STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235636	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Carson City	620 North Second Street Carson City, MI 48811

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation is related to intake #MI00140932 Based on observation, interview, and record review, the facility failed to ensure call lights were within sight and reach for 1 of 3 residents (Resident #70) reviewed for call light placement. Findings: Resident #70 (R70) Review of an Admission Record revealed R70 was a [AGE] year old female, admitted to the facility on [DATE], with pertinent diagnoses of acute respiratory failure with hypoxia (low oxygen levels in the blood), chronic obstructive pulmonary disease (COPD), chronic pain, retention of urine, and severe protein-calorie malnutrition. During an interview on 04/22/24 at 11:06 AM, confidential informant (CI) O reported coming into R70's room multiple times and the call light was not within reach of the resident. During an observation on 04/23/24 at 10:30 AM, R70 laid in bed and the call light was out of sight and out of reach, draped over the footboard. During an observation on 04/23/24 at 11:50 AM, R70 laid in bed resting and the call light remained draped over the footboard, out of reach and out of sight of R70. During an observation on 04/25/24 at 8:05 AM, R70 sat up in the recliner resting with eyes closed and the call light sat curled up at the head of the bed, out of reach of the resident. During an observation on 04/25/24 at 9:00 AM, R70 sat up in the recliner receiving a nebulized breathing treatment and the call light remained curled up at the head of the bed, out of reach. Review of the facility policy Call Lights, last revised 02/15/22, revealed the following .when a resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation relates to intake #MI00-140932 Based on observation, interview, and record review the facility failed to 1.) administer controlled medications following a physician order and professional standards of practice, 2.) ensure medications were administered following nursing professional standards of practice, and 3.) ensure medications were administered follow the physician ordered parameters for 6 residents (R13, R25, R58, R11, R275, R225), resulting in the lack of assessment, monitoring, and documentation, medication errors, and the withholding of medications without a physician order. Findings: Resident #13 (R13) Review of an Admission Record revealed R13 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pain. Review of R13's Order Summary revealed, Gabapentin Capsule 300 MG Give 1 capsule by mouth at bedtime for Pain Start Date 11/27/21. Review of R13's Controlled Substances Proof of Use form revealed R13 did not receive a scheduled dose of gabapentin on 3/30/24. (The medication was not signed out of the narcotic book). Review of R13's March Medication Administration Record revealed it was documented that R13 received her scheduled dose of gabapentin on 3/30/23. Resident #25 (R54) Review of an Admission Record revealed R25 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pain. Review of R25's Order Summary revealed, traMADol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give 0.5 tablet by mouth two times a day for Pain Start Date 11/27/23. To be administered twice a day at 8:00 AM and 8:00 PM. Review of R25's Controlled Substances Proof of Use form revealed R25 did not receive tramadol on 4/13/24 at 8:00 PM, 4/14/24 at 8:00 AM, or 4/20/24 at 8:00 PM. Review of R25's April Medication Administration Record revealed documentation that R25 received all scheduled doses of tramadol. Resident #58 (R58) Review of an Admission Record revealed R58 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R58's Order Summary revealed, traMADol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give 1 tablet by mouth two times a day for pain AND Give 1 tablet by mouth every 12 hours as needed for pain Start Date 4/2/24. To be administered twice a day at 8:00 AM and 8:00 PM. Review of R58's Controlled Substances Proof of Use form revealed R58 did not receive her 8:00 AM dose of tramadol on 4/19/24. Review of R58's April Medication Administration Record revealed documentation that R58 received all scheduled doses of tramadol. During an interview on 04/23/24 at 12:44 PM, Director of nursing confirmed the medication errors for R13, R25, and R58 and reported immediate education on narcotic administration would begin. Resident #11 (R11) Review of an Admission Record revealed R11 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension. Review of R11's Order Summary revealed, Metoprolol Tartrate Oral Tablet 100 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for Hypertension hold for hr (heartrate) below 60 or sbp (systolic blood pressure) below 100. -Start Date- 01/08/2024. To be administered at 8:00 AM and 5:00 PM. Review of R11's April Medication Administration Record revealed: *On 4/8/24 at 5:00 PM R11's heartrate was 56 and the metoprolol was administered. *On 4/10/24 at 5:00 PM R11's heartrate was 58 and the metoprolol was administered. *On 4/12/24 at 8:00 AM R11's heartrate was 58 and the metoprolol was administered. *On 4/19/24 at 8:00 AM R11's heartrate was 58 and the metoprolol was administered. Resident #275 (R275) Review of an Admission Record revealed R275 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes. Review of R275's Order Summary revealed, glipiZIDE Oral Tablet 2.5 MG (Glipizide) Give 1 tablet by mouth two times a day for DM (diabetes mellitus) Give before meals and hold if BS is <120 (hold if blood sugar is less than 120) -Start Date- 04/10/2024. To be administered at 6:00 Am and 5:00 PM. Review of R275's April Medication Administration Record revealed: *On 4/16/24 R275's blood sugar was 103 and the 6:00 AM glipizide was administered. *On 4/18/24 R275's blood sugar was 97 and the 6:00 AM glipizide was administered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*On 4/21/24 R275's blood sugar was 118 and the 6:00 AM glipizide was administered. During an interview on 4/23/24 at 3:35 PM, Licensed Practical Nurse (LPN) C reported the Director of Nursing (DON) had been working as a floor nurse all the time since the unit manager stepped down from her position. LPN C reported that due to the DON frequently working as a floor nurse, so much has fallen through the crack such as missed laboratory testing, missed treatments, and missed medications. LPN C reported a concern with the lack of follow through and follow up with nursing related concerns including medication errors and medications not administered following the providers orders/parameters. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, (Nurses) are responsible for documenting any preassessment data required of certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of warfarin, before giving the medication. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 609). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Never document that you have given a medication until you have actually given it. Document the name of the medication, the dose, the time of administration, and the route on the MAR. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 610). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, The National Coordinating Council for Medication Error Reporting and Prevention (2018) defines a medication error as any preventable event that may cause inappropriate medication use or jeopardize patient safety. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, administering extra doses, and/ or failing to administer a medication. Preventing medication errors is essential. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 605). Elsevier Health Sciences. Kindle Edition. 37577 Resident #2 (R2) Review of an Admission Record revealed R2 was a [AGE] year old female, admitted to the facility on [DATE], with pertinent diagnoses of diabetes mellitus, chronic kidney disease and is a kidney transplant recipient, and history of falling. During an observation on 04/23/24 at 7:59 AM, Licensed Practical Nurse (LPN) S checked R2's blood sugar, sat the glucometer on top of the medication cart without cleaning it and prepared the Lispro (insulin) pen for administration of 2 units per sliding scale. LPN S did not prime the pen prior to administering the insulin SQ (subcutaneous). When administering the insulin SQ, LPN S did not hold the pen to R2's skin for 5 seconds. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the manufacturer guidelines for use of a Lispro insulin pen reflected .priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin . insert the needle into the skin, push the dose knob all the way in, and continue to hold the dose knob in and slowly count to 5 before removing the needle. Resident #43 (R43) Review of an Admission Record revealed R43 was [AGE] year old female, last admitted to the facility on [DATE], with pertinent diagnoses of heart failure, recent fall, chronic kidney disease-stage 3, unsteadiness on feet, and muscle weakness. Review of an Emar (electronic medication administration record) for R43, dated 04/01/24 to 04/30/24, revealed an order for Midodrine 5 mg (milligrams) give one tab in the morning for hypotension (low blood pressure) Hold if SBP (systolic blood pressure) is greater than 120. R2's blood pressure the morning of 4/12/24 was listed as 130/71 and the Emar indicates that the medication was administered to the resident, despite the blood pressure being outside ordered parameters. Resident #225 (R225) Review of an Admission Record revealed R225 was a [AGE] year old female, admitted to the facility on [DATE], with pertinent diagnoses of fractured left clavicle (shoulder bone) and left hand, unsteadiness on feet, and muscle weakness. R225 is her own responsible party. During an interview on 04/22/24 at 10:19 AM, R225 reported that two evenings ago (Saturday 4/20/24) LPN R brought in her night time medications, set them down and quickly left the room. R225 stated that LPN R reeked of alcohol and maybe that's why she didn't stay until I took my medications. I think she (LPN R) was drunk. This concern was reported to the Administrator by this surveyor.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on observation, interview and record review, the facility failed to accurately assess, provide treatments as ordered, and ensure physician oversite for wounds for 2 residents (Resident #276 and #64) out of 18 residents reviewed for alterations in skin integrity/pressure injuries, resulting in an immediate jeopardy when on 12/21/23, an alteration in skin integrity was identified on R276's left heel. R276 was not provided care in accordance with professional standards of practice and facility policy to treat and prevent the deterioration pressure injuries, did not have an accurate assessment of the pressure injury, and was not provided the necessary treatment for a deteriorating pressure injury resulting in the development of osteomyelitis. Additionally, upon return from a hospitalization , R276 was not provided the ordered treatments to prevent the worsening of his pressure injury and/or infection. R64 experienced the worsening/deterioration of the wound on his right heel and developed an additional wound to his left heel with a delay in treatment. This deficient practice placed all residents at risk for pressure injuries at high likelihood for the development of new pressure injuries. All residents with existing wounds are at risk for new and unreported wounds, the delay in wound treatment, the potential for delayed wound healing, infection, and the high likelihood for overall deterioration in health status. The Immediate Jeopardy identified on 4/24/24 and began on 12/21/23 when facility licensed nurses failed to accurately assess, provide treatments as ordered, and ensure physician oversite for R276 and R64's newly identified pressure injury. Nursing Home Administrator and Director of Nursing were notified of the Immediate Jeopardy on 4/24/24 at 4:30 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 4/29/24, but noncompliance remains at scope of isolated and severity of actual harm due to sustained compliance that has not been verified by the State Agency. Resident #276 (R276) Review of an Admission Record revealed R276 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Type II Diabetes with neuropathy (nerve pain), history of chronic osteomyelitis of left heel, venous insufficiency, and peripheral vascular disease (poor blood flow). Review of R276's Skin & Wound-Total Body Skin assessment dated [DATE] revealed no skin impairment/wounds. Review of R276's Nurses Note dated 12/22/23 at 12:02 AM revealed, Resident asked this nurse to assess left lateral heel where he has a healed scab from a previous wound. He said he was having some pain to that area and on inspection scab is closed but has green drainage. Notified NP (nurse practitioner) on call. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R276's Electronic Health Record revealed no order for wound treatment at the time the wound was identified, and the provider was notified. No documentation that R276 was added to residents to be reviewed by the wound team. Review of R276's Radiology Report dated 12/22/23 revealed an xray was completed and showed no signs of osteomyelitis (bone infection). Review of R276's Skin & Wound-Total Body Skin assessment dated [DATE] revealed no documentation skin impairment/wounds. Review of R276's Provider Note dated 12/26/23 revealed, Nurse reports purulent drainage with foul odor to left heel wound. States when she assessed wound this evening, dressing was from 12/21 . (Soiled dressing was left on heel for approximately 5 days.). No wound treatment order was initiated at that time. Review of R276's Provider Note dated 12/27/23 revealed, Left heel with open area and mild serous drainage on old dressing. No surrounding erythema and no odor to wound. (See photo for measurements). Wound cleansed and calcium alginate covered with optifoam applied . Pressure ulcer of left heel, unspecified stage . An order for wound care was implemented following this assessment. (Approximately 6 days from the discovery of the wound). Review of R276's Skin and Wound Evaluation dated 12/27/23 revealed the wound was staged as a Stage 1: Non-blanchable erythema of intact skin, did not identify the date the wound was identified and did not include the providers observation of drainage. Review of R276's Treatment Administration Record revealed, Cleanse L heel w/ NS (cleanse left heel with normal saline). Apply Calcium Alginate to open area cover w/ Opti foam. Encourage blue boots while in bed. With a Start date of 12/28/23. No treatments were documented as completed prior to this order indicating a delay in treatment. Review of R276's Nurses Note dated 12/31/23 revealed, Drsg (dressing) changed to rt (sic) heel. Wound entirely covered with thick white slough. Foul odor persists after cleaning. Scant amt of thick yellow drainage on old dressing. Denies pain, no redness. (Note: R276 had a right leg amputation). Indicating R276's wound had deteriorated and exhibited signs/symptoms of infection. Review of the National Pressure Ulcer Advisory Panel (NPUAP) revealed If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Review of R276's Electronic Health Record revealed no documentation that the provider was notified of the change of the condition of the wound, not followed by the wound team and/or Interdisciplinary Team, and no treatment changes were initiated. Review of R276's Provider Note dated 1/4/24 revealed, LT heel with open wound, cared daily with wound nurse and nursing staff .cleanse wound and apply calcium alginate covered with optifoam daily . No wound assessment, measurements, or treatment changes documented. Review of R276's Skin and Wound Evaluations revealed no other assessments until 1/11/24 which was incomplete. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R276 was assessed by provider on 1/5/24 related to a COVID diagnosis, on 1/8/24 related to a fall, and on 1/12/24, 1/17/24, and 1/22/24 for routine follow-up. Wound assessment and treatments were not discussed. Review of R276's Skin and Wound Evaluations dated 1/17/ 24 revealed an incomplete assessment. Review of R276's Order Summary dated 1/17/24 revealed an order for podiatry consult. (Approximately 4 weeks after the identification of his wound.) Review of R276's Wound Consultant Note dated 1/24/24 revealed, .1. (19) Left heel pressure stage I - This wound measures 1.59 x 0.8 centimeter with a depth of 0.2 centimeter. This wound is partial thickness .Tx: (treatment) This area is to be cleaned daily with wound cleanser and calcium alginate applied to the area for autolytic debridement. Wound should be covered with an ABD pad and wrapped in kerlix. Secure with tape initial and date. Daily . A wound with partial thickness tissue loss is considered a Stage 2 pressure injury. (This was R276's first wound consultation, approximately 5 weeks after the identification of his wound.) The NPUAP defines a Stage 1 pressure injury as intact skin with a localized area of non blanchable erythema/redness. Stage 2 pressure injures are defined as Partial-thickness loss of skin with exposed dermis. Review of R276's Treatment Administration Record revealed the recommended wound treatment was not ordered/implemented. Review of R276's Skin and Wound Evaluation dated 1/24/24 revealed the pressure injury was documented as a Stage 1 and was identified as new. The wound assessment did not include the measurable depth of 0.2 centimeters. Review of R276's Podiatry Report of Consultation dated 1/30/24 revealed the measurements of R276's left heel pressure injury to be 4 cm (width) x 2cm (length) x 0.8cm (depth). Indicating the worsening of the pressure injury. Review of R276's Wound Consultant Note dated 1/31/24 revealed, .1. (19) Left heel pressure stage I - This wound measures 1.46 x 0.79 centimeter with a depth of 0.2 centimeter. This wound is partial thickness .Tx: This area is to be cleaned daily with wound cleanser and calcium alginate applied to the area for autolytic debridement. Wound should be covered with a bordered gauze. Secure with tape initial and date. Daily . Indicating a discrepancy of the measurements of the wound and inaccurate staging of the wound. Review of R276's Skin and Wound Evaluation dated 1/31/24 revealed the pressure injury was documented as a Stage 1 and was identified as new. The wound assessment did not include the measurable depth. R276's wound treatment order was updated to reflect the providers recommendation. Review of R276's January Treatment Administration Record revealed R276's wound care was not completed on 1/4/24 or 1/17/24 with no documentation as to why it was not completed. Review of R276's Podiatry Report of Consultation dated 2/6/24 revealed Posterior ulceration with mild maceration .2.5 cm x 1cm, 0.3cm .no probing to bone .sharp excisional debridement performed today (removal of dead/infected tissue) .f/u in 2 weeks . (Sharp excisional debridement is a surgical procedures using scalpels/scissors to remove infected and dead tissue from a wound bed.) (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R276's Wound Consultant Note dated 2/7/24 revealed, .1. (19) Left heel pressure stage I - This wound measures 1.77 x 0.92 centimeter with a depth of 0.2 centimeter. This wound is partial thickness. There is a light amount of serous drainage from this area . Review of R276's Skin and Wound Evaluation dated 2/7/24 revealed the pressure injury was documented as a Stage 1 and was identified as new. The wound assessment did not include the measurable depth or the wound drainage. Review of R276's Wound Consultant Note dated 2/14/24 revealed, .1. (19) Left heel pressure stage I - This wound measures 4.52 x 1.23 centimeter with a depth of 0.2 centimeter. This wound is partial thickness. There is a light amount of serous drainage from this area . There was no treatment change implemented. Review of R276's Skin and Wound Evaluations revealed no completed wound assessment for 2/14/24. The evaluation was In Progress. Review of R276's Wound Consultant Note dated 2/21/24 revealed, .1. (19) Left heel pressure stage I - This wound measures 2.13 x 1.47 centimeter with a depth of 0.2 centimeter. This wound is partial thickness. There is a moderate amount of serous drainage from this area .Tx: This area is to be cleaned daily with wound cleanser and santyl ointment (wound treatment) and calcium alginate applied to the area for autolytic debridement. Wound should be covered with a bordered gauze. Secure with tape initial and date. Daily. Doxycycline ordered daily for 14 days . Indicating the worsening of the wound including infection which required the use of antibiotics. Review of R276's Skin and Wound Evaluations revealed no completed wound assessment for 2/21/24. The evaluation was In Progress. Review of R276's Wound Consultant Note dated 2/28/24 revealed, .1. (19) Left heel pressure stage I - This wound measures 1.68 x 1.29 centimeter with a depth of 0.2 centimeter. This wound is partial thickness. There is a light amount of perulent (purulent-pus) drainage from this area. Wound bed consists of 100% eschar tissue. Edges are attached and there is no slough, tunneling, undermining, or odor. The surrounding tissue is fragile but without redness, warmth, swelling, pain, induration, or sign of infection . There was no treatment change ordered. Review of R276's Skin and Wound Evaluation dated 2/28/24 revealed the pressure injury was documented as a Stage 1 and was identified as new. The wound assessment did not include the measurable depth. During an interview on 04/29/2024 at 12:50 PM, Regional Nurse Consultant (RNC) A reported that a change in treatment should be implemented if a wound deteriorated or showed no signs of improvement in a 2-week timespan. Review of R276's Podiatry Report of Consultation dated 3/1/24 revealed, 2cm fibrotic wound posterior lateral (left) calcaneus (heel). + malodor (foul odor), + edema (swelling), + erythema (redness), probing to bone. Diagnosis: Cellulitis with probable osteomyelitis left heel region .Recommendations: Patient sent to ER (emergency room) for admission/IV antibiotics, debridement and possible amputation (left) lower extremity. Confirming a significant change in R276's pressure injury from 2/28/24. R276 was hospitalized from 3/1/24-3/10/24 for osteomyelitis (severe bone infection): (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*3/1/24 Hospitalist Service H&P (history and physical) He was seen at the podiatrist office this morning and was instructed to go to the emergency department for IV antibiotics His foot ulcer has been worsening over the past week .at the outlying ED, he was found to have ongoing left foot ulcer, with elevated white blood count of 17 K .LACTIC ACIDOSIS, elevated C-RP (indicates systemic infection/sepsis). *3/2/24 Wound Consult Hospital Wound Services: Asked to see patient for diabetic foot ulcer. Dressing removed with large amount of brown, foul smelling drainage. Cleansed left heel with saline moistened gauze and odor remained. Left heel injury measures 3.5 x 1.75, 1cm with undermining (erosion under the skin surface-resulting in large wound with smaller opening) from 1 to 6 o'clock (along heel bone) of 4 cm. Tissues are brown. Surrounding ulcer is soft yellow/cream tissue .Patient has been following with (name omitted) DPM (podiatrist) for heel ulcer. Yesterday patient went to [NAME] Hospital ER for ulcer to left foot and was then transferred to [NAME] main for podiatry consult and surgery. *3/3/24 Podiatric Surgery Consult Note .Cellulitis LT (left) lower extremity, necrosis (death) of bone, Acute on chronic osteomyelitis LT calcaneus .presents to ED (emergency department) with worsening of left foot ulcer. The pt (patient) had hx (history) of heel ulcer and osteomyelitis. He reports that wound was healed and reopened 3 months ago . *3/5/24-surgical wound debridement (removal of infected/dead tissue from wound) and wound vac (vacuum assisted closure of wound) 3/6/24 Review of R276's Order Summary revealed, wound vac to lt heel at 125mmHg change 3 times per week every day shift every Mon, Wed, Fri for wound care -Start Date- 03/13/2024. Review of R276's Wound Consultant Note dated 3/13/24 revealed, .1. (19) Left heel pressure stage I - This wound measures 2.25 x 1.42 centimeter with a depth of 1.0 centimeter. This wound is full thickness. There is a light amount of serosanguinous drainage from this area . Treatment for the wound vac was continued. Review of R276's Skin and Wound Evaluation dated 3/13/24 revealed the pressure injury was documented as a Stage 1 and was identified as new. The wound assessment measured the length of the wound as 0cm, the width as 0cm, and depth not applicable. Review of R276's Wound Consultant Note dated 3/20/24 revealed, .1. (19) Left heel pressure stage IV - This wound measures 2.43 x 1.18 centimeter with a depth of 1.0 centimeter. This wound is full thickness. There is a light amount of sanguinous drainage from this area . Treatment for the wound vac was continued. Review of R276's Skin and Wound Evaluation dated 3/20/24 revealed no date the wound began and no wound depth measurement. Review of R276's Wound Consultant Notes and Skin and Wound Evaluations revealed no evaluation was completed on 3/27/24. Review of R276's Skin and Wound Evaluation dated 4/3/24 revealed no date the wound began and no wound depth measurement. