sitting in bed, when asked it was reported by R46 she had lost a significant amount of weight since coming into facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R46's electronic medical record (EMR) revealed admission into the facility on [DATE] with pertinent diagnoses of morbid obesity and diabetes. According to the Minimum Data Set (MDS) dated [DATE], R46 had impaired cognition and was dependent on most Activities of Daily Living (ADLS). Record review of weights revealed the following: 6/8/2024 - 240.6 lbs. (pounds) 6/6/2024 - 240.8 lbs. 5/23/2024 -244.2 lbs. 5/8/2024 -244.4 lbs. 4/3/2024 -371.8 lbs. 3/6/2024 -372.9 lbs. 2/712024 -371.8 lbs. 1/10/2024 -372.4 lbs. 12/6/2023 -371.6 lbs. 11/1/2023 -370.5 lbs. 11/1/2023 -370.5 lbs. 10/11/2023 -367.8 lbs. 9/20/2023 -365.4 lbs. 9/1/2023 -363.0 lbs. 7/27/2023 -363.0 lbs. Upon further review of weights, it was documented that R46 had a weight loss of 127.4 lbs. weight loss from 4/3/24 until 5/8/24. During a follow-up interview on 7/10/24 at1:25 PM with R46, several questions were asked, and resident answered questions appropriately. When asked if resident had lost 127 lbs. in one month, R46 responded, No. When asked if facility provided three meals a day and snacks, R46 said, Yes. Resident was asked if happy with the amount of weight loss, R46, smiled and stated, Yes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nutrition/Dietary Note dated 5/14/24, Note Text: Monthly weight obtained and shows 127# weight loss. Supervised reweight recommended. Further review Nutrition/Dietary Note dated 5/24/24 at 11:27 AM-Note Text: RD (Registered Dietician) following r/t weight change. CBW 244.2# indicating 127# (lbs.) loss x 1 month. This large of weight loss not plausible. Pt has had no change in condition. PO (oral) intake 75-100%. Labs obtained 4/22 and WNL (within normal limits) except slightly low Hgb (hemoglobin) of 10.96. No new medications. Recommend continue weekly weights until stable x 4 weeks. NP (Nurse Practitioner) aware of weight showing large change. RD to follow as needed. During an interview 7/11/24 11:26 AM with RD V, It was reported that it was not possible for the resident to lose that much weight in a month with out underlying conditions. It was further reported it was believed that weights were not obtained accurately and related to the resident's therapeutic diet, weight had reduced since admission. Record review of Emergency Department discharge date d 1/11/24, R46 weighed 330 lbs. Further review of weights revealed on 7/11/24 at 10:24 AM, a weight was documented that R46 weighed 242. 4 lbs. During an observation on 7/11/24 at 10:26 AM, a weight was conducted by Director of Nursing (DON) and R46 weighed 233.6 lbs During an interview on 7/11/24 at 12:50 PM with Physician W, it was reported that R46 had been monitored frequently by himself and the Nurse Practitioner and related to their assessments and labs that were done R46 could have not lost that significant amount of weight in a month. Physician W further commented there was no indication that it was pathological. It was further reported that it was believed that the weight of the resident was not accurately obtained by staff and related to R46's diet the weight was lost over the months since admission. R60 Record review of Weight Summary dated 7/10/24, R60 weighed 157.4 lbs. Further review of weights revealed on 7/11/24 at 10:13 AM, R60 weighed 151.6 lbs. This amounted to a 7.4 lbs. weight loss. An observed weight was conducted by staff with Surveyor present. During weight it was observed that resident was not properly positioned. RD V was made aware, and staff positioned resident properly and the resident weight was then obtained revealing a weight of 159.0 lbs., and increase of 7.4 lbs. Record review of R60's electronic medical record (EMR) revealed resident was admitted into the facility on [DATE] with pertinent diagnosis of gastrostomy status (insertion of a tube feeding). According the Minimum Data Set (MDS) dated [DATE], R60 had impaired cognition with a Brief Interview for Mental Status (BIMS) of 5/15. During an interview on 7/11/24 at 1:30 PM with the DON, it was reported that related to R46, it was believed that the weights were not accurately obtained, and the resident did not lose that significant weight in one month, it had been reduced since admission. When asked about the inaccuracies observed and documented for R46 and R60, DON reported that the staff needs more education on obtaining weights and proper documentation. Record review of facility policy Weights dated 5/3/22 documented, The Registered Dietician or designee is responsible for the weight management program to include compliance with weights being obtained, tracking and trending, nutritional assessments, interventions, care plans, and follow-up.