STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235619	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church of Christ Care Center	23575 15 Mile Rd Clinton Township, MI 48035

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive wound care plan for two (R78 and R91) of two residents reviewed. Findings include: R78 On 8/1/24 at 9:23 AM, wound care was observed. A review of R78's record revealed they were admitted to the facility on [DATE] with the following diagnosis: Muscle weakness generalized, need for assistance with personal care, and unspecified encephalopathy. A review of R78's minimum data set revealed a brief interview for mental status (BIMS) score of 6, indicating cognitive impairment. Further record review revealed that R78 had multiple wounds on their sacrum/coccyx, left hip, left foot, and left thigh. A review of R78's care plan documents; R78 is at risk for impairment to skin integrity r/t (related to) fragile skin, impaired mobility, incontinence, and pressure ulcers on admission. Interventions as follows: cushion while up in chair. Encourage good nutrition and hydration in order to promote healthier skin. Keep skin clean and dry. Monitor skin during care for changes and report any changes as required. Pressure reducing mattress, pillows on bed. Reposition R78 frequently and use pressure reducing devices between legs to off load pressure to bony prominences. Skin assessment weekly. R78's care plan does not address R78's wounds. R91 On 07/31/24 at 11:21 AM, the pressure wound on R91's coccyx was observed. A review of R91's record reveals they were admitted to the facility on [DATE] with a diagnosis of osteomyelitis of vertebra (spine infection). A review of R91's minimum data set revealed a brief interview for mental status score of 15, indicating intact cognition. Further record review revealed R91 was being treated for a wound on their coccyx. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R91's care plan revealed the following; R91 has potential for impairment to skin integrity r/t fragile skin, impaired mobility and incontinent episodes. Cushion while up in chair. Encourage good nutrition and hydration in order to promote healthier skin. Keep skin clean and dry. Monitor skin for changes during care and report alterations as required. Pressure reducing mattress. Weekly skin assessment. The care plan does not address R91's wounds. On 8/1/24 at 11:59AM, during an interview with the Director of Nursing (DON) and Unit Manager UM D they were asked what should be included in the care plan of a resident with wounds. The DON explained they expect the location of the wound and a general treatment plan to be included in the care plan. The DON reviewed R78's care plan and stated, I would expect it to be much more elaborate and to mention specific wounds and locations. UM D stated, It should be much more specific. A review of the facility's policy titled states Policy: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. Policy Explanation and Compliance Guidelines: 1. Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). 2. The goal and preferences of the resident and/or authorized representative will be included in the plan of care. 3. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them .7. Interventions will be documented in the care plan and communicated to all relevant staff. 8. Compliance with interventions will be documented in the medical record.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on observation, interview, and record review, the facility failed to follow an OBRA II Evaluation (Omnibus Budget Reconciliation Act, federal law aimed at improving the quality of care and life for resident's of long term care facilities) recommendation timely, inform the resident of their rights regarding their trust, and address guardianship for one resident, (R22) of one resident reviewed for life satisfaction. Findings include: On [DATE] at 11:51 AM, R22 was observed lying in bed and asked how they were feeling. They explained they were unhappy living in the facility and would like to have a cell phone in order to communicate with individuals outside of the facility. They further explained they have a guardian in place whom is their [NAME] who does not come to visit or communicate with them. R22 explained they have inquired and wondered if their was any money available to them to purchase personal items, but no one ever tells them if they do or not, No one ever comes back to talk to me about my concerns. A review of R22's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Depression, Acute Respiratory Failure, Peripheral Vascular Disease, and Hemiplegia and Hemipareses following Cerebral Infarction. Further review of the medical record revealed the resident was cognitively intact, and required total dependence for toileting and transfers. In addition, the medical record revealed R22 had a guardian in place until [DATE] when the guardianship expired. Further review of R22's medical record revealed an OBRA II Evaluation dated [DATE] which revealed the following, B. Subjective Evaluation. [R22] presented with depressed mood. [They] denied concernes expressing emotions, but reported, 'no one cares.' [R22] denied concerns coping with changes, but reported, 'it doesn't matter.' Ongoing depressed mood was evident .