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R276 was hospitalized for a DVT (blood clot) from 4/4/24-4/9/24. Review of R276's Wound Consultant Note dated 4/10/24 revealed, .1. (20) Rear Left Malleolus Lateral pressure stage IV - Picture was taken but did not upload into (Electronic Health Record), nursing staff informed. Wound has improved, measurements and treatment remain the same. Wound measurements from 4/3/24 are 2.85 x 1.69 centimeter with a depth of 1.0 centimeter. This wound is full thickness. There is a light amount of sanguinous drainage from this area . Indicating the wound was not assessed by the wound consultant and/or rounding wound nurse and no treatment changes were made. Review of R276's Skin and Wound Evaluations revealed no completed evaluation for 4/10/24 with the documentation In Progress. Review of R276's Skin and Wound Evaluation dated 4/19/24 revealed the onset date of the pressure injury was documented as unknown and no measurable depth was documented. (Date the area was first identified was 12/21/23). Review of R276's Podiatry Report of Consultation dated 4/19/24 revealed, .continue wound vac until next visit on May 7th . Review of R276's Wound Consultant Note dated 4/19/24 revealed, .1. (20) Rear Left Malleolus Lateral pressure stage IV - This area measures 2.54 x 1.19 centimeter with a depth of 1.0 centimeter. This wound is full thickness. There is a light amount of sanguinous drainage from this area. Wound bed consists of 100% granulation tissue. Edges are attached and there is no slough, tunneling, undermining, or odor. The surrounding tissue is fragile but without redness, warmth, swelling, pain, induration, or sign of infection. Improving. Tx: This area is to be cleaned daily with wound cleanser and calcium alginate applied to the area for autolytic debridement. Wound should be covered with a bordered gauze. Initial and date. Daily. Change to wound vac once supplies become available. Review of R276's Treatment Administration Record revealed the wound vac was not changed on 4/19/24 or 4/22/24. Review of R276's Nurses Note dated 4/22/24 at 4:35 AM revealed, .Wound vac in place . Indicating an inaccurate resident assessment. Review of R276's Medication Administration Note dated 4/22/24 at 3:32 PM revealed, (Wound Vac) supplies unavailable. Supplier number called and to be delivered Wednesday. (Podiatrist) office called to notify but unable to reach at this time. Bordered foam dressing applied while awaiting delivery. Confirming the lack of follow up for an ordered treatment and recommended treatment not completed/ordered. During an observation on 04/22/24 at 10:37 AM, R276 was in his room. He did not have a wound vac applied to his left foot. A wound vac was on his nightstand. During an observation on 04/23/24 at 08:04 AM, R276 did not have a wound vac applied to his left heel. Review of R276's Order Summary and Treatment Administration Record on 4/23/24 revealed no order for wound treatment in place of the wound vac as recommended by Wound Consultant (WC) B on 4/19/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/23/24 at 3:35 PM, Licensed Practical Nurse (LPN) C confirmed that R276 did not have a wound vac in place and was without wound treatment orders. LPN C reported there was no excuse for not having wound vac supplies and for treatments not being entered. LPN C stated a delay in care can cause sepsis and the deterioration/worsening of R276's wound. Review of R276's Order dated 4/23/24 at 4:10 PM revealed, Lt heel; clean daily with wound cleanser and calcium alginate applied to the area for autolytic debridement. Wound should be covered with a bordered gauze. Initial and date. Daily. Change to wound vac once supplies become available. every day shift for wound care -Start Date-04/24/2024 0700. During an interview on 04/24/24 at 09:26 AM, LPN C reported there was a dedicated wound nurse that was responsible for all pressure injuries and wounds in the facility. LPN C reported the wound nurse rounded with the provider, completed weekly wound measurements and pictures, and ensured the orders were entered into the electronic health record. LPN C reported the residents weekly wound assessments included measurements including depth, the description of the wounds, and treatment changes. During an interview on 4/24/24 at 11:26 AM, WC B reported that LPN D was the rounding wound nurse at the facility and would assist with wound measurements and complete the weekly wound assessment form. WC B reported the facility utilized a camera that would measure length and width, but the depth was done manually and was to be documented in the wound assessment. WC B reported he was not notified that the treatment he ordered on 4/19/24 for R276 had not been implemented and reported his expectation was that treatment orders were transcribed into the electronic health record. WC B reported he ordered a bridge (interim) treatment for R276 until the wound vac supplies came in but expected the wound vac supplies would have arrived prior to his return to the facility. During an interview on 4/24/24 at 12:13 PM, LPN D (rounding wound nurse) reported she had not been notified that R276 did not have wound vac supplies. LPN D reported there were appropriate supplies for R276's wound vac and obtained them at that time. Per the facility policy Skin Management last revised 7/14/21, A Guest/Resident at Risk meeting will be conducted at least monthly by the Interdisciplinary Team (IDT). During the meeting, the IDT will evaluate guest/resident skin changes, review treatment modalities, interventions and will make recommendations as needed .Guests/residents reviewed for skin alterations are as follows: *Newly developed vascular, diabetic/neuropathic and pressure injuries *Any pressure or non-pressure area that has shown no signs of healing within a two week time frame . During an interview on 04/25/24 at 12:51 PM, Nursing Home Administrator (NHA) reported that R276's left heel pressure injury had not been identified/reviewed during the Resident at Risk meetings until 4/15/24 when he was reviewed for readmission to the facility following a DVT. During an interview on 04/29/2024 at 12:50 PM, Regional Nurse Consultant (RNC) A reported that the information documented in the Skin & Wound Evaluation pulls over to the dashboard in the electronic health record system and alerts management if a wound is deteriorating/worsening. RNC A confirmed that an accurate depth measurement would be essential in identifying if a wound had deteriorated/worsened. Resident #3 (R3) (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an Admission Record revealed R3 was an [AGE] year-old male, admitted to the facility on [DATE]. Review of R3's Wound Consultant Note dated 3/27/24 revealed, .Sacrum pressure stage III .This wound is full thickness .Tx: This area is to be cleaned daily with wound cleanser. Apply zinc cream to surrounding areas. Apply skin prep to surrounding tissue. Wound should be covered with a bordered gauze. Initial and date. Daily . Review of R3's Order Summary revealed the wound consultant's recommendations were not entered into the electronic health record until 4/26/24. Review of R3's Total Body Skin assessment dated [DATE] revealed, New stage 2 pressure injury noted to right inner buttock. Area cleansed and measured. Measurements 0.8 cm x 0.5 cm x 0.1 cm .treatment ordered . Review of R3's Order Summary on 4/29/24 revealed no order for wound treatment for the newly identified pressure injury. Resident #9 (R9) Review of an Admission Record revealed R9 was a [AGE] year-old female, admitted to the facility on [DATE]. Review of R9's Wound Consultant Notes beginning on 1/31/24 revealed an area of abrasion on her scalp with the following order, This area is to be cleaned daily with wound cleanser and skin prep applied to the area. Wound should be open to air. Daily. Review of R9's Order Summary revealed that from 11/27/23-4/26/24 her treatment was ordered as Skin prep to scalp BID every day and night shift for scabbed areas. Review of R9's Order Summary dated 4/26/24 revealed an order change to, Front scalp abrasions: cleanse site with wound cleanser, pat dry. Apply skin prep, leave open to air. every day shift for scabbed areas Resident #11 (R11) Review of an Admission Record revealed R11 was a [AGE] year-old male, admitted to the facility on [DATE]. Review of R11's Wound Consultant Note dated 4/19/24 revealed, .Right Dorsum-1st Digit Diabetic-This area measures 1.22 x 0.79 centimeter with a depth of 0.1 centimeter. This wound is full thickness. There is a moderate amount of serous drainage from this area . Review of R11's Skin & Wound Evaluation dated 4/24/24 revealed no documentation of the measurable depth or drainage. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R11's Order Summary revealed Cleanse R great toe and second digit with NS, apply Santyl to wound bed, cover w/ Calcium alginate and dry dressing every day shift for Diabetic ulcer. Start Date 2/8/24. Review of R11's April Treatment Administration Record revealed the treatment was not completed on 4/2/24, 4/9/24, 4/10/24, and 4/15/24. Resident #19 (R19) Review of an Admission Record revealed R19 was a [AGE] year-old female, admitted to the facility on [DATE]. Review of R19's Skin & Wound Evaluation dated 4/24/24 revealed an area of Moisture Associated Skin Damage (MASD) on left gluteus measuring 0.8cm x 0.8cm x 0.2cm. (MASD is widespread erythema, maceration, and irregular or diffuse edges.) During an observation and interview on 4/29/24 at 1:15 PM, R19's Skin & Wound Evaluation dated 4/24/24 was reviewed with the Director of Nursing. Review of the picture of the wound revealed a circular open area on the ischial tuberosity (point of pressure on buttocks) with defined edges and a reddened wound bed. DON confirmed that the area of breakdown/injury was a Stage II pressure injury and not MASD. Review of R19's Electronic Health Record revealed no documentation that the family or provider was notified of the Stage II pressure injury. There were no treatments ordered for the newly identified pressure injury. Resident #228 (R228) Review of an Admission Record revealed R228 was a [AGE] year-old female, admitted to the facility on [DATE]. Review of R228's Total Body Skin assessment dated [DATE] revealed, 2 non-documented wounds noted upon total body assessment. 1 wound is localized to the left posterior heel. Area is scabbed over and pea sized. Resident explains she has history of a previous wound here. The second wound is localized to her bottom, which appears to be shearing/ skin tear caused by moisture associated damage .New orders input for daily skin prep to the left posterior heel and zinc oxide ointment for her bottom every shift. Review of R228's Order Summary dated 4/29/24 revealed, Zinc Oxide Ointment to buttocks every day and night shift for MASD and Skin prep to posterior left heel every day and night shift for prevention of skin breakdown on old healing wound. Indicating a delay in treatment. 