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 Based on observation, interview, and record review the facility failed to schedule an ophthalmologist (eye doctor) appointment for one resident (R12) reviewed for vision services resulting in R12 having delayed treatment for cataracts. Findings include: On 07/09/24 at 10:20 AM, R12 was observed laying in bed watching TV. R12 had several books, magazines, word search puzzles, and an IPad on his over-bed table. Upon inquiry R12 said, I like to read and play games on my IPad, but I can't see that well because I have cataracts. I've asked them several times to make me an eye doctor appointment, but nothing gets scheduled. According to R12's Electronic Health Record (EHR), the resident admitted to the facility with multiple diagnoses that included history of a stroke and chronic obstructive pulmonary disease. The Minimum Data Set (MDS) dated [DATE], indicated the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14/15. On 6/5/24, a progress note written by Nurse Practitioner (NP) Z documented that the resident had complained of cataracts getting worse. On 6/9/24 an order was written to make an ophthalmology appointment for R12. The Ophthalmologist's information was provided in the order. On 6/13/24 a progress note written by Social Worker (SW) K indicated that R12 would like to receive vision services for his cataracts and Social Work will continue to follow. There was no documentation to support that an ophthalmology appointment had been made for the resident. On 7/10/24 at 12:45 PM SW K was asked about the ophthalmology appointment for R12. SW K was unaware if any appointment had been made for the resident. SW K reviewed R12's EHR including the progress note written on 6/13/24 and acknowledged there had been no follow up for R12 at this time. On 7/10/24 at 2:43 PM during in interview with NP Z she stated, The resident's ophthalmologist appointment should have been made already. I even put the ophthalmologists contact information in the order. According to the facility's policy titled Hearing and Vision Services, last devices on 4/3/22 reads in part; It is the policy of this facility to ensure that residents have access to and receive proper treatment and assistive devices to maintain vision and hearting abilities. 3. Once vision or hearing services have been identified the social worker/social service designee will assist the resident by making appointments and arranging transportation. According to the facility's policy titled Consultations, last revised on 2/29/24 reads in part; The purpose of this policy is to provide guidelines for physician and practitioner ordered consultations. - Following in the receipt of a physician order for a consultation, the facility will: (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Secure the appointment with the consultant, if the resident of family/responsible party does not wish to do so personally.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38208 Based on observation, interview, and record review the facility failed to label tube feeding (liquid nutrition provided by a tube to stomach) container and hydration flush bag for one resident (R60) out of two residents reviewed for nutrition, resulting in the potential for receiving the incorrect product and dosage. Findings include: During an observation on 7/9/24 at 10:19 AM in R60's room, a bottle of Glucerna (Liquid nutrition) was infusing as well as a hydration bag. The bottle of Glucerna was not labeled with the date started, resident's name or the physician's order for infusing. The hydration bag was not labeled with resident's name, date, order for flush or the contents of the bag. Record review of R60's electronic medical record (EMR) revealed resident was admitted into the facility on [DATE] with pertinent diagnosis of gastrostomy status (insertion of a tube feeding). According the Minimum Data Set (MDS) dated [DATE], R60 had impaired cognition with a Brief Interview for Mental Status (BIMS) of 5/15. Further record review of R60's physician orders revealed Enteral (Tube feeding) Feed Order: every shift. Enteral Nutrition Formula Name: Glucerna 1.5 rate: 70 ml (milliliters): Frequency per hour: Duration: Start Time 1600 (4PM) run until 1400 ml infused . Review of flush orders revealed Flush with 50 cc (cubic centimeters) of H2O (water) ever hour via auto flush while pump is running. During an interview on 7/11/24 at 10:48 AM with Unit Manager (UM) H, it was reported that both containers should have been labeled before the administration to ensure it was given to the correct resident and that the proper dose was infused as ordered by physician. During an interview on 7/11/24 at 12:39 PM with Director of Nursing (DON), it was reported that containers should have been labeled before administering to the resident. DON was asked to provide the facility's policy on correctly labeling tube feeding and hydration before administration. A facility policy or procedure guideline was not provided by the end of survey on this proper procedure.