[R22] stated that all [they] wanted was a cell phone to talk to family and friends; this was reported to the guardian and NF (nursing facility) social worker who stated they would work on this matter .NF staff report they have looked into getting [R22] a cell phone, but reports they are running into the issue that [R22] does not have State ID (identification), which is now required. Requested that this be followed up with the guardian as well as being able to communicate with family/friends this may halp reduce [their] overall symptoms of depression and provide support . On [DATE] at 9:21 AM, Social Worker Director A (SWD A) was asked about the OBRA Evaluation's recommendations regarding a cell phone for R22, and she reported there were attempts to obtain a cell phone and conversations with the resident's guardian regarding R22's need for a an ID however, they are still in the process of obtaining the cell phone. Regarding R22 not having a guardian in place, SWD A explained the resident's son was willing to be the resident's guardian however, when asked where they were in the guardianship process, SWD A did not provide an explainantion, and later indicated an outside agency would be coming to the facility to help manage the guardianship for R22. A review of R22's Social Work progress notes did not reveal any form of communication with the resident, their previous guardian, R22's son, or with any phone service related to attempts to obtain a phone for the resident. In addition, progress notes revealed there has not been any contact with the resident's guardian since [DATE]. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:31 PM, Business Office employee (BO) B was asked if R22 had a resident trust in place, which was confirmed, noting a positive balance. BO employee B was asked how residents are made aware of their resident trust balance, and explained quarterly statements are sent to the resident and/or their responsible party. On [DATE] at 1:31 PM, R22 was asked if they had received any statements regarding their resident trust, and appeared confused, and explained they weren't aware they had a trust with funds available to them although they had asked about it. In addition, R22 explained no one had spoken to them from the facility regarding attempts to obtain a cell phone. R22 was asked if they had spoken to their son recently, and explained they are estranged, and could not recall the last time they had spoken to them. On [DATE] at 3:12 PM, The Director of Nursing (DON) was asked about her expectations for recommendations regarding OBRA assessments, and acknowledged that recommendations should be followed. Regarding concerns of a resident trust, the DON acknowledged that she did not have enough knowledge to answer the question. Regarding guardianship, the DON acknowledged their should be a guardian in place. On [DATE] at 12:50 PM, policies regarding social work services, guardianship, and resident rights were requested from the facility, and the Nursing Home Administrator explained the facility does not have a social work services or guardianship policy, and that they only have an umbrella resident rights policy, only specific rights.

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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** 34851 Based on observations, interview, and record review the facility failed to provide showers for one sampled resident (R19) of six reviewed for activities of daily living. Findings include: On 7/30/24 at 9:20 AM, R19 was asked about their care at the facility. R19 explained it had been three weeks since they had a shower. R19 continued and stated, I'm supposed to get one today on the afternoon shift. R19 further explained the agency staff can be rude at times, they don't do their jobs with changing their brief timely. R19 also stated, The agency staff don't know how to take care of me before they come in, I have to tell them how to care for me. On 7/30/24 at 8:55 AM, R19 was asked if they received their shower yesterday. R19 stated, No. She said I came back too late. R19 was asked to further explain. R19 explained the Certified Nursing Assistant (CNA E) told them R19 came back too late to their room and could no longer get their scheduled shower. On 7/31/24 at 8:58 AM, the Minimum Data Set (MDS) Nurse assisted in finding the documentation in the Electronic Medical Record (EMR) for R19's showers. A review of R19 shower documentation noted N/A which meant not applicable/not given on Tuesday, 7/30/24. A review of R19 medical record revealed R19 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Acute respirator failure with hypoxia. Further review of R19's medical record noted R19 with a moderately impaired cognition. A review of R19's shower schedule noted, Tuesday PM shift and Friday AM shift. Further review of the shower documentation noted blanks without documentation of shower being provided on Tuesday July 23rd and Friday July 26th. On 8/01/24 at 1:30 PM, the Unit Manager was asked about R19's shower documentation for July 30th and the report the CNA told the resident that it was too late to give a shower. The Unit Manager reported she was not sure why the shower wasn't given and the CNA should not tell the resident it was too late. The Unit Manager was given the CNA's name and was asked if that CNA was the facility staff of if they were agency staff. The Unit Manager stated, Agency (staff). A review of the facility's policy titled, Activities of Daily Living (ADLs) dated, 3/14/24, revealed, Policy: The facility will, based on the resident ' s comprehensive assessment and consistent with the resident ' s needs and choices will implement a care plan to assure ADL needs are met. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation; 3. Toileting; 4. Eating to include meals and snacks; and 5. Using speech, language or other functional communication systems. Policy Explanation and Compliance Guidelines: 1. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 2. Based on assessment of the resident ' s ADL capabilities and needs, a care plan will be personalized to meet his/her needs & preferences. 3. The clinical staff will implement the ADL care plan. 4. The ADL care plan will be modified on an ongoing to basis to reflect the resident ' s functional status and personal preferences.

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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** 49102 This citation has two deficient practices. Deficient practice #1. This citation pertains to Intake MI00145622. Based on interview and record review, the facility failed to follow hospital discharge instructions and orders for one sampled resident (R158) of three residents reviewed for continuum of care. Findings include: R158 was admitted on [DATE] with the diagnoses of displaced intertrochanteric fracture of left femur, retention of urine, and dementia. R158 was discharged to the hospital on 5/18/24 due to a change in condition. A review of R158's closed medical record revealed a hospital discharge form titled, Patient Summary -Discharge Instructions, Orders and Medications. A review of this form revealed the following: Discharge Orders: Remove foley catheter in four days on May 6th for trial of void. Further review of hospital discharge instructions revealed, Follow up appointment with Urology with in 5 to 7 days ; Follow up with primary care physician within 5-7 days; Call to set up appointment with Orthopedics within 2 weeks; and Call for follow up appointment with Trauma Clinic within 2 weeks; On 8/1/24 at 1:30 PM an interview was held with the unit secretary (Staff C) who makes the follow up appointments. When asked about R158's follow up appointments. Staff C stated, I dont know what happened with this resident. I dont think the appointments were made and I cant find my copies. On 8/1/24 at 1:45 PM an interview was held the unit manager, Nurse D and when asked about the process of follow up with hospital instructions, Nurse D stated The nurse is supposed to follow up with all orders and ensure they are followed. On 8/1/24 at 2:00 PM an interview was held with the Director of Nursing (DON) about the process of ensuring follow up instructions and orders on discharge from hospital are followed. The DON stated, The nurses are responsible for ensuring the orders and instructions are followed. It is my expectation that orders are followed and nurses transcribe orders accordingly. On 8/01/24 at 3:01 PM, a request was made for a new admission orders policy and it was not recieved by the end of the survey. 50223 Deficient practice #2. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to assess and address a change in condition and control pain for one (R107) out of one resident reviewed. Findings include: A review of R107's record reveals they were admitted to the facility on [DATE] with diagnosis as follows: Alzheimer's and essential hypertension (high blood pressure). A Brief Interview for Mental Status on 7/10/24 reveal a score of 4 indicating cognitive impairment. A review of R107's record revealed progress notes stated the following: -4/30/24 Nursing progress note: Resident observed by activities staff sitting upright next to wheelchair near counter in activities room. When asked by activities staff how (they) fell resident stated, I was standing up and tried to step back and I fell down. Resident assisted back into wheelchair by staff. Writer assessed vitals 129/79 98.3 96% 65 17, mild pain 2/10 to lower back, no injuries noted. Writer administered PRN (as needed) Tylenol for pain. Neurochecks initiated. Response: attending physician, Responsible party and Director of Nursing (DON) made aware. No new orders at this time. -5/2/24 Nursing progress note: Nurse observed resident standing up in hallway next to w/c (wheelchair) when (they) lost (their) balance, fell backwards hitting (their) back against the wall and slid to the floor. Resident was wearing non skid shoes at the time, had not had a incontinent episode in brief. Has a diagnosis of Alzheimers disease and is very compulsive. Action: Resident skin was assessed with no injuries noted, denies pain/discomfort, no s/s of scute distress noted. Resident was assisted off the floor by nurse and PT (physical therapist), v/s (vital signs) stable, and ROM (range of motion) WNL (within normal limits). Physician, POA (power of attorney) and nurse manager made aware. -5/3/24 Physician progress note: Patient was seen for: fall 5/2/24. Patient was seen today per nursing staff request due to above concerns. nursing staff observed patient sitting on the floor next to wheelchair. Denied any pain or discomfort. Able to move all extremities. Denied hitting head or LOC (loss of consciousness). Nurse reported (they) believe patient is having pain .Assessment and plan s/p (status post) fall: no significant musculoskeletal injury. Monitor and