29073 Resident #64 (R64) (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an Admission Record reflected R64 admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia, severe, without behavioiral disturbance, psychotic disturbance, mood disturbance and anxiety. R64 was given a secondary, during stay diagnosis on 8/8/2023 of pressure ulcer of right heel, stage 3. R64 was also diagnosed with Methicillin susceptible staphylococcus aureus (MSSA). Review of an admission Minimum Data Set (MDS) assessment dated [DATE] reflected R64 admitted to the facility with one stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister), and 2 unstageable pressure ulcers with suspected deep tissue injury in evolution. The most recent MDS assessment dated [DATE] reflected R64 had a stage 3 pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). The assessment indicated the stage 3 was present on admission. R64 was no longer coded as having any unstageable-deep tissue, suspected deep tissue injuries. Review of a Care Plan last revised 1/03/2024 reflected R64 has actual impairment to skin integrity r/t (related to) heel stage 3 pressure injury. The Goal of the care plan was that R64 would not develop an infection to the wound and was not centered on healing or preventing the worsening of the wound. Interventions included, Conduct weekly head to toe skin assessments and report new/abnormal findings to physicians as needed; enhanced barrier precautions: don gown and gloves during high-contact resident care; Observe location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to physician. During an observation on 4/23/2024 at 1:39 p.m., Licensed Practical Nurse (LPN) Q removed the dressing covering the pressure ulcer on R64's right heel. The dressing was dated 4/20 and indicated the dressing was last changed three days prior to the observation. The dressing was saturated with brown, serous drainage. The skin around the pressure ulcer on R64's right heel was macerated (the softening and breaking down of skin resulting from prolonged exposure to moisture). LPN Q said that the dressing was to be changed daily. R64 also had a round, nickel sized dark reddened area on the lateral aspect of his left heel. LPN Q said she was not aware of the area. Additionally, there was a thick scab on R64's right great toe. LPN Q said she wasn't comfortable reapplying a fresh dressing until R64's right heel had a chance to air dry and said she would return in an hour to reassess the area. Review of the April 2024 Treatment Administration Record (TAR) reflected an order Cleanse right heel with NS (normal saline), apply skin prep to surrounding skin, and cover with calcium alginate and bordered gauze every day shift-Start Date-02/08/2024. The record reflected the dressing had not been changed on 4/21/24 or 4/22/2024. A dressing change was not documented as done on 4/1/2024. Review of the March 2024 TAR reflected the order Cleanse right heel with NS (normal saline), apply skin prep to surrounding skin, and cover with calcium alginate and bordered gauze every day shift-Start Date-02/08/2024. The ordered treatment was not completed on 3/8/24 or 3/13/24. During a follow-up observation on 4/23/24 at 3:37 p.m., LPN Q was assisted by LPN C in getting measurements and completing the dressing change. LPN Q obtained a camera phone and took pictures of the areas which she explained would measure the wound at the same time. No manual measurements or measurement of the depth of the wound were taken at this time. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Skin & Wound Evaluation V7.0 dated 4/19/2024 (4 days prior to the wound observations made on 4/23/24 indicated R64's right heel wound measured 3.8 cm long x 2.3 cm wide. No depth was recorded despite there being measurable depth apparent in the photograph that accompanied the evaluation. Review of the Skin & Wound Evaluation V7.0 dated 4/23/2024 reflected R64's right heel measured 12.6 centimeters (cm) long x 7.0 cm wide. No depth was recorded on the evaluation, despite there being measurable depth to R64's stage 3 pressure ulcer to the left heel and represented a significant deterioration/worsening in the condition of R64's wound. Review of a Skin & Wound Evaluation V7.0 dated 4/23/24 reflected R64's left heel had a 1.3 cm long by 1.0 cm wide wound. No additional details were recorded on the skin and wound evaluation. Review of the Skin & Wound EvaluationV7.0 dated 4/24/24 reflected R64 had a stage 3 pressure ulcer on the right heel that was present on admission. This evaluation indicated the wound measured 4.3 cm long by 2.4 cm wide. No depth was recorded. The wound measurements taken on this day reflected a deterioration of the wound compared to the measurements taken on 4/19/24 (noted above) and differed significantly from the measurements recorded the day before (4/23/24). Further review of the Electronic Health Rec [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39083 Based on observation, interview, and record review, the facility failed to maintain safe water temperatures, resulting in the potential for scalding residents, affecting residents using the 200 hall spa, and Room #'s 214 and 204. Findings include: On 4/22/24 at 1:53 PM, the bathroom sink hot water temperature, of room [ROOM NUMBER], was measured using a digital probe thermometer and was found to be 123 degrees F. On 4/22/24 at 1:55 PM, the bathroom sink hot water temperature, of room [ROOM NUMBER], was found to be 127 degrees F. At this time, Resident #52 stated that the water gets very hot. On 4/22/24 at 2:04 PM, the 200 hall spa room hand sink hot water was measured to be 130 degrees F. During an interview on 4/22/24 at 2:12 pm, Maintenance Director U was queried on the hot water temperatures and stated that they turned the water temperature up to 140 degrees last year and discovered some sinks were missing point-of-use mixing valves, which haven't been installed yet. According to the facility's Water Temps, log, dated for April 2024, it notes the following high temperatures, Beauty Shop Hair Sink - 120.5, 107 Shower - 121.4, 109 Shower - 121.6, 300 Spa East Shower 122.3, 300 Spa [NAME] Shower 121.9. The log for March 2024 notes the following high temperatures, Beauty Shop Hair sink - 120.3, 100 Spa - 121, 300 Spa East Shower - 122.4, 300 Spa [NAME] Shower - 122.5. The logs consistently show water temperature levels over 120 degrees back to January 2024.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on observation, interview, and record review, the facility failed to ensure appropriate treatments and orders were in place to prevent catheter associated urinary tract infections for 1 resident (Resident #64) out of 3 residents reviewed for catheters and urinary tract infections, resulting in the potential for complications from cross contamination and infections. Findings: Resident #64 (R64) Review of an Admission Record reflected R64 admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia, pressure ulcer of right heel, stage 3, Methicillin Susceptible Staphylococcus Aureus (MSSA) and obstructive and reflux uropathy. During an on 4/23/24 at 3:37 PM, LPN Q was assisted by LPN C in completing a dressing change and catheter care. LPN Q obtained three 10 milliliter pre-filled normal saline syringes, uncovered R64's lower body, leaned away from R64's catheter to avoid any splashes, separated/disconnected the drainage tubing from the catheter insertion near the urethra at the tip of the penis. LPN Q pinched the open end of the drainage tubing with her left hand, uncapped the prefilled syringe and flushed R64's urethra with all three syringes, one after the next. LPN Q then reattached the drainage tubing to the catheter emerging from R64's urethra. LPN Q and LPN C said they did not know why R64 was having his urethra flushed in this manner twice a day and did not know why the flush was being done with normal saline. LPN Q and LPN C did not don gowns or face shields to protect against contact or droplets. Review of the April 2024 Treatment Administration Record (TAR) reflected an order Sodium Chloride Solution 0.9% Insert 30 cc (cubic centimeters) in the urethra every day and night shift for Cath Flush foley cath with normal saline flushes x3, BID (twice a day)-Start Date-9/20/2023. During an interview on 4/23/24 at 3:20 PM, the Director of Nursing (DON) was asked why there was an order for R64 to have twice daily catheter flushes with normal saline since 9/20/2023. The DON speculated the order came from a hospitalization and reported she would check into the matter. Review of an email dated 4/23/2024 at 3:33 PM indicated the DON had reached out to R64's urologist and were awaiting a return call. During an interview on 4/24/24 at 8:32 AM, the DON said she could not locate any information about where the order for catheter flushes in the manner ordered for R64 originated. During a telephone interview on 4/29/2024 at 2:00 PM, the Medical Assistant (MA) V for Urologist W treating R64, reported their office had been contacted by the facility DON regarding the catheter flushes. The MA V said that Urologist W did not order the catheter flushes and would not recommend them as opening the closed drainage system twice a day is a significant risk for infection.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to ensure best practice standards were followed for residents receiving supplemental oxygen, for 2 of 3 residents reviewed (Resident #67 and Resident #70). Findings: Resident #67 (R67) Review of an Admission Record revealed R67 was a [AGE] year old female, last admitted to the facility on [DATE], with pertinent diagnoses of chronic obstructive pulmonary disease and obstructive sleep apnea. Review of a physician order reflected the following for R67: Oxygen 2-3 liters per minute via nasal cannula as needed for shortness of breath. During an observation on 04/22/24 at 11:41 AM R67 received supplemental oxygen via a nasal cannula at 2. 5 liters/minute. There was no date on the oxygen tubing indicating when it had last been changed. During an observation on 04/24/24 at 9:46 AM R67 laid in bed with eyes closed, receiving supplemental oxygen at 2.5 liters/minute via nasal cannula. There was no date on the oxygen tubing indicating when it had been changed last. Resident #70 (R70) Review of an Admission Record revealed R70 was a [AGE] year old female, admitted to the facility on [DATE], with pertinent diagnoses of acute respiratory failure with hypoxia (low oxygen levels in the blood) and chronic obstructive pulmonary disease (COPD). Review of an Emar-Etar (electronic medication and treatment administration record) dated April 2024 did not contain an order for the rate of oxygen delivery that R70 received continuous and did not contain a documentation process to capture whether or not nursing staff observed the oxygen delivery regularly to ensure it was set correctly. Review of a Care Plan related to R70's respiratory needs did not contain an intervention of supplemental oxygen use and did not contain any concerns that staff should watch for with a patient who had COPD and received oxygen. During an observation on 04/22/24 at 11:01 AM, R70 received supplemental oxygen via a nasal cannula that was correctly in place. The concentrator delivering the oxygen was set at 3 liters. The oxygen tubing did not have a date on it, indicating when it was last changed. The bottle of water used to humidify the oxygen was not dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/22/24 at 11:05 AM, confidential informant (CI) O reported entering R70's room on several occasions and the oxygen had been cranked all the way up. CI O also reported that yesterday there were two nebulizer treatments loaded and ready for use. One sat at the foot of the bed and the other sat on the bedside table. During an observation on 04/23/24 at 8:00 AM, R70 sat up in the recliner, oxygen delivered via nasal cannula at 3 liters, and no date found on the oxygen tubing or bottle of water used to humidify the oxygen. During an observation on 04/24/24 at 8:25 AM, R70 sat up in the recliner receiving a nebulized breathing treatment. The oxygen tubing now had a sticker on it dated 04/18/24. The humidified bottle of water did not have a date on it. During an interview on 04/24/24 at 10:26 AM, the Director of Nursing (DON) could not explain why R70's oxygen tubing now had a date on it, and the date was from 4/18/24. The DON stated that a company comes in weekly and changes out all the necessary tubing on a weekly basis. The company has their own list that they use and will also look into rooms to see if there are any new residents here that require tubing changes.