STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235646	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caretel Inns of Linden	202 South Bridge Street Linden, MI 48451

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Numbers MI00134717, MI00140086 and MI00143075. Based on observation, interview and record review, the facility failed to ensure that residents were treated in a respectful and dignified manner for two residents (Resident #20 and Resident #41) and a Confidential Group of residents, from a facility census of 55 residents, resulting in residents having soiled briefs due to call lights not being answered timely, call lights not within reach, and staff talking on personal cell phones while in the residents' rooms while providing resident care, resulting in residents' feelings of frustration, anger and embarrassment. Findings Include: FACILITY On 8/20/2024 0 at 2:05 PM, during an interview with a Confidential Group of Residents A big concern of everyone here is the call bell. It takes forever to be answered- that 'ding ding ding'. The worst part is they come in and say, 'I just have to finish something else' and 1/2 hour to 45 minutes later they come back; and then they rush. We are tired of hearing that. Nobody should wait 45 minutes to an hour to have your brief changed. There is skin breakdown that could happen. Waiting that long happened several times in the last month: usually during the day. During the interview, the Confidential Group also said Grievances were not always followed up on. The Group stated, They don't give us a chance to speak, power to make decisions for ourselves. The previous Activities director would go over concerns, but not now. The Confidential Group said the staff talk on their phones during resident care. They said the staff enter the resident's room talking on the phone and during care and sometimes they are on an ear bud. The Group stated, I can hear every word, when they talk to their boyfriends and everything. We don't want to hear that. You are trying to talk to them and they are on their phone. They have put up notices not to do that and they are still on their phone. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Confidential Group said they had just recently started getting snacks at bedtime, and stated, Sometimes we don't want just a sandwich. They said they were not offered fruits, or cookies for the HS (nighttime snack). The other day they brought me graham crackers, how about the ones with cheese or peanut butter crackers; that would be great. We receive them hit and miss. Some of the Confidential group said they had received an HS snack Maybe twice since I've been here, and I am diabetic. We think we can do a much better job with more appropriate snacks, such as cookies, pudding or a variety of sandwiches, not just 2 different ones. We need more options. During the interview with the Confidential Group, they said the hallways did not look clean, They could vacuum the hallways more often, they do not dust. There are only 3 housekeepers and that is not enough. They never dust in our rooms. Some of those people are also doing the laundry too. They need a laundry person too; they mix up the clothes. Tomorrow (Wednesday) is laundry day for the 100 hall, but they haven't returned the clothes from Monday. We won't have a bag to put our dirty clothes in. One Confidential person stated, They put my dirty clothes on the floor of the closet. They don't take them down to laundry. The Confidential Group said they don't feel their voices are heard or respected at times, The staff thinks they are in charge and we are the ones that should be able to voice our opinions; for example, I would like to make a call and they just walk out. A review of the Concerns from the Resident Council meetings from January through July 2024 were reviewed, there were 15 concerns related to housekeeping, laundry and maintenance services. In addition, there were, 9 concerns related to clinical care. On 8/22/2024 at 10:09 AM, the Director of Nursing/ DON was interviewed about the Confidential Group of Residents' concerns. She said she had attended the monthly Resident council meetings in the past when she was invited but had not requested to attend. Reviewed the Group had a variety of concerns, and it wasn't only one person; there were many. During the interview on 8/22/2024 at 10:09 AM, the DON said grievances were addressed as they occurred. She said the grievance could be written on paper and the residents would receive help as needed. Reviewed the Group did not feel the grievances were adequately followed up on and their opinions and voices were not heard. Asked if anyone had followed up with them to see if they were satisfied with the current process. Reviewed with the DON the Group felt disrespected when staff did not answer their call lights timely to ensure the residents received care as needed, especially with toileting. DON said she would address with staff- During the interview, the topic of staff talking on their personal phones while providing care to the residents was discussed. The DON said the staff could carry their phones on them but were not to use the cell phone in resident rooms and could not use ear buds. She said ear buds had been a struggle and was recently addressed with the staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The topic of resident snacks was reviewed with the DON, she said they were aware that it was an issue and a newer process was enacted. She said each resident had been asked what they wanted for snacks and the items were placed in the sub-kitchen with the residents' name on them. She said the nurse aides were to pass them out in the evening. Reviewed the residents felt the choice for snacks was limited and diabetic residents were concerned that many times they did not receive an appropriate snack. The DON said it was a new process for snacks, about 2 weeks. Reviewed the residents were upset they had gone so long with no snacks and wished to be part of the process. On 8/22/2024 at 10:40 AM, the Director of Maintenance/Housekeeping and Laundry M was interviewed about cleaning in the resident rooms and hallways. He said there were 3 housekeepers, and they were trying to keep up. He said there had been more in the past. Reviewed the residents said some of the staff had left and there were not enough housekeeping and laundry staff to clean their rooms, hallways and ensure a smooth consistent process for their laundry. Reviewed with the Maintenance Director there were several grievances from the Resident Council group related to housekeeping and laundry issues. He said he had seen them and tried to fix them. Reviewed a Group Concern in April 2024 related to the lawn being unmowed and the residents suggested hiring a landscaping service if the facility could not maintain it. The Maintenance Director said the facility was trying to change staff schedules to ensure the lawn was maintained. Discussed with him outside the conference room window, into one of the facility courtyards, the grass was long and not mowed, there were dead trees and shrubs and dead leaves and live trees growing in the eavestroughs. The courtyard looked unkempt and faced resident room windows, as well as the room was usually used for monthly Resident Council meetings. 