report any changes to physician. Pain management: will order tramadol (pain medication) 50mg (milligram) every 6 hours PRN (as needed). -5/3/24 2:30 PM, Order: Tramadol 50 mg Give 1 tablet by mouth every six hours as needed for pain management for seven days. Discontinued 5/10/24 -5/3/24 9:11 PM, medication administration note: PRN Administration was effective. Follow up pain scale was: 10 (severe pain) -5/4/24 7:55 PM, Nurses progress note: Received the resident at 7 am up in a wheelchair sitting in the hallway by the nurses station. The resident is alert x1-2 and can answer some yes or no question. The resident consumed 50% of breakfast and is very anxious. Resident had a grimace on his face, and the resident toileted and repositioned. Resident states (they) are having back pain, and prn medication was given. Resident states during dinner, I haven't been eating like I normally do due to I am in pain, my back and stomach hurts very bad. PRN pain medication was administered, repositioned, and in bed. The resident states he is still very uncomfortable and in a lot of pain. MD notified. The resident refused lunch and dinner, nutritional supplement and boost pudding were offered, and (R107) consumed 50% of both. Staff will continue to encourage meals and fluids. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A 5/5/24 Change in condition evaluation reveals the following: food or fluid intake decreased or unable to eat and/or drink adequate amounts .Pain (uncontrolled) .fall .no oral intake for 2 consecutive meals .lower abdominal pain or tenderness . repeated troubled calling out .Loud moaning or groaning crying facial grimacing body language tense fidgeting .abdominal pain back injuries and complaints .abrupt onset of severe pain secondary to fall or injury or pain with new neurological signs. -5/5/24 3:02 PM, Nursing progress note: Received resident at 7 am up in wheelchair sitting by nurses station. The resident is alert and orientedx1-2 with some confusion. The resident consumed 25-50% of breakfast and lunch. The resident stated (they) are in a lot of pain, prn pain medication was administered, and the resident was put back in bed. The resident still complains of pain and discomfort. -5/16/24 Behavior note: Before dinner, writer assessed resident's vitals and blood pressure was low. Resident was located in chair with no complication. The CNA (certified nursing assistant) assisted the resident with dinner and the resident did not complete the meal. Resident stated that he did not want to eat anymore food. Resident showed slight lethargic but still was able to communicate. After dinner family member comes to hall and say that (R107) isn't being (themself). Writer assessed resident and tried waking (them) up. Resident showed he had lethargic and could not speak clear. Writer assessed blood pressure again and resident blood pressure have gotten lower. Writer contacted doctor regarding residents' behavior and (they) requested for resident to be sent out to nearest hospital. Resident was hospitalized [DATE]-[DATE] A review of the hospital records revealed that R107 was admitted for acute kidney injury, dehydration and hypotension (low blood pressure). Hospital record indicates that R107's blood pressure was low on admission and R107 was given intravenous fluids. The hospital admission history and physical notes indicate they were not informed or aware of any recent falls or trauma. 5/21/24 Physician history and physical: This is an 82 yo (year old) male who was admitted from an acute care facility after he was treated for worsening confusion fatigue and weakness. Patient is confused and all info in this cart was obtained from the chart. 5/21/24 nurses progress note: requires total assistance from nursing staff with care 5/27/24 nurses progress note: received resident at 3 pm up in wheelchair at nursing station. Resident is alert and oriented x2 and able to make some needs known . resident is in a pleasant mood. Resident consumed 25-50% of dinner. Resident complains of pain. Prn pain medication given. 5/31/24 behavior note: resident alert and oriented x2. Resident has confusion and cannot verbalize all needs or pain. Further record review reveals that R107 was hospitalized [DATE] for altered mental status and difficulty breathing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/13/24 2:34 PM Hospital admission history and physical stated: presented to the ED (emergency department) on 7/12 due to concerns of altered mental status and difficulty breathing. Patient is A&Ox2 and is a poor historian. Information is obtained from chart review and patients' son via phone call only. Patient was reportedly noted to be coughing for the last two days as well as having difficulty breathing and decreased volume of his voice. Son has asked for patient to be brought to the hospital for evaluation. Facility doctor did not see the patient and decided against hospital transfer at that time. Patients status declined last night and was noted to have increased coughing, more drooling and AMS (altered mental status) prompting a visit to the ED. On arrival to the ED patient was at 92% o2 (oxygen) saturation on RA (room air) but was having difficulty breathing. Was placed on 2L (two liters per minute) NC (nasal canula) and given two breathing treatments that did help. Patient was also tachycardic (fast heart rate) and tachypneic (fast breathing). Patients