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on observation, interview, and record review, the facility failed to operationalize policies and procedures to appropriately evaluate and assess for pain and implement pharmacological and nonpharmacological interventions for pain control for 1 of 18 sampled residents (Resident #27) reviewed for pain management, resulting in the absence of pain assessments and an increased perception of pain and unmet pain needs. Findings include: Resident #27 Review of an Admission Record revealed R27 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Stroke with right sided hemiplegia (paralysis) and right upper extremity/hand contracture. Review of a Minimum Data Set (MDS) assessment for R27, with a reference date of 3/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 2, out of a total possible score of 15, which indicated R27 was severely cognitively impaired. Review of R27's MDS Pain Interview dated 3/22/24 revealed: Should Pain Assessment Interview be Conducted? Yes Ask resident: Have you had pain or hurting at any time in the last 5 days? No Should the Staff Assessment for Pain be Conducted? No During an interview on 04/24/24 at 09:26 AM, Licensed Practical Nurse (LPN) C reported that R27 had severe cognitive impairment but would be able to communicate if she was in pain in the moment and stated she has no recall and would not even be able to tell me what she had for breakfast. LPN C reported R27 had a history of pain and had been prescribed Norco in the past. LPN C reported pain assessments, especially a pain look back, would have to be completed by staff on behalf of R27, further stating R27 would not be able to remember the last 5 days with her memory recall. LPN C reported that to assess R27's pain she would require the Pain Assessment in Advanced Dementia (PAINAD) scale and the facility licensed nurses were responsible for ensuring her pain was managed. Review of R27's Pain Summary revealed: 12/19/2023 0 Numerical 1/2/2024 8 Numerical 2/28/2024 0 Numerical 4/18/2024 3 PAINAD (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Indicating R27's pain was not adequately assessed and was also not consistently assessed using the PAINAD. Review of R27 Order Summary dated 11/10/20 revealed, Acetaminophen Tablet 325 MG Give 2 tablet by mouth every 4 hours as needed for Pain. Review of R27's Electronic Health Record revealed R27 received a dose of Tylenol 650mg for a pain level of 3 on 4/18/24 with no documentation of the type, severity, onset, duration, location, or quality of pain to ensure adequate follow-up and communication to healthcare providers. During an observation and interview on 04/23/24 at 03:25 PM, R27 was using her left hand to open the fingers on her right hand and displayed facial grimacing indicating pain. When asked if her right hand was painful, she verbalized yes. Facility staff were notified. During an observation and interview on 04/24/24 at 07:55 AM, R27 was cradling her right hand with her left hand. When asked if her right hand was painful, she verbalized yes. Facility staff were notified. During an interview on 04/30/24 at 4:01 PM, Minimum Data Set Nurse (MDSN) P reported she completed the MDS pain assessment for R27 on 3/22/24. MDSN P reported that R27's had severe cognitive impairment and her memory comes and goes but felt that R27 was giving appropriate answers at the time of the assessment. MDSN P confirmed that a resident identified with severe cognitive impairment should have a Staff Assessment for Pain conducted. MDSN P was not aware that R27 only had pain assessments on 12/19/23, 1/2/24, 2/28/24, and 4/18/24 and stated, best practice is to consistently monitor for pain. Review of R27's Pain Care Plan revealed, (R27) is at risk for pain r/t hx of CVA (related to history of cerebral vascular accident/stroke) with right sided hemiplegia, and RUE (right upper extremity) contracture .chronic pain . Date Initiated: 04/26/2019 .Anticipate (R27's) need for pain relief PRN and respond immediately to any complaint of pain Encourage/Provide Non-Pharmacological interventions to prevent/manage pain as needed such as Positioning devices, Relaxation techniques such as deep breathing, shower. Distraction such as music, television, activities of choice .Evaluate characteristics of pain on a scale of 0-10 .Observe and report any s/sx of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Report abnormal findings to the physician .Observe/record: (R27's) complaints of pain or requests for pain treatment. Review of R27's Functional Ability Care Plan revealed, (R27) has a functional ability deficit and requires assistance with self care/mobility R/T: Fatigue/weakness, Limited Mobility, CVA with right side hemiplegia and upper extremity contracture, generalized weakness, impaired vision, minimal hearing deficit, incontinence of bowel and bladder. (R27's) need for assistance can fluctuate from shift to shift and day to day depending on her mood or if she is tired. Date Initiated: 10/05/2023 .Wear right hand resting splint from AM to HS or to (R27's) tolerance daily to prevent (no further description in care plan) . (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Pain Management dated 4/11/23 revealed, Policy-The facility will evaluate and identify residents for pain, determine the type, location and severity and develop a care plan for pain management .1.Upon admission/re-admission, quarterly, with a significant change in condition and PRN (as needed) residents will be evaluated for pain by the licensed nurse. 2. Additionally, residents will be monitored for the presence of pain and evaluated when there is a change in condition and whenever new pain or an exacerbation of pain is suspected. 3. Observe resident for indicators of pain .4. In residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors . Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Because pain is dynamic, accurate assessment requires you to monitor it on a regular basis along with other vital signs. Some institutions treat it as the fifth vital sign. Pain assessment is not simply a number. Relying solely on a number fails to capture the multidimensionality of pain and may be unsafe, particularly when the number fails to reflect the entire pain experience or when a patient does not understand the use of the selected pain-rating scale. Pain assessment is a nursing responsibility. However, assistive personnel (AP), physical therapists, social workers, and others also screen for pain by asking patients whether they are uncomfortable or in pain. When pain is noted by any care provider, it is essential that a nurse be informed immediately so that he or she can make a thorough assessment to confirm the patient's discomfort and provide appropriate treatment. The ability to establish a nursing diagnosis, decide on appropriate interventions, and evaluate a patient's response (outcomes) to interventions depends on the fundamental activity of a factual, timely, accurate pain assessment. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1070). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Use evidence-based tools to ensure appropriate pain assessment (Horgas, 2018). o Use the PAINAD to assess pain in patients with advanced dementia (Horgas, 2018). o Use behavioral pain assessment tools. o Use evidence-based tools to ensure appropriate pain assessment (Horgas, 2018). o Use the PAINAD to assess pain in patients with advanced dementia (Horgas, 2018). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1071). Elsevier Health Sciences. Kindle Edition.

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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. 29073 Based on interview and record review, the facility failed to ensure that the Director of Nursing (DON) did not serve as a charge nurse in a facility with a daily average census of more than 60 residents resulting in a lack of consistent clinical services oversight and negative resident outcomes when the DON was a charge nurse for over 110 hours since January 2024. Findings: During an interview on 4/24/24 at 8:32 AM, the Director of Nursing (DON) reported that she has had to work as a charge nurse in the facility. The DON reported that because she is a salaried employee, she is supposed to keep track of the number of hours she works as a charge nurse on a form that is submitted for the Payroll Based Journal (PBJ) report. The DON said that she is getting better about accounting for the number of hours she has to work as a charge nurse. Review of Time Sheet-Exempt Staff forms from January 1, 2024-April 20, 2024, revealed the DON had worked as a charge nurse for over 111 hours. The weeks the DON worked as a charge nurse; she was not able to work Regular hours as the full-time DON. During an interview on 4/23/24 at 3:35 PM, Licensed Practical Nurse (LPN) C reported the Director of Nursing (DON) had been working as a floor nurse all the time since the unit manager stepped down from her position. LPN C reported that due to the DON frequently working as a floor nurse, so much has fallen through the crack such as missed laboratory testing, missed treatments, and missed medications. LPN C reported a concern with the lack of follow through and follow up with nursing related concerns. Review of the Director of Nursing Services job description specified The Director of Nursing plans, coordinates and manages the nursing department. Responsible for the overall direction, coordination and evaluation of nursing care and services provided to the residents. During an interview on 4/24/2024 at 8:32 AM, the DON reported that a part of her oversight included running a report every morning on the Dashboard of missed medications and treatments. The DON could not explain why no follow-through regarding the missed treatments was completed to avoid future missed treatments and to prevent negative outcomes. According to the DON, Skin and Wound Evaluations are used to determine how wounds were progressing and that is what is used by the Interdisciplinary Team (IDT) during Resident at Risk meetings held every week to review concerns such as wounds. Resident at Risk meeting notes were requested at this time. During an interview on 4/25/24 at 1:00 p.m., the Nursing Home Administrator (NHA) reported that she could not find any evidence that R64 or R276 had been reviewed during Resident at Risk meetings pertaining to wounds. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An Immediate Jeopardy (IJ) at F-686, Pressure Ulcer Prevention and Care, was identified on 4/24/2024 and began on 12/21/23 when facility licensed nurses failed to accurately assess, provide treatments as ordered, and ensure physician oversite for R276's newly identified pressure injury. R64 experienced the worsening/deterioration of the wound on his right heel due to missed treatments and developed an additional wound to his left heel with a delay in treatment. It was identified during the annual survey that Licensed Practical Nurses were administering IV medications through Peripherally Inserted Central Catheters (PICC) lines. The DON did not have evidence any LPNs who administered these treatments had oversight or specialized training to carry out these orders which was outside the scope of practice for LPNs.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on interview and record review, the facility failed to ensure residents received medications as ordered for 1 resident (Resident #64) out of 5 residents reviewed for unnecessary medications. Findings: Resident #64 (R64) Review of an Admission Record reflected R64 admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia, pressure ulcer of right heel, stage 3, Methicillin Susceptible Staphylococcus Aureus (MSSA) and obstructive and reflux uropathy. Review of an After Visit Summary dated 4/16/2024 reflected R64 was seen by Urologist W for Urinary retention and Bilateral hydronephrosis. Instructions from Urologist W indicated: Take antibiotic dose now (in urology office) and then 2nd dose tonight (at nursing home). The after visit summary also included contact information for the urologist's office if there were any questions or concerns. Review of the April 2024 Medication Administration Record (MAR) reflected the order Bactrim DS Oral Tablet 800-160 mg, give 1 tablet by mouth at bedtime for Chronic foley Prophylactic-Ongoing no end date per Urologist-Start Date 4/16/2024. The MAR showed R64 had been given the antibiotic from 4/16/2024-4/28/2024, without an order from Urologist W to do so. During a telephone interview on 4/29/2024 at 2:00 PM, the Medical Assistant (MA) V for Urologist W reported that the antibiotic prescribed for R64 was to be taken for one day only for prophylaxis (prevention) because the urologist completed a catheter exchange in the office. The resident was given one dose of antibiotic in the office, and the second dose was to be taken at the facility per the After Visit Summary. The antibiotic was not intended to be given indefinitely. During an interview on 4/23/24 at 3:20 PM, the Director of Nursing (DON) was asked why a prophylactic antibiotic had been started for R64 despite not having an extensive history of urinary tract infections (UTI), any recently documented signs and symptoms of a UTI, or laboratory testing. The DON said she was not sure and would direct the question to the Infection Control Nurse, Registered Nurse (RN/ICP) E. During an interview on 4/29/2024 at 2:51 PM, (RN/ICP) E indicated the following regarding the antibiotic order for R64: (a) R64 was taking Bactrim DS daily because the urologist had started the medication and ordered it that way, and (b) RN/ICP did not have a copy of the order from the Urologist and had not double checked the order to ensure it was transcribed correctly. When asked, RN/ICP E was not able to identify what McGeer's criteria would be required for a resident with an indwelling catheter that was started on an antibiotic.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. 