37771 Resident #20: A review of Resident #20's medical record revealed an admission on 6/7/24 with diagnoses that included dementia, chronic obstructive pulmonary disease, weakness and difficulty in walking. A review of the Minimum Data Set assessment revealed the Resident has severely impaired cognition and needed substantial/maximal assistance with most mobility, upper body and lower body dressing and partial/moderate assistance with oral hygiene. A review of Section B-Hearing, Speech, and Vision, the Resident was documented as makes self-understood with ability to express ideas and wants and understood others with clear comprehension. On 8/21/24 at 10:45 AM, an observation was made in Resident #20's room of Resident #20 lying in bed, with a sheet over her and head of bed slightly elevated. The Resident did not engage in conversation and was able to readjust herself in bed. An observation was made of Resident #20's call light positioned on the floor by her bed and was not secured to the bed or in reach for the Resident. On 8/21/24 at 11:15 PM, an observation was made with the Administrator (NHA) of Resident #20's call light on the floor. The administrator positioned the call light within the resident's reach. Resident #41: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #41's medical record revealed an admission into the facility on [DATE] and readmission on 7/24/24 with diagnoses that included difficulty in walking, weakness, diabetes, chronic pain, and arthritis. A review of the Minimum Data Set assessment revealed the Resident had intact cognition and was dependent on helper for toilet transfer and sit to stand and needed substantial/maximal assistance of lying to sitting on the side of bed. On 8/19/24 at 11:22 AM, an observation was made of Resident #41 dressed, sitting in her wheelchair in her room. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about issues with the care received at the facility. The Resident reported an extended time for their call light to be answered and stated, It may take an hour before they come in here. Sometimes they are here and then leave again and I have to wait an hour to get anyone to come back. The Resident expressed frustration and reported she has bowel movement that just comes out of me, lack of control of her bowels and stated, I have to sit in it and wait till they come or come back. The Resident reported that she had been seated on the side of the bed and ended up leaning over and fell on to her pillow with her legs over the side of the bed and stated, I just fell over, someone came in and seen me like that and just left, reported she did not have her call light and stated, they didn't come back to help me sit up. The Resident reported falling asleep in that position and was uncomfortable and in pain when she woke up. The Resident stated, Why didn't they help me sit back up? I don't have the strength to get myself back to sitting. During the interview, the Resident was pulling on her sweatshirt that was behind her back and underneath her and reported it was too hot and wanted the sweatshirt out. The Resident was asked where her call light was and reported she didn't know. An observation was made of the call light placed in the middle of the bed, not in reach for the Resident. The Resident had her wheelchair with the back facing the bed. When asked if she could maneuver her wheelchair around and reach across the bed to the call light, the Resident reported she could not turn her wheelchair around and would not be able to reach across the bed for the call light. The Surveyor reported to a staff member who adjusted the call light in reach for the Resident.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Number MI00140086. Based on interview and record review, the facility failed to protect Resident #59's right to be free from sexual abuse by Resident #309, resulting in Resident #309 found alone in Resident #59's room with his hand down her pants. Findings Include: Abuse Resident #59: A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #59 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Dementia, hypothyroidism and anemia. The MDS dated [DATE] revealed Resident #59 had severe cognitive loss with a Brief Interview for Mental Status (BIMS) score of 1/15. The MDS also indicated the resident needed supervision with mobility. Resident #309: A record review of the Face sheet and MDS assessment indicated Resident #309 was admitted to the facility on [DATE] with diagnoses: history of a stroke, weakness, history of prostate cancer, diabetes, kidney disease, anxiety, depression and hypertension. The MDS assessment dated [DATE] indicated the resident had a BIMS score of 8/15 identifying moderate cognitive impairment. The MDS assessment also indicated the resident was independent with ambulation. Resident #309 was discharge to another facility on 11/21/2023. On 8/21/20 24 at 9:41 AM, the Director of Nursing/DON was interviewed. She said there was an incident related to Resident #309 entering Resident #59's room during the night on 9/25/2023. The DON said she was the Assistant Director of Nursing/ADON at the time and someone else from the Corporate office was in charge of investigating the incident; a corporate nurse was filling in as the DON. The DON said there was also a different Administrator at the time of the incident. She said a staff member observed Resident #309 in Resident #59's room. She said the Certified Nursing Assistant/CNA J still worked at the facility. The DON said CNA J saw Resident #309's walker outside Resident #59's room and when the CNA entered the room, she observed Resident #309 with his hand down Resident #59's pants. She said the CNA assisted the resident out of the room and contacted the Nurse and the Administrator was notified. On 8/21/2024 at 9:50 AM, Unit Manager E was notified when she came in the next day. She said the police were called and Resident #59's responsible party was called. She said Resident #59's responsible party did not want the resident to go to the hospital. She said he felt if the resident had been awake, she would not have let anyone touch her. The responsible party felt going to the hospital for assessment would traumatize the resident as she would not understand what was happening. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview on 8/21/2024 at 9:50, The DON and Unit Manager E were asked if Resident #309 had any previous incidents or inappropriate behavior similar to this. The Unit Manager said Resident #309 had a prior ongoing relationship that was consensual with another resident. She said since the residents both had cognitive loss, the responsible parties decided they would only visit with each other in the dining room. Then the female resident moved and there had been no other issues, until the issue with Resident #59. They said Resident #309 transferred to another facility on 11/21/2023. On 8/22/2024 at 11:47 AM, CNA J was interviewed about the incident between Resident #309 and Resident #59 and stated, I walked into the room and I saw another resident close to the side of the bed and he had his hands inside her pants. When I went in I had him immediately come out. I got the nurse. A review of the incident investigation dated 9/29/2023 at 2:04 PM provided the following: . On September 25, 2023 (Resident #309) allegedly entered the room of (Resident #59). A CNA, noticing (Resident #309) walker outside the door of (Resident #59's) room, followed him immediately into the room and escorted him out around 3:38 AM. The CNA reports observing (Resident #309) inappropriately touching (Resident #59) . enhanced safety measures including 'hourly' checks, have been implemented for (Resident #309) . The investigation confirms that the incident did occur . The facilities intervention of Hourly checks did not prevent Resident #309 from repeatedly attempting and succeeding in entering female residents' rooms. A review of the progress notes for Resident #309 revealed the following: 9/24/2023 at 4:41 AM, Resident up since before beginning of shift wandering halls. Continues to be up wandering the halls throughout the shift all night . 9/25/2023 at 3:50 AM, Resident up wandering halls all night. Found in other residents room, who was sleeping. Redirected. Resident aware he is not to be in other residents rooms upon questioning. 