WBC (white blood cells) were elevated at 11.6. Chest CT (computed tomography) showed consolidation in the right lower lobe concerning for aspiration pneumonia. Also showed calcification of the 8th and 9th ribs concerning for healing rib fractures.Ct findings concerning of healing rib fractures. Consider speaking to case management after clarifying with son if this is from a known fracture. Further review of the hospital record revealed that the R107's condition deteriorated on 7/13/24 and the patient was placed on a ventilator (breathing machine). Patient was transitioned to comfort care and removed from the ventilator on 7/23/24, was transferred back to skilled nursing facility on 7/26/24 on hospice and passed away on 7/30/24. Death certificate lists cause of death as coronary artery disease and aspiration pneumonia. On 8/1/24 at 12:40 PM, During an interview, the DON was asked what the process is when a resident falls. The DON responded, Step one they're on the floor. Nurse assesses them prior to moving them. Then they are transferred back into bed then further assessment, vital signs, i&A (incidents and accidents) report is made, physician and responsible party are notified and preferably I am also notified. The nurses do a Fall risk evaluation, check vital signs (vital signs), pain assessment and they try to determine route cause of fall so it can be added to the care plan. Progress notes are entered. Neuro checks are done. The DON was asked what occurs if a resident is complaining of pain after the fall? The DON stated, It's the same process and they would notify the physician of the location of the pain then we would usually get an x-ray. On 8/1/24 at 2:26 PM, during an interview, Certified nurse assistant (CNA K) was asked, what the process is when a resident falls. (CNA K) stated, I would notify the nurse immediately then they would evaluate and make sure nothing is broken and do vitals. On 8/1/24 at 2:30 PM, during an interview with Unit Manager (UM D) was asked what the process is when a resident complains of pain after a fall. (UM D) explained the nurse should do a pain assessment, notify the doctor and try nonpharmacological pain relief methods first. (UM D) was asked to review the record for R107 related to their falls, pain, and hospitalization s. (UM D) is observed reviewing the record. (UM D) was asked what her expectation would be for this resident and if she believes the proper steps were followed. (UM D) stated no. the pain was not addressed. When you put a note in about an issue you have to do something about it and follow up. If that issue is not resolved, they have to do something about it. They have to call the MD (medical doctor) back then take it to the DON. The expectation is that we would address it. If his appetite is already decreasing and its interfering with his activities its already serious and we need to do something. (UM D) was asked if they suspected that there may have been an injury from the recent fall. (UM D) stated Oh yes that's why I said we have to address it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Notification of Changes states the following, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. The facility must notify the resident's physician and notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 1. Accidents / Falls2.Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status.3. Circumstances that require a need to alter treatment. A pain management policy was requested and not returned prior to the end of the survey.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 Based on observation, interview and record review, the facility failed to assess, identify, provide treatment and prevent pressure ulcers for two residents (R78 and R21) of seven reviewed for pressure ulcers, resulting in the development and worsening of pressure ulcers. Findings include: R78 On 07/31/24 at 11:12 AM, Registered Nurse (RN) H was observed assessing R78's wound in their room. A strong foul odor was noted coming from the wound when RN H pulled R78's covers back. A review of R78's record revealed they were initially admitted to the facility on [DATE], and readmitted on [DATE] with the following diagnoses: Muscle weakness generalized, wounds and unspecified encephalopathy. The Brief Interview for Mental Status (BIMS) revealed a score of 6/15 indicating a cognitive impairment. On admission R78 was identified as high risk for developing pressure ulcers. A review of the readmission physician note dated 5/24/24 documented, Wound care physician progress note: .L (left) foot callus/hallux- Stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed), lower left thigh, anterior (skin graphed area) measuring 3.5 x 1 x 0.0 centimeters (cm)-Stage 4 (Full thickness tissue loss with exposed bone, tendon or muscle), upper left thigh anterior measuring 4 x 1.3 x 3.5cm- left knee diabetic ulcer 2 x 2.5cm. Left hip/Gluteal P/U (pressure ulcer) debrided - measuring 19 x 14.5 x 16cm with undermining of 4cm.