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230 This citation pertains to intakes MI00144625 and MI0014484. Based on observation, interview, and record review the facility failed to provide sufficient nursing staff to meet the needs of residents' dependent upon staff for care needs. This deficient practice has the potential to affect all 72 residents that reside at the facility. On 7/9/24 at 9:52 a.m. during the Entrance Conference, it was confirmed the resident census was 72 (32 residents on the second floor; 40 residents on the first floor). On 7/09/24 at 10:46 a.m. during the initial pool process, the second floor had two nurses and two nurse aides to provide care for 32 residents. On 7/9/24 at 10:50 a.m. Unit Manager H said there is usually two nurse aides for 32 long term residents. Unit Manager H was not able to confirm the number of residents that required two-person assistance with care (transfers, bed mobility, showers, toileting). LPN T said there are three nurse aides at times but there are usually just two. LPN T did not respond to the inquiry of two nurse aides being sufficient to care for 32 residents. On 7/9/24 at 12:40 p.m. it was confirmed it is usually two-day shift nurse aides assigned to care for 32 long term care residents on the first floor. On 7/10/24 at 1:10 p.m. the number of residents that required two-person assistance for care needs was reviewed. The first floor had 10 residents that requiredd a minimum of two people for care needs. The second floor had 15 residents that required a minimum of two people for care needs. On 7/11/24 at 12:17 p.m. the second floor appeared to have an increase in nurse aides on the day shift. It was confirmed there were 31 residents with 4 nurse aides. CNA S was interviewed and said there are usually only two nurse aides providing care, not four. CNA S was asked was that enough staff to care for over 30 residents. CNA S hesitantly stated, I do my best for my residents with check and changes (incontinence care), passing water, showers, bed baths. We try to help each other when we can. Some nurses will help, but most will not. I can only do so much in 8 hours. On 7/11/24 at 3:44 p.m. during QAPI/QAA the Nursing Home Administrator (NHA) was interviewed and said staffing was sufficient. It is currently not being QA'd because it had not been identified as a concern. The acuity of care versus the number of staff scheduled to meet the needs of the residents was brought to the NHAs attention. The NHA was unable to explain why staffing was not scheduled according to resident acuity/needs. On 7/12/24 at 10:32 a.m. Staffing Coordinator R was interviewed and said the facility staff according to census not acuity. More aides can be scheduled with the Director of Nursing's approval. There should be at least three aides on the units speaking as a former nurse aide. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/12/24 at 10:55 a.m. the Director of Nursing (DON) was interviewed and said staffing is based on census not acuity. At times staffing can be maneuvered by acuity. There is more staffing on the skilled unit because it's a difficult unit and is usually staffed first. An aide will be reassigned from another unit first to be assigned to the skilled unit. The DON confirmed there is always three aides on the first floor and two on the second floor. The DON confirmed that is not sufficient staff according to acuity. Review of the Facility Assessment, last reviewed 4/25/24, documented in part for a census of 95 (residents) there should be 1 aide per 8 residents. According to the Facility Assessment there should have been a minimum of 3 aides on the second floor and a minimum of 4 aids on the first floor, or a total of 9 aides for a census of 72 and there was not. Review of the facility's policy titled Staffing, dated 11/3/23, documented in part: The facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for the residents in accordance with the resident's plan of care. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on their plan of care . 15194 R21 In an interview concerning staffing on 7/9/24 at 12:40 P.M. R21 stated, There is not enough staff to take care of the residents. Usually there are two nurse aides on the unit. When you put on the call light for assistance with transfers for example, the aide on my side of the unit may answer my light but if the aide on the other side of unit is busy, the aide that answered my call light will have to go and find assistance, because I am a two-person transfer. There are always two nurse aides on this floor. It's worse on weekends. Staff will tell you there is no staff, and they will assist you as soon as possible. The day I was taken to therapy soiled/wet was an example. There were only two aides working that day. (Review of the Floor Assignments for 6/21/24 confirmed there were two nurse Aides on the unit. On 7/10/24 at 2:30 P.M. CNA B stated when the unit is short of staff, or someone calls off. Residents don't always receive showers like they are supposed to. We are not robots. In a confidential interview with CNA A, concerning staffing CNA A stated, . staffing someday's was bad, and it did affect their ability to provide better services. Rarely do we get additional or replacement help. On 7/12/24 at 10:00 A.M., review of the first-floor assignment sheets for the [NAME] Bridge Unit for 7/9/24 revealed three Nurse Aides were assigned, with one call in leaving two Nurse Aides on the Unit for 32 residents.