9/25/2023 at 3:52 AM, a Behavior Note: Wandering into other residents room; Found standing over sleeping female resident with blankets pulled down to her waist, shirt pulled up and his hands in her pants; Resident escorted out of his room to his own room on another hall . Resident states he knows he isn't allowed in other rooms. Asked resident if he understood what he was doing in the room and he stated he knew he was touching resident. 9/27/2023 at 3:04 AM, . Resident up walking halls When not visualized found down on 100 hall. Escorted to front desk and reminded to not go down 100 hall . 10/5/2023 at 6:28 PM, Resident wandering throughout the day . Resident attempted to enter the bedroom of a female resident this morning . 11/21/2023 at 1:09 PM, Resident discharging to (another Long Term Care facility) . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Social Services Quarterly note dated 10/4/2023 at 11:58 AM, revealed the following: . Resident is alert with confusion but able to make needs known to staff . For the question regarding Wanders it was marked No. For the question regarding Socially inappropriate behavior it was marked No. There was no mention of the resident wandering into female residents' rooms and demonstrating sexually inappropriate behavior. A review of the physician orders indicated there were no orders to aide in preventing the resident from continued inappropriate sexual behavior. There was no identified plan to aide in preventing continued behavior. A record review of the Care Plans for Resident #309 revealed there was no Care Plan mentioning the resident wandered or that he wandered into female resident's rooms or that he demonstrated sexually inappropriate behavior. There was no behavior Care Plan with interventions to aide in preventing the resident from continued inappropriate behavior. A review of a Discharge Planning Review, dated 11/21/2023 at 11:41 AM, revealed Resident #309 was transferring to another long-term care facility. In the section titled, Recap of the resident's stay, it said long term care, medication management. The overall summary of discharge, section was blank. There was no mention that the resident had sexually inappropriate behavior and continued to attempt to enter female residents' rooms. A review of the facility policy titled, Abuse Reporting, dated 8/2004, revised 2/24 and approved 2/2024 revealed, Abuse, neglect mistreatment, exploitation, or misappropriation of resident property are not tolerated at any time . Goal: To prevent abuse, neglect, mistreatment, exploitation, or misappropriation of resident property . There was no mention of Resident-to-Resident Abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 22348 This Citation pertains to Intake Number MI00136526. Based on interview, and record review, the facility failed to retain documentation regarding an injury after a fall investigation was completed and that the documentation was retained for one resident (Resident #56) of three residents reviewed for incident report investigations and retention of documentation, resulting in missed opportunities to prevent potential abuse or neglect, implement corrective measures and appropriate interventions and prevent further harm to occur. Findings include: Resident #56 (R56): 08/20/24 03:16 PM, a Facility Reported Incident submitted to the State Agency was reviewed. The surveyor requested the investigation file of R56 reported Fall Incident dated 4/6/2023. The Electronic Medical Record (EMR) Incident/Accident (I/A) Report dated 4/6/23 was incomplete; boxes were not checked, and no pertinent information was entered in the incident report documentation. According to the Fall Incident Report dated 4/6/23 at midnight: Incident Description: Patient observed on the floor by CNA (Certified Nursing Assistant) staff at approximately 00:00 on 4/6/23. Patient reported to writer: I am trying to go home. Patient noted to have put on shoes by himself and was found crawling on floor per CNA. Patient A/O (Alert/Oriented) to self and place and recognizes care staff. No injuries noted. Patient denied hitting head. No change from previous HS assessment. Neuro checks initiated. DON notified. Patient sitting up in wheelchair at nurses' station in view of nursing staff for safety. I am trying to go home. Injury type: No injuries observed at the time of incident. Level of Pain: (no entry). Mental Status: (no entry) Page 2 of 4: No entries Page 3 of 4: No entries Page 4 of 4: No entries On page 4 of the facility I/A report under Notes: Written on 4/18/23, Root cause analysis: Pt. observed on the floor crawling. Pt. is alert to self only. Pt. with increased restlessness at night. Pt. self-transfers and self ambulates. (signed electronically by the Director of Nursing). On 8/20/24 at 4:00 PM, a review of the hospital record dated 4/6/23 revealed: Final Diagnosis: [W19.XXXA] Fall, initial encounter [S14.109A] Acute traumatic injury of the spine (CMS/HCC) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. CT scan of his head and neck was obtained. CT of his head was negative. However, CT of the cervical spine was concerning for an acute superior endplate fracture of T1. An MRI has been recommended. Cervical collar was placed, and an MRI was ordered . Result of R56's CT Head wo Contrast printed on 4/6/2023 at 6:54 AM, revealed: Final Result: 1. 20-30% acute ventral height loss involving the C7 vertebral body. Additional slight height loss is seen involving the superior endplate of T1 which is also concerning for an acute injury. These were not present on prior CT imaging dated 02/03/2023. 2. New since CT imaging is interspinous widening at C6-7 concerning for ligamentous injury. MRI is suggested for further evaluation. 3. No CT evidence of an acute intracranial abnormality . Furthermore, the facility investigation for R56 I/A did not show results of the neurosurgeon's follow-up appointment. No rehabilitation/therapy assessments, evaluations, or progress notes were found, and no pain assessment, intervention, or plan of care was documented. On 08/20/24 at 03:26 PM, an interview with the Director of Nursing (DON) was conducted. The DON agreed that the Incident report was incomplete. All pertinent questions and boxes should have been checked and filled. When queried about the nurse who filled out the incident report, the DON revealed that the Agency nurse was assigned to R56 and filled it out. The DON further explained that she did not recall a lot because she was new to the position as DON in April of 2023. The DON stated that: the incident was reported because the resident came back from the hospital wearing a C-collar because he broke his neck. R56 had to wear the C-Collar at all times and was able to work with therapy. On 8/21/24 at 10:00 AM, a complete Facility Report Investigation regarding R56 Fall on 4/6/23 was requested. The Administrator on 8/21/24 at 3:21 PM stated that they only had a folder with a copy of the electronic file consisting of 3 pages submitted to the state. There were no interviews, no list and names of staff involved, and no written statements attached to this investigation. The Administrator further explained that this was from 2 administrators before her. The Administrator agreed that the investigation and the Incident Report (I/A Fall) dated 4/6/23 were incomplete and should have been retained, especially since it was reported to the State Agency (SA). The Administrator confirmed that there was no documentation in the file to support the conclusion that neglect was not substantiated. The Administrator stated: This is not a complete investigation. 08/21/24 03:21 PM, a review of the credentialing records of the agency nurse was conducted. No current contact information was provided to the surveyor for the interview. On 8/21/24 at 3:12 PM, a review of the facility policy for MR (Medical Record) Retention of Facility Records Other than Medical (Last review date: 02/01/2022 was conducted. The policy specified that the suggested period of retention for (Administrative Office) Internal Investigation Reports is four (4) years, and for Nursing (Accidents/Incident) Reports is three (3) years (Sec.300.1870). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 3:25 PM, the Falls Management Guideline (last review date: 3/24) was conducted. It was noted: This facility is committed to maximizing each resident's physical, mental, and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed . .Facility Guideline following a fall incident: 1. If a fall occurs, the following actions will be taken: a. RN/LPN at the time of fall occurrence: .vi. Complete an incident report in risk management. This report includes the circumstances surrounding the fall, devices in use, full body observation for injury, pain, range of motion, and neuro checks as needed. .vii. The nurse at the time of fall will review and update the resident's fall plan of care with new intervention . .viii. All incidents/accidents with serious physical injury will be immediately reported to the Administrator/Director of Nursing or designee .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to develop and implement a person-centered baseline care plan to guide the care provided to two residents (Resident #307 and Resident #308) of 34 residents reviewed for care plans, resulting in the failure to provide instructions to the staff for effective and person -centered care to promote well-being and provide an appropriate diet for Resident #307 and dialysis catheter care for Resident #308 . Findings Include: Resident #307: Nutrition A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #307 was admitted to the facility on [DATE] with diagnoses: Cancer of the lung, liver and bone; Pulmonary edema, respiratory failure, pneumonia, and glaucoma. On 8/19/2024 at 4:23 PM, during a tour of the facility, Resident #307 was observed lying in bed with family at the bedside. The resident's family said they had to speak with someone from dietary as the resident was unable to chew, and he needed a different textured diet. He had been having difficulty since admission with eating. A review of the Care Plans for Resident #307 identified the following: A nutrition Care Plan dated 8/21/2024: (Resident #307) has a chewing problem and he is at risk for malnutrition . dated created, initiated and revised 8/21/2024. All interventions were dated 8/21/2024. The Care Plan was enacted 4 days after the resident was admitted . Resident #308: Nutrition A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #308 was admitted to the facility on [DATE] with diagnoses: Diabetes, chronic kidney disease, requires renal dialysis, Myelodysplastic syndrome, anemia, heart disease and peripheral vascular disease. On 8/20/2024 at 8:55 AM, Resident #308 was observed lying in bed, awake. He said he received dialysis treatments on Mondays, Wednesdays and Fridays in the afternoon. A meal tray was observed partially eaten on his bedside table. When asked how his breakfast was, he shook his head back and forth but didn't say anything. A review of the Care Plans for Resident #308 revealed the following: (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Resident #308) has nutritional problem or potential nutritional problem related to Diet restrictions. She (he is a male) is risk for Malnutrition . created, initiated and revised 8/21/2024. All interventions were dated 8/21/2024 with Interventions including: Provide, serve diet as ordered. Observe intake and record every meal, date initiated 8/21/2024. The Care Plan was initiated 6 days after the resident was admitted . Resident #308 also had a Dialysis Care Plan dated 8/16/2024, but there was no mention of dietary needs. Resident #307 and Resident #308 did not have resident-specific Care Plans to address their dietary needs as required within the first 48 hours of admission. A review of the facility policy titled, Care Plans, dated 10/03 and reviewed 5/21 provided, Each resident will have a care plan that is current, individualized, and consistent with their medical regimen . A preliminary care plan is developed for each resident within 48 hour of admission to the facility. This care plan includes the admission assessments and orders by the physician that address the resident's immediate needs .'

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive resident-centered care plan for Resident #23's use and maintenance of their CPAP machine for one resident (Resident #23) of 15 residents reviewed for comprehensive care planning, resulting in the potential for unmet care needs. Findings include: Resident #23: A review of Resident #23's medical record revealed an admission into the facility on [DATE] with diagnoses that included diabetes, weakness, and obstructive sleep apnea. A review of the Minimum Data Set assessment, dated 8/9/24, revealed a Brief Interview of Mental Status score of 12/15 that indicated moderate cognitive impairment and needed supervision or touching assistance with toileting hygiene and most mobility, and partial/moderate assistance with bathing self and lower body dressing. On 8/19/24 at 1:17 PM, an observation was made of Resident #23 sitting in a wheelchair in their room. The Resident was interviewed, answered questions and engaged in conversation. An observation was made of a CPAP (continuous positive airway pressure machine often used to treat sleep apnea to assist in keeping the airway open). A container of distilled water was on the bedside table near the CPAP machine. The distilled water was partially used and was not labeled with an open date. The mask and tubing were observed to not have a date of when the tubing had been changed. The water chamber of the CPAP had water inside. The Resident was asked about the CPAP and how it was cleaned. The Resident reported that he would fill it with water but had not cleaned it. When asked if staff have cleaned out the water chamber, the Resident stated, I fill it myself, they don't take it apart. It has not been apart since I been here, and the mask and tubing have never been changed. The Resident reported long use of a CPAP when he was at home and stated, I know it is wrong because I have always used a CPAP machine. They have not changed out the mask and that should be changed every 30 days. The Resident reported asking for the mask to be changed but that it had not been changed. When asked if that was the machine from home, the Resident indicated it was brought in by the facility and not theirs from home. On 8/21/24, a review of Resident #23's medical record revealed a lack of documentation found for the cleaning of the CPAP and when the tubing and mask were changed. A review of the care plan for Resident #23 revealed no care plan for the use and maintenance of a CPAP machine. On 8/22/24 at 11:04 AM, an interview was conducted with the MDS Program Director, Nurse O regarding Resident #23's lack of care planning for the use and maintenance of the Resident's CPAP machine. When asked about the need for a care plan for the CPAP, the Nurse indicated there should be a care plan when a Resident was using a CPAP. The Nurse stated, We have a care plan set for CPAP, it must have gotten missed. I will add it for him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility policy titled, Care Plans, reviewed 5/21, revealed, General: Each resident will have a care plan that is current, individualized, and consistent with their medical regimen . 2. The comprehensive care plan is developed within 7 days of the resident arrival to the facility. 3. The care plans are developed by the members of the interdisciplinary team based on their observations and interaction with the resident and/or resident's significant others. 4. The care plans are updated at least every 90 days or with a significant change of the resident by the team member initiating the care plan .