- Right buttock Stage 3 (Full thickness tissue loss) 2.5 x 2 x 0.1cm- Pressure ulcer to coccyx 3.8 x 2 x 0.1 cm. See Mar (medication administration record) for new treatment orders-R (right)-Upper Abdomen discolored scar with scabbed area. A review of the physician order dated 5/24/24, and the MAR/TAR (treatment administration record) revealed the following, Cleanse Coccyx with wound cleaner, apply honey and calcium alginate, cover with foam dressing daily and PRN (as needed). Review of the May, June and July MAR/TAR revealed between the dates of 5/24/24 to 7/6/24 there was no documentation showing that treatment was completed for the coccyx wound. Review of physician orders dated for 5/28/24: (Weekly) Skin assessment every Thursday AM (morning) shift. A review of the weekly nursing skin assessments revealed that between the dates of 5/28/24 to 7/11/24, two weekly nursing skin assessments were completed. There was no documented wound assessments or measurements of the coccyx wound between the dates of 6/3/24 to 7/1/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Further review of the Wound Care Physician Progress Notes documented on 5/26/24, 6/3/24, 6/10/24, 6/17/24 and 6/24/24, measurements and descriptions of left hip wound, left back thigh, upper left thigh surgical site, and documented: Other areas (coccyx and left heel) not measured today due to patient being frustrated and uncomfortable .Other areas not measured Coccyx assessed area remains open continue current treatment and other areas not measured staff reports coccyx is doing well. Patient has been unable to tolerate changing positions. A Wound Care Physician Progress Note dated 7/1/24 includes description and measurements for left hip wound, left back thigh, upper left thigh and stated, Coccyx was able to be viewed today due to positioning area measures 15.1cmx8.7cmx0.5cm. Has thick slough tissue present. Coccyx Cleanse with wound cleanser, apply Santyl to slough tissue, cover with foam dressing daily. 7/15/24-Wound Care Physician Progress Note includes description and measurements of left hip wound, left back thigh wound, upper left thigh, and stated, Coccyx measures 10.9x7.7cmx0.5 (which was previously measured on 5/24/24 at 3.8 x 2 x 0.1 cm). Has thick slough present. A review of a Wound Care Physician progress note dated 7/22/24 lists descriptions and measurements for left hip wound and upper left thigh and coccyx, and stated, .Wound looks worse. Spoke with daughter in person and discussed hospice care. On 8/1/24 at 9:23 AM, Licensed Practical Nurse (LPN) Fand LPN G were observed performing wound care to R78. When queried about an oberserved open area approximately 1cm (centimeter) x 0.5cm was noted at the top right area above the large coccyx wound, LPN F said, I think thats new. A foam dressing was observed on R78's left ankle and a gauze wrap was observed on R78's left foot, both of which were not dated. LPN G was asked if there were any wound on R78's foot or ankle and was observed to remove the dressing from R78's foot and ankle revealing multiple unstageable pressure ulcers with eschar (dead tissue) to the bony prominences of R78's inner left foot and a 3cmx1cm linear wound on R78's anterior ankle. R78's left heel was noted to be black over the entirety of the heel and up both sides of the foot. A review of the resident's medical record revealed no assessments, treatments, or physician orders for R78's left heel. On 8/1/24 at 11:42 AM, during a phone interview, Nurse Practitioner (NP I) was asked about R78's wound progression and care since their facility admission. NP I stated (R78) was [initially] admitted to the facility with a left hip wound, some excoriation to their bottom and a surgical incision to their left thigh.NP I stated, I did not look at (R78's) bottom because the nursing staff said it was stable and they did not want to cause R78 any trauma. NP I explained around 7/15/24 they realized that R78's coccyx had declined and had to be addressed saying, there was dead tissue, and the slough was so thick it was like leather. NP I stated they talked to R78's daughter about hospice. NP I' confirmed the assessments were not performed and explains that it was their expectation that the nurses would notify them of a change. NP I was asked if they had seen the wounds on R78's left foot. NP I responded that they do not remember seeing areas on the left foot. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 8/1/24 at 11:59 AM, an interview was conducted with the Director of Nursing (DON). The DON explained the unit nurses do the daily wound care treatments even when the wound care nurse is not on leave. The DON was asked if the unit nurses document a skin and wound assessment. The DON explained a comprehensive wound and skin assessment is done on admission and then weekly. The DON was asked who places the orders for wound care and how the orders get entered into the EMR (electronic medical record). The DON stated, It depends, sometimes the wound care nurse puts them in and sometimes NP I enters them. Either one can put orders in. The DON was informed that there was no documentation of treatment of or assessment of R78's Coccyx wound between 6/3/23 and 7/1/24. The DON stated, I'm not sure how that could be because (NP I) was the person that was monitoring it. The DON confirmed that there was an assessment of R78's buttocks/sacral area documented on 6/3/24 and the next documented assessment of R78's coccyx is on 7/1/24. It was brought to the DON's attention that wound care orders placed for the coccyx wound were not implemented on the treatment record and were not performed. The DON is observed reviewing the EMR and stated, I agree. I don't see that and I don't know why. The DON confirmed that the wound care order placed 5/24 for R78's coccyx