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 38230 Based on interview and record review, the facility failed to ensure a Registered Nurse (excluding the Director of Nursing) was on duty for eight consecutive hours a day, seven days a week; resulting in the potential for inadequate coordination of emergent or routine care that could cause negative outcomes. This deficient practice had the potential to affect all 72 residents in the facility. Findings include: On 7/12/24 9:46 a.m. review of the nurses' schedule for the month of June 2024, revealed there was no Registered Nurse (RN) coverage on June 1st through June 3rd (Saturday-Monday). On 7/12/24 at 10:32 a.m. during an interview with the Staffing Coordinator R who confirmed, on June 1st and 2nd there was no RN coverage, and the Director of Nursing came in to provide coverage. On June 3rd the RN that was scheduled to come in called off and the Director of Nursing had to come in to cover. On 7/12/24 at 11:05 a.m. The Director of Nursing was interviewed and confirmed there was no RN coverage for the dates of June 1st-3rd due to call offs and came in to provide coverage, I was later told that I was not able to provide RN coverage because I was the Director of Nursing.

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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** 38230 Based on interview and record review the facility failed to ensure that the facility responded to pharmacist Medication Regimen Review (MRR) recommendations timely for one resident (R8) of five residents reviewed for a medication regimen review, resulting in the potential for the continuance of unnecessary medications and lack of communication of recommended medication changes. Findings include: On 7/11/24 at 9:57 a.m. review of the clinical record documented R8 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included major depressive disorder, heart failure, generalized anxiety disorder, and morbid obesity. According to the quarterly Minimum Data Set assessment dated [DATE], R8 had intact cognition and required extensive two-person assistance with activities of daily living. Review of R8's physician orders documented the resident's current medications as follows: -Buspirone HCl Oral Tablet 15 MG (Buspirone HCl)- Give 1 tablet by mouth every 8 hours for Anxiety. Start date 4/12/24. -Escitalopram Oxalate Oral Tablet 20 MG (Escitalopram Oxalate)- Give 1 tablet by mouth one time a day for Depression. Start date 3/23/24. Review of monthly pharmacy recommendations in the electronic medical record documented the following: 6/16/24- See report for any noted irregularities and/or recommendations. 5/14/24- See report for any noted irregularities and/or recommendations. 4/18/24- See report for any noted irregularities and/or recommendations. On 7/10/24 at 3:53 p.m. the facility was asked to provide the detailed pharmacy reports and recommendations. They were not located in the electronic medical record (EMR). On 7/12/25 at 10:55 a.m. the Director of Nursing (DON) was asked to verify the monthly pharmacy reports and recommendations for R8 for April, May, and June. The DON said the pharmacy did not email any reports and/or recommendations for said months. See report for any noted irregularities and/or recommendations was checked in error in the EMR. The DON explained the pharmacy reviews are completed offsite and any reports and/or recommendations are emailed when completed. The DON presented reports that were emailed by the Consultant Pharmacist. Review of the recommendations did not include R8. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 1:28 p.m. Pharmacist U who completed monthly medication regimen reviews was interviewed and explained chart reviews are completed offsite. Pharmacist U further explained that once irregularities are identified, the reports are emailed to contact person at the facility (usually the DON). The facilities EMR document there is an irregularity, but the actual reports are emailed to the facility. Once facility reviews them and either accepts or declines the recommendations, the response should be documented somewhere in the EMR. If there is no response to the recommendation, irregularities will continue to be documented until addressed. Pharmacist U confirmed R8 had irregularities that were not addressed for the months of April (4/17/24), May (5/14/24), and June (6/16/24). They are reported as follows: Consultant Pharmacist Recommendation to Prescriber: Federal guidelines state psychopharmacological drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize mood, or treat psych disorder. This resident has been taking Buspar 15 mg BID since 6/2023. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? There was no response to recommendation when reviewed by pharmacy in May and June. Review of the facility's policy titled Organizational Aspects - The Consultant: Medication Regimen Review (Monthly Report), effective March 1, 2018, documented in part: The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending physician, and if appropriate, the medical director and/or the administrator.