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 This Citation pertains to Intake Number MI00133932. Based on observation, interview and record review the facility failed to implement and carry out interventions to prevent the development of pressure ulcers for one resident (Resident #39) of three residents reviewed for pressure ulcers resulting in the development of four facility-acquired pressure ulcers (1-Stage 3 and 3-Unstageable). Findings include: Resident #39 (R39): Resident #39 is [AGE] years old and most recently admitted to the facility on [DATE] with diagnoses that include dysphagia, cerebral infarction, traumatic brain injury and pressure ulcers. R39 has a brief interview for mental status score (BIMS) of 6, indicating severe cognitive impairment and R39 is currently receiving hospice services. On 08/19/24 at 11:43 AM, R39 was observed in bed, appropriately dressed, well groomed, free of odors, laying supine, R39 was non-verbal, but did nod at a few yes/no questions. On 08/19/24 at 03:28 PM, record review revealed that R39 has multiple pressure ulcers, some of which were facility acquired. The pressure ulcers located on both elbows and the left and right iliac crest are facility acquired as of 8/7/24 and the coccyx. pressure ulcer was present on admission. -Left Elbow measures 0.50Lx1.00W and classified as unstageable, identified 8/7/24. -Right Elbow measures 1.5Lx1.5W and classified as unstageable, identified 8/7/24. -Left Iliac Crest measures 3.5Lx1.5W and classified as a Stage 3, identified 8/7/24. -Right Iliac Crest measures 2.5Lx3.0W and classified as unstageable, identified 8/7/24. On 08/19/24 at 3:45 PM, record review revealed a care plan titled, alteration in skin integrity, interventions included an air mattress, wedge for positioning, and a heels up to help with offloading weight, specialty air mattress to bed, pressure redistribution cushion when up in a chair/wheelchair, off load heels, reposition/shift weight at frequent intervals to resident's comfort. On 08/20/24 at 09:04 AM, R39 was observed in bed, well dressed, groomed and positioned on their back. No wedge cushion noted for positioning, air mattress was in place, heels were elevated on pillows. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 08/20/24 at 12:57 PM, an interview was conducted with LPN 'B'. LPN 'B' was asked about the pressure ulcers R39 has. LPN 'B' stated the coccyx wound was present on admission and classified as unstageable, it is now a Stage 4 since the wound bed can be visualized. LPN 'B' stated the pressure ulcers on his elbows and the iliac crests are new as of 8/7/24. LPN 'B' stated these occurred after R39 had a change in tube feed rate. LPN 'B' believes his wounds are improving. LPN 'B' was asked what interventions were in place prior to the pressure ulcers developing on the elbows and iliac crests LPN 'B' stated that R39 had elbow guards in place, was turned every two hours and has an air mattress in place. LPN 'B' was asked if they thought every intervention was in place, but the pressure ulcers still developed. LPN 'B' stated yes, they believed so. LPN 'B' was asked if they completed an unavoidable skin condition form for R39. LPN 'B' stated that yes, they use the form and that it was completed in the electronic medical record (EMR). LPN 'B' looked at the EMR for R39 but was unable to locate the completed form. LPN 'B' was asked why R39 was positioned on their back during most of the survey. LPN 'B' stated that the nursing assistants are supposed to be turning R39 intermittently to offload pressure. LPN 'B' stated they would enter an order for the nursing staff to be reminded to turn R39 more often. On 08/20/24 at 01:47 PM, record review revealed an Unavoidable Skin Condition Form is now present in the EMR, dated 8/20/24. On 08/20/24 at 01:54 PM, record review revealed the alteration in skin care plan had been edited on 08/20/24 to now include elbow protectors. On 08/20/24 at 02:58 PM, R39 was observed on their back in bed, the right elbow has an elbow protector in place, but the left elbow does not and no wedge cushion noted On 08/21/24 at 10:30 AM, R39 was observed on their back in bed, right elbow pad in place and a pillow under the right arm, the left elbow had a dressing on it and a pillow providing pressure relief under it. On 08/22/24 at 03:36 PM, record review revealed R39 has a Braden Score of 14, indicating that they are at moderate risk for pressure ulcer development. Record review of the policy titled Skin Management, approved 7/19 revealed: 7. An initial plan of care is developed upon admission if the resident is at risk or has a current pressure or non-pressure injury, areas that should be addressed are as follows: Identifying the contributing risk factors for breakdown, including history of skin impairment. Hydration Nutrition Preventative devices, including support surfaces for bed and chairs (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Preventative skin care Pain Physical activity Positioning requirements Proper body alignment Education, when appropriate Pressure Injury Evaluation of Avoidability 1. The Director of Nursing or designee is responsible for ensuring that the Evaluation of Pressure Injury form is completed accurately and timely if applicable to the resident's condition. Significant changes in condition Decline in overall health status Hospice, Palliative and/or Comfort care is initiated Anticipated development of pressure injury Facility acquired pressure injury Worsening condition of a pressure injury 2. The completed form will be scanned into the guest's EMR under documents. 3. The Evaluation of Pressure Injury form should be completed annually for any unavoidable pressure related injury.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to implement a restorative nursing program for one resident (Resident #25), of three residents reviewed for limited range of motion, resulting in the potential for decline in independence of self-care, physical ability, and overall decreased level of functioning. Findings Include: Resident #25: A review of Resident #25's medical record revealed an admission into the facility on [DATE] and re-admission on 1/10/22 with diagnoses that included kyphosis and scoliosis, bilateral foot drop, weakness, difficulty in walking, chronic pain, muscle wasting and atrophy and need for assistance with personal care. A review of the Minimum Data Assessment revealed the resident was cognitively intact, had impairment on both lower extremities, was independent with eating and oral hygiene, needed partial/moderate assistance with toileting hygiene, bathing, needed substantial/maximal assistance with lower body dressing, and personal hygiene, sit to lying, lying to sitting on side of bed, sit to stand and chair/toilet transfers. On 8/20/24 at 9:22 AM, an observation was made of Resident #25 lying in bed. The Resident was interviewed, answered questions and engaged in conversation. When asked about therapy services, the Resident indicated she gets therapy off and on, and reported receiving therapy and then completing it and had no therapy for a while and would receive it again. When asked if she was on a restorative therapy plan after completion of therapy, the Resident reported she did not know what that was and did not receive any therapy after PT (physical therapy) was completed. The Resident stated, They said if they do that other thing, then that might affect getting therapy again. The Resident indicated that she can't really walk anymore but wanted to keep as active as possible. On 8/20/24, a review of Resident #25's medical record revealed no documentation of restorative therapy plan or program, no care plan for a home exercise program and no tasks with range of motion or exercises to prevent a decline in abilities for Resident #25. On 8/20/24 at 3:42 PM, an interview with the Director of Nursing (DON) regarding the facility Restorative Therapy program. The DON reported they do not have a Restorative team and that they were working on having all the CNA's (certified nursing assistants) have training and indicated they want full training for all aides and all the aides will