wound does not have a schedule and does not appear on the treatment record. The DON stated Nope, it didn't even show up. 40384 R21 On 7/30/24 at 12:40 PM, R21 was observed lying in bed on their back, feet flat on the bed. Attempts to ask the resident questions were to no avail due to their cognition. A review of the facility's acquired pressure ulcers revealed R21 had developed a new Stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising) pressure ulcer. A review of R21's medical record revealed they were admitted into the facility on [DATE] with diagnoses of Cerebrovascular Disease, Multiple Sclerosis, and Hyperlipidemia. Further review revealed the resident was cognitively impaired, and required dependence for Activities of Daily Living. Further review of the medical record revealed the Stage 2 pressure ulcer on R21's coccyx worsened, and they also developed a Stage 2 pressure ulcer on their buttocks. A review of R21's Care Plan revealed the following, Focus: [R21] has a potential/actual impairment to skin integrity r/t immobility and incontinence. Date initiated: 04/20/2024 .Outcome: [R21] will have no seruous complications related to skin. Date Initiated: 04/20/2024 .[R21] skin injury of the coccyx will not worsen due to unavoidable clinical status, and will progress through the healing stages through next review date. Date initited :05/01/2024 . A review of R21's Nursing Skin Evaluations for the month of April 2024 revealed that evaluations on 4/2/24, 4/23/24 and 4/30/24, there were no skin impairments noted for R21. A review of the 5/14/24 Nursing Skin Evaluation noted a wound to the resident's coccyx. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of R21's skin/wound progress notes revealed the following: -4/22/2024 15:38 (3:38pm), Wound Care Physician Progress Note: Patient was seen for pressure injury . Patient was seen today per nursing staff request due to the above concerns, patient lying in bed, Patient developed a stage 2 to coccyx. Area measures 2.3cmx2.0cm (centimeters). Minimal drainage observed . -5/13/2024 15:24 (3:24pm), Wound Care Physician Progress Note: Patient was seen for pressure injury . Patient was seen today per nursing staff request due to the above concerns, patient lying in bed, Patient developed a stage 2 to coccyx. Area measures 5.6cm x 5.6 cm x 0.3cm. Minimal drainage observed. No c/o (complaint of) pain. Wound measured larger today . -5/20/2024 16:16 (4:16pm), Wound Care Physician Progress Note; Patient was seen for pressure injury . Patient was seen today per nursing staff request due to the above concerns, patient lying in bed, Patient developed a stage 2 to coccyx. Area measures 2.6cmx 3.6 cmx 0.1cm. Minimal drainage observed. No c/o pain . -5/26/202419:28 (4:28pm), Wound Care Physician Progress Note; Patient was seen today per nursing staff request due to the above concerns, patientlying in bed, Patient developed a stage 2 to coccyx. Area measures 2.3cmx 2.1 cmx 0.2cm. Minimal drainage observed. No c/o pain. Wound looks better. Skin growing over top of wound . -6/4/2024 17:06 (5:06pm), Skin/Wound Note. [R21] was seen by wound caretoday for p/u to coccyx measuring 2 x 2 x 0.1cm. Wound bed is pink with even edges, has min (minimal) drainage, non-painful to touch.Continue current wound care orders . -6/10/2024 15:30 (3:30pm); Wound Care Physician Progress Note: Patient was seen for; pressure injury, lump right breast .Patient was seen today per nursing staff request due to the above concerns, patient lying in bed, Patient developed a stage 2 to coccyx. Area measures 3.7cm x 3.1 cm x 0.2cm . -6/24/2024 15:12 (3:12pm), Wound Care Physician Progress Note: Patient was seen today per nursing staff request due to the above concerns, patient lying in bed, Patient developed a stage 2 tococcyx. Area measures 5.0cm x 5.3 cm x 0.1cm. Minimal drainage observed. No c/o pain.Wound bed beefy red. Was larger this week . -7/1/2024 17:26 (5:26pm); Wound Care Physician Progress Note: Patient was seen today per nursing staffrequest due to the above concerns, patient lying in bed, Patient developed a stage 2 to coccyx. Area measures 2.9cm x 2.9 cm x 0.1cm. Minimal drainage observed. No c/o pain.Wound bed beefy red. Developed MASD (Moisture associated skin damage). Coccyx measures; 4.5cm x 2.0cm x 0.1cm . -7/15/2024 13:45 (1:45pm), Wound Care Physician Progress Note: Patient was seen today per nursing staffrequest due to the above concerns, patient lying in bed, Patient developed a stage 2 to coccyx. Area measures 1.7cm x 0.8 cm x 0.2cm. Minimal drainage observed. No c/o pain.Wound bed beefy red. Developed MASD. Coccyx measures; 3.4cm x 2.0cm x 0.5cm . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-7/29/2024 15:51 (3:51pm), Wound Care Physician Progress Note: Patient was seen today per nursing staff request due to the above concerns, patient lying in bed, Patient developed a stage 2 to coccyx and right buttock. Area measure to right buttock measures 3.0cm x 2.1 cm x 0.8cm. Minimal drainage observed. No c/o pain. Wound bed beefy red. Coccyx measures; 6.0cm x 4.2cm x 0.3cm . On 8/1/24 at 12:05 PM, the Nursing Home Administrator was asked about the concerns with pressure ulcers amnd acknowledged the concern is something the facility is aware of, and is being followed in their Quality Assurance meetings. A review of the Pressure Injury Prevention Guidelines revealed the following, .Policy Explanation and Compliance Guidelines:1.Individualized interventions will address specific factors identified in the resident ' s risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics) .3.Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. 4. In the absence of prevention orders, the licensed nurse will utilize nursing judgment in accordance with pressure injury prevention guidelines to provide care and will notify physician to obtain orders .8.Compliance with interventions will be documented in the medical record. a. For at-risk residents: treatment or medication administration records. b.For residents who have a pressure injury present: treatment or medication administration records; weekly wound summary charting. 9.The effectiveness of interventions will be monitored through ongoing assessment of the resident and/or wound. Considerations for needed modifications include: a.Development of a new pressure injury. b.Lack of progression towards healing or changes in wound characteristics. c.Changes in the resident ' s goals and preferences, such as at end-of-life or in accordance with his/her rights .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40384 Based on interview and record review, the facility failed to review and report monthly pharmacist medication recommendations for four residents, (R19, R31, R35 and R70) of five residents reviewed for unnecessary medications. Findings include: R31 A review of R31's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Major Depression, Hypertension, and Diabetes. Further review revealed the resident was cognitively intact and requires extensive assistance for Activities of Daily Living. Further review of R31's medical record revealed that five medication regimen reviews were completed on 7/29/24, 4/26/24, 1/24/24, 12/23/23, and 9/23/23 and noted the following, See report for any noted irregularities and/or recommendations. Action: [blank]. Response: [blank] 34851 R19 A review of R19's medical record revealed they were admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included Generalized Anxiety disorder, Anxiety disorder due to known Physiological condition, Schizoaffective disorder, Bipolar type, Psychosis, Bipolar disorder. Further review revealed the resident was cognitively impaired and requires extensive assistance for Activities of Daily Living. Further review of R19's medical record revealed a medication regimen review was completed on 7/26/24, and noted the following, See report for any noted irregularities and/or recommendations. Action: [blank]. Response: [blank]. R35 A review of R35's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Alzheimer's disease with late onset, Dementia, Cognitive communication, and Major depressive disorder. Further review revealed that the resident was cognitively impaired and requires extensive assistance for Activities of Daily Living. Further review of R35's medical record revealed five medication regimen reviews were completed on 11/30/23 and 7/27/24, and noted the following, See report for any noted irregularities and/or recommendations. Action: [blank] Response: [blank]. R70 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R70's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Major Depression, Alzheimer's, Dementia, and Depressive disorder. Further review revealed that the resident was impaired cognition and requires extensive assistance for Activities of Daily Living. Further review of R70's medical record revealed that four medication regimen reviews were completed on 12/27/23 and 7/16/24 and noted the following, See report for any noted irregularities and/or recommendations. Action: [blank]. Response: [blank]. On 7/31/24 at 12:30 PM, the irregularities and/or recommendation reports from the pharmacist were requested from the facility. On 8/1/24 at 10:39 AM, the Nursing Home Administrator (NHA) indicated they were unable to obtain the reports from the pharmacy. On 8/1/24 at 3:07 PM, the Director of Nursing (DON) was asked about the missing pharmacy recommendations, and admitted the facility needed to come up with a better system to ensure the irregularities and recommendations are reviewed by the physician, and communicated to the pharmacist. A review of the Drug Regimen Review revealed the following, .PROCEDURE: 2. The Pharmacy Consultant will perform a monthly drug regimen review on each resident unless the resident condition/risk will indicate a more frequent schedule that is individualized and communicated between the facility clinical staff and the Pharmacy Consultant. 3. Irregularities identified will be documented on a separate, written report and sent to the attending physician, medical director, and director of nursing, listing the resident name, relevant drug and irregularity the pharmacist has identified. If in the professional judgement of the pharmacy consultant that an irregularity requires urgent action, the pharmacy consultant will immediately report the irregularity to the Director of Nursing and/or Unit Charge Nurse and the attending physician by phone .5. The attending physician will document in the resident record that the identified irregularity has been reviewed and what, if any action has been taken to address it. If the physician chooses not to act upon the pharmacy consultant recommendations, the physician must document rationale as to why the change is not indicated in the resident record .