29073 Based on observation, interview and record review, the facility failed to ensure that intravenous (IV) medications were administered by licensed nurses who had demonstrated proficiency with IV medication administration through training and monitoring in accordance with State professional standards of practice. This failure, of administering intravenous medications outside their scope of practice, increased the potential for adverse complications for one resident (R35), from a sample of 18 residents, who was observed receiving IV antibiotics administered by a Licensed Practical Nurse (LPN), untrained in intravenous medication administration. Findings include: Review of a facility Charge Nurse Job Description revealed the charge nurse 2. Provides safe and accurate Medication Related interventions to residents. 23. Accepts only those nursing assignments that are commensurate with one's own education preparation, experience, knowledge and ability; obtains instruction and supervision as necessary when implementing nursing procedures or practices. Review of a policy Medication Administration last revised 10/17/2023 revealed Authorized Personnel - Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications. Review of the website https://www.michigan.gov/documents/PracticalNurse-Licensed_12876_ 7.pdf, document dated 1/24/22, revealed in the State of Michigan (MI), the LPN may flush a peripheral IV line in preparation for the Registered Nurse (RN) to give an IV medication, but the LPN cannot actually give the IV medication. Review of the website https://www.michigan.gov/media/Project/Websites/mdcs/JOBSPECS/P/PracticalNurseLicensed.pdf?rev=40b6144954ac42edaf820e382c7c963a, document dated 1/01/17, and titled Michigan Civil Service Commission Job Specification Practical Nurse Licensed, revealed [LPN] administers medications orally, intramuscularly and subcutaneously . Review of the Board of Nursing Administrative Rules, provided by the Bureau of Professional Licensing in the State of Michigan, revealed the Nursing Administrative Rules regulate the delegation of activities from a Registered Nurse (RN) to an LPN. Review of section R (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	338.10104 Delegation, Rule 104 revealed, (1) Only a registered nurse may delegate nursing acts, functions, or tasks. A registered nurse who delegates nursing acts, functions, or tasks shall do all of the following: (a) Determine whether the act, function, or task delegated is within the registered nurse's scope of practice. (b) Determine the qualifications of the delegate before such delegation. (c) Determine whether the delegate has the necessary knowledge and skills for the acts, functions, or tasks to be carried out safely and completely. (d) Supervise and evaluate the performance of the delegate. (e) Provide or recommend remediation of the performance when indicated. (2) The registered nurse shall bear ultimate responsibility for the performance of nursing acts, functions, or tasks performed by the delegate within the scope of the delegation. Resident #35 (R35) Review of an Admission Record revealed R35 admitted to the facility with diagnoses that included discitis of the lumbosacral region, cellulitis of the back, streptococcus as the cause of diseases classified elsewhere, and a pressure ulcer of sacral region. Review of a Medication Administration Record (MAR) for April 2024 revealed an order Penicillin G Potassium Injection Solution Reconstituted (Penicillin G Potassium) Use 20 million units intravenously one time a day for Sepsis and wound until 05/02/2024 23:59 (11:59 PM) PCNG 20 million units in NACL.9% 1040 cc (cubic centimeters) 41.6 ml (milliliters)/hr (hour) infused over 24 hours-Start Date-4/11/2024. During an observation on 4/23/2024 at 10:38 AM, Licensed Practical Nurse (LPN) S entered R35's room with IV (intravenous) supplies and medication. LPN C disconnected the current IV set from the pump, cleaned the PICC (peripheraly inservted central catheter) line with an alcohol swab and flushed the PICC line with normal saline. LPN C then hung the new bag of IV antibiotics, attached new tubing to the bag, primed the tubing, attached the tubing to the PICC on R35's right upper arm, set the pump and left the room. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/2024 at 2:33 PM, the Director of Nursing (DON) was asked if LPN S had specialized training to administer IV medications. The DON reported that LPN S did not have specialized training at the facility but thought she had been trained to administer IV medications at a different facility. Review of an email communication sent on 4/24/2024 at 4:22 PM, the DON reported she did not have proof of specialized training for any LPN to administer IV medications through PICC lines.

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F 0880 Level of Harm - Actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation is related to intake #MI00140932 Based on interview and record review, the facility failed to 1.) promptly identify an outbreak of acute respiratory illness and implement facility infection prevention and control policies and procedures, 2.) implement transmission-based precautions for residents with signs and symptoms of acute respiratory illness to prevent the spread of infection, 3.) ensure prompt testing for residents with signs and symptoms of acute respiratory illness, 4.) investigate the outbreak and document the surveillance of respiratory infections, and 5.) follow transmission based precautions for suspected Clostridum difficle (C-diff). This deficient practice resulted in the widespread transmission and infection of residents and staff with COVID-19, Influenza, and Respiratory Syncytial Virus. Findings: Review of the facility policy Infection Prevention Program Overview last revised 9/9/22 revealed, INFECTION PREVENTION PROGRAM-MISSION OF PROGRAM- The facility establishes a program under which it: Investigates, identifies, prevents, reports and controls infections and communicable disease for all guests/residents, staff, contractors, consultants, volunteers, visitors and others who provided care and services to the guests/residents on behalf of the facility, and students in the facility's nurse aide training program or from affiliated academic institutions .*Decides what procedures such as isolation, should be applied to an individual guest/resident *Maintains a record of incidents and corrective actions related to infections .Preventing Spread of Infection *When the infection control program determines that a guest/resident needs isolation to prevent the spread of infection, the facility must isolate the guest/resident . The major activities of the program are: A. Surveillance of infections with implementation of control measures and prevention of infections * There is on-going monitoring to identify possible communicable diseases or infections among guests/residents and personnel and subsequent documentation of infections that occur. *Preventing the spread of infections is accomplished by use of standard precautions and other barriers, appropriate treatment and follow-up, and employee work restrictions for illness. *Staff and guest/resident education will focus on risk of infection and practices to decrease the risk. B. Outbreak Investigation *Systems are in place to facilitate recognition of increases in infections as well as clusters and outbreaks . REPORTING MECHANISMS FOR INFECTION PREVENTION A. Guest/resident infection cases are monitored by the IP (Infection Preventionist). The IP completes the Infection Surveillance Tracking Tool in InfectionWatch and: 1. Reports to the Infection Prevention Committee 2. Provides feedback to staff as needed. 3. Reports notifiable disease to the local health department as directed. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	B. Employee infections are reported by the employee to his/her supervisor then to the IP. The IP enters the employee infection data into InfectionWatch and reports to the: 1. Infection Prevention Committee monthly 2. The QAPI Committee on a quarterly or more often as needed. C. Compliance with Infection Prevention practice is monitored and documented by the IP through surveillance and observation . Review of the State Operations Manual revealed, Recognizing, Containing and Reporting Communicable Disease Outbreaks The facility must know how to recognize and contain infectious disease outbreaks. An outbreak is the occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time.31 If a condition is rare or has serious health implications, an outbreak may involve only one case. While a single case of a rare infectious condition or one that has serious health implications may or may not constitute an outbreak, facilities should not wait for the definition of an outbreak to act. For example, one case of laboratory confirmed influenza in a resident should alert the facility to begin an outbreak investigation. If an outbreak is identified, the facility must: *Take the appropriate steps to diagnose and manage cases, implement appropriate precautions, and prevent further transmission of the disease as well as documentation of follow-up activity in response; and *Comply with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks. Timeline of Covid-19 Outbreak *On 12/9/23 a CNA (Certified Nursing Assistant) tested positive. There was no documentation that an outbreak investigation/contact tracing was initiated to contain and prevent the spread of COVID-19 in the facility. Comments Worked shifts 48 hours prior on 100 hall. 100 hall residents tested days 1, 3, and 5. There was no documentation that staff members were included in the covid testing or any other residents that may have been exposed (dining room, activities, therapy, etc). *On 12/11/23 R58 tested positive *On 12/15/23 an LPN (Licensed Practical Nurse) tested positive with symptom onset 12/12/23. *On 12/18/23 a CNA tested positive with symptom onset 12/16/23 *On 12/18/23 a dietary worker tested positive with symptom onset 12/17/23 *On 12/23/23 R38 tested positive *On 12/24/23 a CNA tested positive with symptom onset 12/23/23 *On 12/27/23 R58 tested positive *On 12/27/23 an activities staff member tested positive with symptom onset 12/27/23 (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	*On 12/28/23 an RN (Registered Nurse) tested positive with symptom onset 12/28/23 *On 12/30/23 a facility staff member tested positive with symptom onset 12/29/23. No close contact with residents (receptionist). Indicating other staff members that may have come in contact with the staff member were not monitored for potential exposure. *On 12/30/23 a CNA tested positive with symptom onset 12/29/23 *On 1/1/24 a CNA tested positive with symptom onset 1/1/24. There was no documentation that staff members were included in the contact tracing or any other residents that may have been exposed (dining room, activities, therapy, etc). *On 1/1/24 R3 tested positive *On 1/1/24 R276 tested positive *On 1/3/24 R8 tested positive *On 1/4/24 R289 tested positive *On 1/6/24 R25 tested positive *On 1/7/24 a CNA tested positive with symptom onset 1/6/24. Comments: Sent home 1/7 on 300 hall. Worked shifts 48 (hours) prev (previously. 300 Hall residents tested day 1, 3, 5. There was no documentation that staff members were included in the covid testing or any other residents that may have been exposed (dining room, activities, therapy, etc). *On 1/7/24 R65 tested positive *On 1/7/24 R50 tested positive *On 1/8/24 a CNA tested positive with symptom onset 1/7/24. Comments: Sent home at beginning of shift on 100H. Residents on 100 hall tested days 1,3,5. There was no documentation that staff members were included in the covid testing or any other residents that may have been exposed (dining room, activities, therapy, etc). Confirming the spread of infection to other halls. *On 1/8/24 R6 tested positive *On 1/10/24 R290 tested positive *On 1/19/24 R286 tested positive *On 1/30/24 R55 tested positive *On 2/17/24 an environmental worker tested positive for COVID with onset of symptoms 2/16/24. Comments: Laundry aid who worked the day of testing positive 2/17. Wears N95 regularly . There was no documentation that an outbreak investigation and/or contact tracing was initiated, routine testing was initiated, or that the health department was notified of a positive Covid result. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	*On 3/1/24 a CNA tested positive with symptom onset 3/1/24. No additional information regarding the date last worked or the unit worked provided. There was no documentation that contact tracing was initiated to identify staff and residents exposed. *On 3/8/24 an RN tested positive with symptom onset 3/7/24. No additional information regarding the date last worked or the residents in contact were provided. There was no documentation that contact tracing was initiated to identify staff and residents exposed. *On 3/13/24 R291 tested positive. There was no documentation that contact tracing was initiated to identify staff and residents exposed. *On 3/20/24 a dietary staff member tested positive on 3/20/24 with symptom onset 3/19/24. No additional information regarding the date last worked or the residents in contact were provided. There was no documentation that contact tracing was initiated to identify staff and residents exposed. *On 3/31/24 a CNA tested positive with symptom onset 3/30/24. No additional information regarding the date last worked or the unit worked provided. There was no documentation that contact tracing was initiated to identify staff and residents exposed. During an interview on 5/1/24 at 2:32 PM, Regional Nurse Consultant (RNC) A confirmed there was no outbreak investigation related to the Covid outbreak that began on 12/9/23. Timeline of Influenza Outbreak Review of the Centers for Disease Control and Prevention Key Facts About Influenza dated 3/22/24 revealed, Period of Contagiousness-You may be able to spread flu to someone else before you know you are sick, as well as when you are sick with symptoms. *People with flu are most contagious during the first 3 days of their illness. *Some otherwise healthy adults may be able to infect others beginning one day before symptoms develop and up to five to seven days after becoming sick. *Some people, including young children and people with weakened immune systems, may be contagious for longer periods of time. Onset of Symptoms-The time from when a person is exposed and infected with influenza virus to when symptoms begin is about two days, but can range from about one to four days. Https://www.cdc.gov/flu/about/keyfacts.htm#print *On 12/9/23 a CNA (Certified Nursing Assistant) tested negative for COVID but exhibited headache, fever, and chills beginning on 12/8/23. The CNA was not tested for influenza or RSV and was estimated to return to work on 12/14/23. *On 12/13/23 a staff member tested positive with symptom onset 12/11/23. There was no documentation that an outbreak investigation and/or contact tracing was initiated. The unit the LPN worked, and the last date worked, was not identified to monitor the residents for signs and symptoms of influenza. There was no documentation that residents exposed were offered antiviral medications. *On 12/15/23 a staff member tested positive with symptom onset 12/13/23. There was no documentation that contact tracing was initiated to identify residents exposed and to monitor the residents for signs and symptoms of influenza. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	*On 12/20/23 R8 began exhibiting symptoms of a respiratory illness. R8 was noted to have a new unproductive cough. LS were CTA (lung sounds were clear to auscultation). A covid test was done and was negative. An order was placed in the elctronic health record, for a covid test to be done again in 48 hours. On 12/23/23 the facility Obtained specimen for Influenza A and B and RSV testing to be completed. On 12/24/23 R8 was found to be positive for Influenza A. There was no documentation that R8 was placed in droplet isolation while symptomatic for a respiratory illness and while the test results were pending (placing staff and residents at risk for exposure) until 12/23/23 Guest to be in droplet isolation precautions until results of RSV and Influenza results received. On 12/24/23 the provider ordered Tamiflu 30mg capsule two times a day. Review of the FDA (food and drug administration) package insert for Tamiflu revealed TAMIFLU is for treating adults and children age 1 and older with the flu whose flu symptoms started within the last day or two. R8's respiratory symptoms began approximately 4 days prior to the initiation of Tamiflu. There was no documentation that contact tracing was initiated to identify other staff and residents that were exposed. *On 12/24/23 R283 tested positive. There was no documentation that Tamiflu was offered and/or ordered. *On 12/26/23 an environment worker tested positive with symptom onset 12/26/23. There was no documentation that contact tracing was initiated to identify residents exposed and to monitor the residents for signs and symptoms of influenza. *On 12/27/23 R284 tested positive. There was no documentation that Tamiflu was offered and/or ordered. There was no documentation that contact tracing was initiated to identify residents exposed and to monitor the residents for signs and symptoms of influenza. *On 2/17/24 an environmental worker tested positive for Influenza A with onset of symptoms 2/13/24. Comments: Did not work 48 hours prior to scheduled shift . *On 3/18/24 a CNA tested positive with symptom onset 3/18/24. No additional information regarding the date last worked or the unit worked provided. There was no documentation that contact tracing was initiated to identify staff and residents exposed. *On 3/20/24 a CNA tested positive with symptom onset 3/19/24. No additional information regarding the date last worked or the unit worked provided. There was no documentation that contact tracing was initiated to identify staff and residents exposed. *On 3/25/24 a CNA tested positive with symptom onset 3/25/24. No additional information regarding the date last worked or the unit worked provided. There was no documentation that contact tracing was initiated to identify staff and residents exposed. During an interview on 5/1/24 at 2:32 PM, RNC A confirmed there was no outbreak investigation completed for the influenza outbreak. No further documentation was received prior to survey exit. Timeline of RSV Outbreak *On 1/26/24 a CNA tested positive with symptom onset 1/22/24. Comments: Worked 1/22 on 300 Hall. Sent for PCR 1/23 after negative POC (point of care). PCR (polymerase chain reaction) came back + RSV 1/26. An outbreak investigation/contact tracing was not initiated. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	*On 1/30/24 R55 tested positive *On 2/5/24 R34 tested positive *On 2/7/24 R65 tested positive *On 2/9/24 R287 tested positive *On 2/9/24 R20 tested positive *On 2/12/24 R52 tested positive *On 2/13/24 R23 tested positive *On 2/16/24 R36 tested positive *On 2/17/24 R276 tested positive *On 2/20/24 R57 tested positive *On 2/20/24 R125 tested positive *On 2/21/24 R58 tested positive *On 3/4/24 R278 tested positive *On 3/4/24 R8 tested positive *On 3/4/24 R45 tested positive *On 3/6/24 R4 tested positive *On 3/22/24 R279 tested positive *On 3/27/24 R22 tested positive *On 3/29/24 R11 tested positive *On 3/31/24 R55 tested positive During an interview on 04/30/2024 at 10:58 AM, RN/ICP E reported the policy for transmission-based precautions for RSV for contact isolation only. RN/ICP E reported that initially she was placing residents positive for RSV in contact and droplet isolation, however, Corporate Infection Control Preventionist (CICP) T reported only contact precautions were required for RSV. During an interview on 04/30/24 at 01:20 PM, ICP E reported that she did not have an outbreak investigation for the RSV outbreak, because she wasn't trained how to do one. She reported that she knows now and moving forward outbreak investigations will be completed. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	During an interview on 4/30/24 at 02:50 ICP E reported that staff and residents were first tested for COVID and if that was negative, testing for RSV and Influenza was completed. Beginning in March 2024, a Resp-4-flex swab was obtained (COVID, RSV, Influenza A&B testing). ICP E reported if the COVID and Influenza testing was negative, contact precautions and standard precautions remained and droplet precautions were no longer implemented. During an interview on 5/1/24 at 10:28 AM, RNC A reported that the RSV vaccination was not offered to residents residing in the facility and was not required by CMS (center for medicare and medicaid services). Ongoing Respiratory Tracking On 4/30/24 there remained no system in place for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services despite the notification to the Regional Nurse Consultant (RNC) and Nursing Home Administrator of the serious concerns with the infection control program on 4/29/24. On 4/30/24 there were 2 residents (R67 and R278) that were started on cough medication for symptoms of a respiratory illness. There were no transmission-based precautions in place and no surveillance for an unknown respiratory illness (following an outbreak of Covid, RSV and Influenza from 12/9/23-3/31/24.). Review of R67's Order Summary dated 3/19/24 revealed, GuaiFENesin Liquid 100 MG/5ML Give 10 ml by mouth every 4 hours as needed for Cough. Review of R67's Medication Administration Record revealed R67 received a dose of the Guaifenesin (cough medicine) on 4/24/24, 4/28/24, and 4/30/24. Review of R67's Electronic Health Record revealed R67 had a diagnosis of pneumonia and received antibiotics for the diagnosis from 3/27/24-4/1/24. There was no documentation that R67 was being monitored for an increase in respiratory symptoms which required the use of guaifenesin. Review of R278's Order Summary dated 4/30/24 revealed, GuaiFENesin ER Tablet (Extended Release) 12 Hour 600 MG (milligram) Give 1 tablet by mouth every 12 hours for cough productive for 5 Days. Review of R278's Medication Administration Record revealed R278 received a dose of guaifenesin in the morning of 4/30/24 and the evening of 4/30/24. Review of R278's Electronic Health Record revealed R278 had a diagnosis of pneumonia and received antibiotics for the diagnosis from 4/11/24-4/21/24. There was no documentation that R278 was being monitored for an increase in respiratory symptoms which required the use of guaifenesin. During an interview on 5/1/24 at 2:32 PM, RNC A confirmed that R67 and R278 were not being monitored or tested for a possible respiratory virus (RSV, COVID, Influenza) and were not in transmission-based precautions. 29073 (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	ENHANCED BARRIER PRECAUTIONS Resident #35 (R35) Review of an Admission Record revealed R35 admitted to the facility with diagnoses that included discitis of the lumbosacral region, cellulitis of the back, streptococcus as the cause of diseases classified elsewhere, and a pressure ulcer of sacral region. Review of a Care Plan revealed R35 was at risk for complications of IV (intravenous) therapy and had a PICC (Peripherally inserted Central Catheter) line to his right arm. Interventions included Enhanced Barrier Precautions: don gown and gloves during high-contact resident care. Review of the April 2024 treatment Administration Record (TAR) reflected R35 was in Enhanced precautions for medical indwelling device and chronic wounds-Start Date-4/10/2024. During an observation on 4/23/2024 at 10:38 AM, Signage on the door of R35's room indicated he required enhanced barrier precautions. The sign indicated providers and staff were to wear gloves and a gown for high contact resident care activities such as dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy and wound care: any skin opening requiring a dressing change. A tower of Personal Protective Equipment (PPE) was available near the door. During the observation on 4/23/24 at 10:38 AM, Licensed Practical Nurse (LPN) S entered R35's room with IV (intravenous) supplies and medication. LPN C disconnected the current IV set from the pump, cleaned the PICC line with an alcohol swab and flushed the PICC line with normal saline. LPN C then [NAME] the new bag of IV antibiotics, attached new tubing to the bag, primed the tubing, attached the tubing to the PICC on R35's right upper arm, set the pump and left the room. LPN S donned gloves for the administration of the IV medication but did not don a gown. Resident #64 (R64) Review of an Admission Record reflected R64 admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia, severe, pressure ulcer of right heel, stage 3, Methicillin Susceptible Staphylococcus Aureus (MSSA) and obstructive and reflux uropathy. Review of the April 2024 Medication Administration Record (MAR) reflected Enhanced Precautions every shift for medical indwelling device and chronic wound-Start Date-4/10/2024. During an observation on 4/23/2024 at 1:39 PM, signage outside R64's room indicated he was in Enhanced Barrier Precautions. PPE was in a tower outside the door. LPN Q entered R64's room and physically assisted R64 transfer from his wheelchair into bed and assisted R64 getting his legs onto the bed once seated on the edge of the bed. LPN Q disconnected his urinary catheter collection bag from the wheelchair and maneuvered the tubing and catheter while securing the device to the bed. LPN Q removed R64's shoes, socks, and with gloved hands, removed a dressing saturated with serosanguanious drainage from R64's right heel. LPN Q did not don a gown for the extensive contact with R64. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	During an observation on 4/23/24 at 3:37 PM., LPN Q was assisted by LPN C in completing a dressing change and catheter care. LPN C held up R64's left lower leg and support the foot while LPN Q cleaned and dressed the stage three pressure ulcer. LPN C also held up R64's right lower leg while LPN Q treated an area and photographed a wound on R64's right heel. LPN Q obtained three 10 milliliter pre-filled normal saline syringes, uncovered R64's lower body, leaned away from R64's catheter to avoid any splashes, separated/disconnected the drainage tubing from the catheter insertion near the urethra at the tip of the penis. LPN Q pinched the open end of the drainage tubing with her left hand, uncapped the prefilled syringe and flushed R64's urethra with all three syringes, one after the next. LPN Q then reattached the drainage tubing to the catheter emerging from R64's urethra. LPN Q and LPN C said they did not know why R64 was having his urethra flushed in this manner twice a day and did not know why the flush was being done with normal saline. LPN Q and LPN C did not don gowns or face shields to protect against contact or droplets during the procedures. 37577 Resident #228 (R228) Review of an Admission Record revealed R228 was a [AGE] year old female, last admitted to the facility on [DATE] with pertinent diagnoses of pneumonia, chronic kidney disease stage 3, and a recent fall with fracture. R228 is her own responsible party. During an observation/ interview at the nurses station on 04/24/24 at 11:50 AM, Nurse Practitioner (NP) H told RN I that an order to check R228 for c-diff (clostridium dificile-a contagious stomach disorder) was being placed into the computer. NP H had been made aware that R228 had loose watery stools. Review of physician orders for R228 revealed an order on 04/24/25 for: stool for c-diff (clostridium dificile-contagious stomach disorder) today due to loose stools. During an interview on 04/24/24 at 12:45 PM, the Director of Environmental Services indicated that if there is an outbreak, a change or addition to who is in enhanced barrier precautions, or if a patient is placed in isolation, the ICP/ADON notifies her and then the information is passed to the housekeeping staff right away. During an observation on 04/24/25 at 2:40 PM, R228 did not have any signage or PPE tower alerting staff and visitors that R228 was in isolation. During an interview on 04/2524 at 7:45 AM, the Director of Environmental Services had not been made aware of any changes to the rooms that are designated enhanced barrier precautions or isolation contact precautions. During an interview on 04/25/24 at 7:50 AM, CNA F (a) assisted R228 to use the bathroom without the use of contact precaution PPE, (b) reported being aware that stool samples were ordered for R228 to rule out c-diff, and (c) stated that until the results come back staff are to follow universal precautions. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	During an observation on 04/25/24 at 7:55 AM, R228's room did not have signage for staff to use contact precautions when entering the room, nor was there a PPE (personal protective equipment) tower outside R228's room. During an interview on 04/25/24 at 8:10 AM, RN G stated, if a patient had an order to check for c-diff, the patient is placed in isolation until the results are back. During an interview on 04/25/24 at 9:10 AM, the DON indicated that she had not been made aware that R228 was being tested for c-diff and that anyone being tested for c-diff is placed in contact precautions right away until the results are back.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to ensure that a resident who required an antibiotic was prescribed the appropriate antibiotic for 1 of 10 residents (Resident #43) reviewed for antibiotic use, resulting in inappropriate antibiotic utilization and the potential for antibiotic resistance. Findings: Resident #43 (R43) Review of an Admission Record revealed R43 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: chronic kidney disease. Review of R43's Provider Note-Telehealth dated 4/13/24 revealed, Nurse reports resident did not void for 12 hours, straight catheter done, urine dark with sediments, urine dipstick positive for UTI (urinary tract infection). Augmentin (antibiotic) 500 mg TID (three times a day) for 10 days ordered. Follow up with rounding provider. Review of a Nurses Note dated 4/13/24 revealed, Resident did not void during morning shift despite IV (intravenous) fluids and intake of fluids orally. Resident attempted to urinate without success. Nurse cathed (catheterization) resident with output of 800 cc (cubic centimeters) and urine is dark amber with odor, and sediment. Resident denies pain when attempting to urinate, and denies flank or bladder pain. Review of R43's Order Summary dated 4/13/24 revealed, UA (urinalysis) and C&S (culture and sensitivity) if indicated and Amoxicillin-Pot Clavulanate Tablet 500-125 MG-Give 1 tablet by mouth three times a day for bacterial infection for 10 Days. Indicating an antibiotic was prescribed for R43 prior to a urinalysis and culture and sensitivity being completed and resulted. Review of R43's Laboratory Result revealed a urine was collected on 4/13/24. The urinalysis results did not reflex to a culture and sensitivity. Review of R43's April Medication Administration Record revealed R43 received Augmentin 3 times daily beginning the morning of 4/14/24 through the evening of 4/23/24 (all doses administered). Review of R43's Electronic Health Record revealed no documentation for a rationale from the provider to initiate antibiotic use without a positive urinalysis and without the results of a culture and sensitivity. Review of R43's Infection Note dated 4/17/24 completed by Infection Control Preventionist (RN/ICP) E revealed, Resident was diagnosed with a UTI and prescribed Augmentin 4/14 after a positive urine dip stick (straight cath). No UA or C&S collected. See progress note made by NP (nurse practitioner) 4/13. NP (name omitted) also made aware. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235636	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Carson City	620 North Second Street Carson City, MI 48811

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/24 at 10:27 AM, RN/ICP E reported that when the urine dip was done it flagged RN/ICP E to complete a McGeer Criteria Assessment (set of criteria used to diagnose urinary tract infections). RN/ICP E identified that the urinalysis and culture and sensitivity were not completed and still R43 was placed on Augmentin. RN/ICP E confirmed that R43 exhibited no signs or symptoms of a urinary tract infection, did not meet the McGeer Criteria, and did not have a history of urinary tract infections. RN/ICP E reported that a culture and sensitivity should be received and reviewed prior to the initiation of an antibiotic to ensure an appropriate antibiotic is prescribed. Review of the facility policy Infection Control Antibiotic Stewardship & MDROs last revised 9/9/22 revealed, . The program will encourage appropriate prescribing; and reduce adverse effects which often include gastrointestinal problems, C. Difficile diarrhea, yeast infections and antibiotic resistance in aging adults. 2. The medical director and director of nursing will use his/her influence as medical and nursing leaders to help ensure antibiotics are prescribed only when appropriate. 3. The infection preventionist will be responsible for promoting and overseeing antibiotic stewardship activities in the facility. Responsibilities include educating employees about the importance of antibiotic stewardship, and adhering to programs that prevent the spread of infection and improve antibiotic use .6. The use of prophylactic antibiotic treatment, long term antibiotic maintenance use for chronic infections and treatment with broad-spectrum antibiotics while a culture is pending, should be discouraged by the medical director and consultant pharmacist .10. The facility will communicate with the physician based on guest/resident history, evaluation, signs and symptoms, and diagnostic tests if applicable of suspected guest/resident infections to determine the best course of treatment. 11. Laboratory and diagnostic testing will be used judiciously. Positive urine tests do not always warrant an additional culture and sensitivity in the absence of clinical signs and symptoms of infection. When a culture is positive, antibiograms and lab results will be utilized to help prescribers select the best antibiotic for each guest/resident based on the guidelines for prescribing protocols .

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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 0883 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to provide the pneumococcal immunization per consent and the recommendation by the Centers for Disease Control and Prevention (CDC) for 1 (Resident #287) out of 5 reviewed for immunizations, resulting in residents not receiving the pneumococcal immunization. Findings: Resident #287 (R287) Review of an Admission Record revealed R287 was an [AGE] year-old female, admitted to the facility on [DATE]. Review of R287's Pneumococcal Immunization Consent revealed R287 consented/requested the pneumonia vaccine on 1/23/24. Review of R287's Nurses Notes dated 2/7/2024 revealed, (name omitted), an ER (emergency room) nurse from (hospital), called and stated that the guest was being admitted r/t (related to) RSV (Respiratory Syncytial Virus), right lobe pneumonia, CXR (chest x-ray) showing failure . Review of R287's Nursing Summary dated 2/9/24 revealed, Guest out to the hospital for 2 overnights due to community acquired pneumonia and diagnosed with RSV . During an interview on 5/1/2024 at 3:10 PM, Infection Control Preventionist (RN/ICP) E reported that R287 did not receive the pneumonia vaccine. RN/ICP E reported that R287 admitted on the 1/23/24 and was discharged before RN/ICP E realized that R287 did not receive the pneumonia vaccine. I guess that I just missed that one. Review of the facility policy Immunizations: Pneumococcal Vaccination (PPV) of Guest/Residents last revised 3/27/23 revealed, I. GUIDELINE: The Advisory Committee on Immunization Practices (ACIP) recommends vaccinating persons at high risk for serious complications from pneumococcal pneumonia, including those [AGE] years and older and all guests/residents of nursing homes. Recognizing the major impact and mortality of pneumococcal disease on guests/guest/residents of nursing homes and the effectiveness of vaccines in reducing healthcare costs and preventing illness, hospitalization and death, this facility has adopted the following policy statements: 1. All guests/residents of our facility should receive the pneumococcal vaccine if they are [AGE] years of age or older or younger than [AGE] years with underlying conditions that are associated with increased susceptibility to infection or increased risk for serious disease and its complications .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39083 Based on observation, interview, and record review, the facility failed to maintain clean ventilation filters, resulting in reduced air quality and reduced air circulation, affecting resident rooms 204, 214, 326, and 327. Findings include: On 4/22/24 at 1:53 PM, the packaged terminal air conditioning unit (PTAC) filter, located in room [ROOM NUMBER], was observed to be caked with dust. On 4/22/24 at 1:55 PM, the PTAC unit, located in room [ROOM NUMBER], was observed to be caked with dust. At this time, Resident #52 stated that they haven't seen maintenance change the filter since before winter and that the air seems to come out slower. On 4/24/24 at 11:53 AM, the PTAC units, located in rooms [ROOM NUMBERS], were observed to be caked with dust. During an interview on 4/24/24 at 1:10 PM, Maintenance Director U stated that the PTAC filters are changed every six months, but they are supposed to be checked monthly and are changed as needed. According to the facility's preventative maintenance program prompt, Clean air filters, it notes, 1. Remove or open access cover 2. Remove air filter and inspect for cleanliness. If filter is dirty, either wash or replace depending on type of filter. If clean, reinstall filter. 3. Re-install access cover 4. Clean grill on cover 5. Close and make sure it is secure. 6. At a minimum, air filters are to be replaced or thoroughly cleaned depending on type of filter every three months. 7. Clean evaporator coils if lint build-up is present 8. Inspect electrical motors and wires. The log shows the task was completed last on 3/31/2024.