be restorative aides. The DON indicated the training has not been completed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 9:57 AM, a review of Resident #25's Occupational Therapy (OT) Discharge Summary, with discharge date [DATE], revealed, Discharge Status and Recommendations, Prognosis: Prognosis to Maintain CLOF (current level of functioning) = Good with consistent staff follow-through . D/C (discharge) Recs (recommendations): Home exercise program. RNP (restorative nursing program): To facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNP's has been completed with the IDT (interdisciplinary team): cont (continue) with exercises. A review of Resident #25's Physical Therapy Discharge Summary with date of service 4/5/24 to 6/26/24, revealed, Discharge Recommendations: DC (discharge) from PT (Physical Therapy) due to highest practical level of function achieved. RNP: patient has HEP (home exercise program). On 8/22/24 at 10:21 AM, an interview was conducted with the Therapy Program Manager (TPM) Q regarding Resident #25's discharge from therapy programs, OT and PT. The TPM reported Resident #25 had completed therapy on 6/26/24. When asked about her discharge recommendations, the TPM reported she was given a home exercise program. When asked what that consisted of, the TPM indicated she was given papers of exercises that the Resident could do on her own and stated, If she is independent with it then we have them do it on their own. The TPM indicated she would have been given papers for upper body strengthening with range of motion and/or therapy band exercises but with review of the medical record, there was no plan described. The TPM stated, She can do it at her pleasure, it's not that she has to do it. When asked if Resident #25 was a good candidate for a Restorative Therapy Program, the TPM stated, Yes she is, and reported it would oversee her ability and staff there to help as needed. The TPM explained they are trying to implement a restorative program and it had been brought up at the last QAPI meeting and reported, it was discussed but not implemented yet and the plan was to go forward with the all staff meeting later this month. When asked about discharge from Physical Therapy with recommendations that stated, due to highest practical level of function achieved, queried what the recommendations were, the TPM explained the Resident was not able to ambulate, and she was just to complete the home exercise program. When asked about preventing lower body contractures, the TPM stated, Yes, PT would work with the lower body and OT with the upper body, and when asked if she should have exercises with the lower body strengthening as well as upper body, the TPM indicated she should. When asked if obtaining Restorative Therapy program would hinder Resident #25 getting PT and OT services, the TPM stated, No, it makes it easier, and explained staff would be more apt to see a change or decline then just at their quarterly screens. On 8/22/24 at 3:11 PM, an interview was conducted with the Administrator (NHA) regarding the lack of a Restorative Therapy program for Resident #25. The NHA indicated that last month in QA (quality assurance meeting) the Restorative Therapy Program was brought up and talked about doing it our every day and that the Therapy Manager would educate in an all staff meeting and go over the program and discussed the program developing through QA. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Restorative Nursing Program, dated 8/2024, revealed, General: A resident may be started on a restorative nursing program when he or she is admitted to the facility with functional restorative needs, but is not a candidate for formalized rehabilitation therapy, or when functional restorative needs arise during a long-term stay, or in conjunction with formalized rehabilitation therapy. Restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy . 3. The facility's restorative nursing program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. 4. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care .

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review the facility failed to ensure interventions were enacted to promote nutrition for two residents (Resident #307 and Resident #308) of 4 residents reviewed for food or nutrition, resulting in Resident #307 and Resident #308 lacking timely assessments and monitoring to aid in identification of nutritional needs. Findings Include: Resident #307: Nutrition A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #307 was admitted to the facility on [DATE] with diagnoses: Cancer of the lung, liver and bone; Pulmonary edema, respiratory failure, pneumonia, and glaucoma. On 8/19/2024 at 4:23 PM, during a tour of the facility, Resident #307 was observed lying in bed with family at the bedside. The resident's family said they had to speak with someone from dietary as the resident was unable to chew, and he needed a different textured diet. He had been having difficulty since admission with eating. A review of the Tasks tab in the electronic medical record/emr, for What percentage of the meal was eaten, for Resident #307 indicated the following: There was no recording of a meal on 8/17/2024. The resident was admitted approximately 4:00 PM on 8/17/2024 and would have been at the facility during the evening meal. 8/18/2024: 8:00 AM and 12:00 PM- it was documented the resident ate between 51-75% of each meal. There was nothing recorded for the evening meal. 8/19/2024: There was an entry at 12:29 AM (midnight) with 0-25% recorded and there were 2 entries for 3:06 PM- one was 75-100% and the other was 51-75%. It was unclear if this was in reference to one meal or two meals. 8/20/2024: There was an entry at 3:38 AM with 75-100% marked and an entry at 9:45 PM with 0-25% marked. There were 2 entries for the day and neither were at scheduled meal times. The facility was not accurately identifying Resident #307's food intake with each meal. A review of the Weights for Resident #307 identified he was weighed on 8/19/2024 at 3:41 PM and weighed 112.8 pounds: this was 2 days after admission. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the nursing Admission Assessment, start date 8/18/2024 at 10:38 AM and completed on 8/19/2024 at 7:28 PM, Section D: Oral/Nutritional section, indicated the resident did not have a chewing problem. There was no mention of a diet. The assessment was completed 2 days after the resident was admitted . A review of the physician orders identified the following: Standard Diet, Regular texture, thin consistency, start date 8/17/2024 at 3:53 PM. Standard Diet, Mechanical Soft texture, Thin consistency, start date 8/19/2024 at 3:39 PM. A Dietary Progress Note written on 8/19/2024 at 6:17 PM, by Dietary Manager H did not indicate the resident had a problem chewing his food. A review of the Dietary assessments by the Registered Dietitian/RD I for Resident #307 indicated it was initiated on 8/20/2024 and completed on 8/21/2024: 4 days after the resident was admitted . Section C. Diet Order question 2. Resident/Family concerns about texture of food? was documented as n/a (not applicable). The family and resident did express concerns about the texture of the initial diet order of Regular texture. A review of the Care Plans for Resident #307 identified the following: A nutrition Care Plan dated 8/21/2024: (Resident #307) has a chewing problem and he is at risk for malnutrition . dated created, initiated and revised 8/21/2024. All interventions were dated 8/21/2024. The Care Plan was enacted 4 days after the resident was admitted . Resident #308: Nutrition A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #308 was admitted to the facility on [DATE] with diagnoses: Diabetes, chronic kidney disease, requires renal dialysis, Myelodysplastic syndrome, anemia, heart disease and peripheral vascular disease. On 8/20/2024 at 8:55 AM, Resident #308 was observed lying in bed, awake. He said he received dialysis treatments on Mondays, Wednesdays and Fridays in the afternoon. A meal tray was observed partially eaten on his bedside table. When asked how his breakfast was, he shook his head back and forth but didn't say anything. A record review of the physician orders on 8/20/2024 at 10:15 AM, revealed there was no dietary order. A nursing progress note dated 8/15/2024 at 9:20 PM stated, The resident is on a renal diet with regular consistency and thin liquids . (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Dietary Progress Note, dated 8/19/2024 at 6:28 PM revealed, Dietary attempted to speak to resident on 8/16/2024 and 8/19/2024. On 8/16/2024 resident stated he was tired and wanted to take a nap before 1 PM pick up time for dialysis. On 8/19/2024, dietary tried speaking to resident again and he was still out to Monday's dialysis appointment. The resident was not assessed for food preferences until after he was in the building for 5 days. On 8/21/24 at 9:30 AM, Resident #308 was observed resting in bed, awake, moaning, when asked if he was uncomfortable, he said no. The resident said he just had breakfast, and was trying to rest. A review of the A review of the Tasks tab in the electronic medical record/emr, for What percentage of the meal was eaten, for Resident #308 indicated the following: There was nothing documented on the day of admission 8/15/2024. 8/16/2024: A meal was documented at 1:17 AM with 25-50% eaten. No clarification on what meal this was. There were also 2 meals documented at 3:45 PM both for 0-25% eaten. It was unclear what meals were referenced. 8/17/2024: Meals were documented at 1:53 AM at 51-75%; 8:00 AM at 26-50% and 12:00 PM at 26-50%. There was no documented evening meal. 8/18/2024: 4 meals were documented- 12:17 AM at 76-100%; 2 meals at 4:31 PM at 76- 100% and a meal at 9:49 PM at 76-100%. It was unclear what meals were being referenced. 8/19/2024: A meal was documented at 10:02 AM at 26-50%; 5:49 PM at 0-25% and 9:08 PM at 0-25%. 8/20/2024: There were only 2 meals documented: 11:41 AM at 26-50% and 2:14 PM 26-50%. There was no evening meal documented. 8/21/2024: One entry said 3:20 AM at 0-25%. The food acceptance documentation was inconsistent. A review of the Dietary Profile assessment for Resident #308 indicated a start date of 8/18/2024 at 9:58 AM and completed 8/21/2024 at 10:04 AM and listed the resident's diet as LCS/NAS/, no bananas, no oranges, 1600 ml fluid restriction. It said he had regular food texture and regular fluid consistency. For food preferences likes and dislikes and fluid preferences it said See diet card. The Dietary Profile was started 3 days after the resident was admitted and finished 6 days after he was admitted . The resident was receiving Dialysis services and was not consistently eating well. The Dietary Profile assessment dated [DATE] Resident Observation: Comments said, 83 (year old) male admitted [DATE] for respiratory failure and renal failure . She (he's a male) is risk for malnutrition . continue to monitor. The assessment was not completed until the resident had been in the facility for 6 days. A record review of the Dietitian Assessment by Registered Dietitian/RD I indicated it was started on 8/21/2024 at 12:18 PM and was still in progress (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 2:22 PM Dietary Manager H was interviewed. She said she worked daily at the facility, usually 5 days a week. The Dietary Manager said the diet orders were initially sent to the dietary department from nursing after the nurse completed the Admission Assessment. She said it was a paper order that was in the New Admission Packet the nurses were given for each resident. The Dietary Manager said there was a diet order on paper, with the resident's name, and room number. She said the order was placed in the electronic medical record/emr by nursing and included a description of the diet, what type of liquid consistency. The Dietary Manager said when she received the diet order she would look into the emr to see if there was any variance from the paper order. The physician orders saved on the prior day 8/20/2024, indicated the resident had no order for a diet. Upon review during the interview (8/21/2024) there was now an order for a diet and that it was put in on 8/16/2024. Reviewed both pages with the Dietary Manager identifying an absence of a diet order earlier and now there was. She said nurses had to confirm the orders prior to having the orders listed on the physician order page. On 8/21/24 at 2:50 PM, both the Registered Dietitian/RD I and Dietary Manager H were interviewed. The RD I said she was at the facility 1 day a week, but if the facility needed her they could contact her via phone. The RD and Dietary Manager Hprovided a copy of the paper diet order for Resident #308. It said Regular diet, which was crossed off and then Renal diet was written in and dated 8/15/2024; both said nursing provided the order. Reviewed the physician orders in the emr did not mention a diet earlier today and now it does, and it was dated 8/16/2024. The RD said she did not put the order in emr: nursing did. Reviewed with the RD and Dietary Manager the Dietary assessment completed on 8/21/2024, 6 days after the resident was admitted . The RD said she had 1 week to complete it. Reviewed that the resident received Dialysis services 3 days a week and this placed him at a higher risk for decline. The RD said the resident had not been eating well and because he received dialysis, she put in orders for 2 supplements that day (8/21/2024) and was waiting for physician approval. A review of the physician orders indicated 2 supplement orders were placed on 8/21/2024 at 2:35 PM and were awaiting physician approval to be enacted. On 8/21/24 at 3:02 PM, Dietary Manager H was interviewed and she reviewed Resident #308's Dietitian assessment was initiated today 8/21/2024 and was not yet completed. She said the RD completed the Dietitian assessment and she completed the Dietary Profile. The Dietary Profile was completed on 8/21/2024, 6 days after the resident was admitted . A review of the Care Plans for Resident #308 revealed the following: (Resident #308) has nutritional problem or potential nutritional problem related to Diet restrictions. She (he is a male) is risk for Malnutrition . created, initiated and revised 8/21/2024. All interventions were dated 8/21/2024 with Interventions including: Provide, serve diet as ordered. Observe intake and record every meal, date initiated 8/21/2024. The Care Plan was initiated 5 days after the resident was admitted . Resident #308 also had a Dialysis Care Plan dated 8/16/2024, but there was no mention of dietary needs. Resident #308 was admitted from the hospital to the facility on [DATE] and was to receive Dialysis services 3 days a week for renal failure. His nutritional needs were not assessed until 6 days after admission. The resident was not eating well and the staff were not consistently monitoring his meal intake or nutritional needs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Resident Rights, date created 5/22 and reviewed 10/2023 provided, Employees shall treat all residents with kindness, respect and dignity . choose a physician and treatment and participate in decisions and care planning .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review the facility failed to ensure that physician's orders and facility policy were followed for enteral feeding for one resident (Resident #39) of one resident reviewed for tube feeding, resulting in the resident not receiving the total ordered amount of enteral feeding and a lack of documentation of the amount of enteral feeding infused. Findings include: Resident #39 (R39): Resident #39 is [AGE] years old and most recently admitted to the facility on [DATE] with diagnoses that include dysphagia, cerebral infarction, traumatic brain injury and pressure ulcers. R39 has a brief interview for mental status score (BIMS) of 6, indicating severe cognitive impairment and R39 is currently receiving hospice services. On 08/19/24 at 11:13 AM, observation revealed the enteral feeding pump of R39 infusing at 50ml/hr. On 08/19/24 at 11:20 AM, record review revealed a physician's order for enteral feeding that read, Enteral Feed Order, one time a day, start Osmolite 1.5 at 60ml/hr for 16 hours, up at 1800 (6:00 PM), down at 1000 (10:00 AM) or until 960ml completed. On 08/20/24 at 09:04 AM, observation revealed the enteral feed infusing at 50ml/hr. On 08/20/24 at 03:39 PM, it was verified with LPN 'B' that the enteral feeding pump was set to 50ml/hr and the infusion amount had been cleared from the last administration. On 08/21/24 at 11:33 AM, record review of the August Medication Administration Record (MAR) revealed staff is signing out the enteral feeding starting at 1700 (5:00 PM) and signing out taking it down at 1000 (10:00 AM). There is no documentation of the total amount being infused. At the lower rate of 50ml/hr it would take over 19 hours to infuse the ordered amount of 960ml. The facility is infusing the enteral feeding for 17 hours according to the MAR. On 08/21/24 at 03:31 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked about the lower rate of enteral feeding being infused. The DON stated that if the resident is feeling nauseous then the enteral feeding rate can be lowered, and it has been reduced a few times. The DON was asked if there is a spot for staff to record total intake since the rate has been lowered by 10ml/hr compared to the order. The DON stated there is no place to document total intake of tube feed and that it just gets signed out. The DON was asked if staff should be documenting total intake since the rate is lower on the pump compared to the order. The DON stated that if the nursing staff is signing off on the order, then they (DON) are assuming R39 is getting the total amount of enteral feeding ordered. On 08/22/24 at 11:05 AM, observation revealed that the enteral feeding was not infusing at this time. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the policy titled, Enteral Tube Care and Maintenance, reviewed 09/22 revealed: To Administer Per Pump: 1. Prepare bag/tubing: label with date and time hung and initials of nursing hanging feeding. 2. Turn on pump and set rate. 3. Verify feeding tube placement as appropriate to type of tube used. 4. Flush with 30ml tap water. 5. Start pump administration. 6. Monitor patients for signs or symptoms of intolerance or aspiration during feeding. 7. Clear pump at the end of each shift after documenting the total amount infused.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to ensure proper storage, cleaning and labeling of oxygen/respiratory equipment for Resident #9, Resident #23, and Resident #34, of four residents reviewed for oxygen and respiratory care, resulting in the potential of respiratory infection and deterioration in health and wellbeing. Findings include: Resident #23: A review of Resident #23's medical record revealed an admission into the facility on [DATE] with diagnoses that included diabetes, weakness, and obstructive sleep apnea. A review of the Minimum Data Set assessment, dated 8/9/24, revealed a Brief Interview of Mental Status score of 12/15 that indicated moderate cognitive impairment and needed supervision or touching assistance with toileting hygiene and most mobility, and partial/moderate assistance with bathing self and lower body dressing. On 8/19/24 at 1:17 PM, an observation was made of Resident #23 sitting in a wheelchair in their room. The Resident was interviewed, answered questions and engaged in conversation. An observation was made of a CPAP (continuous positive airway pressure machine often used to treat sleep apnea to assist in keeping the airway open). A container of distilled water was on the bedside table near the CPAP machine. The distilled water was partially used and was not labeled with an open date. The mask and tubing were observed to not have a date of when the tubing had been changed. The water chamber of the CPAP had water inside. The Resident was asked about the CPAP and how it was cleaned. The Resident reported that he would fill it with water but had not cleaned it. When asked if staff have cleaned out the water chamber, the Resident stated, I fill it myself, they don't take it apart. It has not been apart since I been here, and the mask and tubing have never been changed. The Resident reported long use of a CPAP when he was at home and stated, I know it is wrong because I have always used a CPAP machine. They have not changed out the mask and that should be changed every 30 days. The Resident reported asking for the mask to be changed but that it had not been changed. When asked if that was the machine from home, the Resident indicated it was brought in by the facility and not theirs from home. On 8/21/24, a review of Resident #23's medical record revealed a lack of documentation found for the cleaning of the CPAP and when the tubing and mask were changed. Resident #34: A review of Resident #34's medical record revealed an admission into the facility on [DATE] with diagnoses that included anxiety disorder, emphysema, and chronic obstructive pulmonary disease. A review of the Minimum Data Set assessment revealed the Resident was cognitively intact and needed partial/moderate assistance with upper body dressing and personal hygiene, substantial/maximal assistance with lower body dressing and was independent with eating and toileting hygiene. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 9:55 AM, an observation was made of Resident #34 lying in bed sleeping but did not arouse when her name was called. The Resident was lying in bed, her oxygen tubing was laying over the overbed table. An observation was made of a nebulizer on the bedside table with tubing, mask and nebulizer attached. The medication chamber of the nebulizer was wet inside with liquid remaining in the chamber and not allowed to air dry. On 8/20/24 at 3:31 PM, a review of Resident #34's Medication Administration Record revealed an Albuterol inhalation nebulizer ordered as needed and last given on 8/17/24. On 8/21/24 at 10:42 AM, an interview was conducted with Resident #34's Family Member and Resident #34 who answered some questions and engaged in some conversation. The Family Member was asked about the Resident wearing Oxygen and reported she should be wearing it but will take it off herself. When asked about nebulizer treatments, the Family Member indicated the Resident does use the nebulizer but was unsure how often. The nebulizer equipment was stored in a bag in the bedside table drawer and the Family Member took it out. An observation was made of moisture and a small amount of liquid in the medication chamber. On 8/21/24 at 3:08 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #23's CPAP machine cleaning and replacement of the mask and tubing. The DON indicated that when a Resident has a CPAP, there was a batch order that includes the cleaning of the CPAP machine. A review of the orders by the DON revealed an order for the CPAP but not the batch orders. The DON indicated that the Pulmonologist had completed an evaluation about the time of admission and had put the order in for the CPAP but there is no batch order that includes the cleaning. The cleaning would be generated by the batch order and documented on, but the batch order was not put in and there was no documentation of cleaning, water chamber filled, mask storage and CPAP schedule. Further review of the medical record revealed a lack of documentation that the mask and tubing were changed. The DON was asked when the mask and tubing should be changed and cleaning of the water chamber and reported she would have to review the policy. On 8/21/24 at 3:20 PM, an observation was made of Resident #23's CPAP machine. There was no date on the tubing or mask. The distilled water was opened and when asked if the water was to be dated, the DON was unsure of facility policy and stated, If I were to open it, I would automatically date it. An observation was then made of Resident #34's nebulizer equipment that was stored inside a bag in the bedside table. Upon inspection of the medication chamber, there was an observation of moisture in the medication chamber. When asked about facility policy on the storage of the nebulizer, the DON indicated that they should be cleaned out and dried before storage to prevent mold growth. A review of facility policy titled, Specific Medication Administration Procedures: IIB8: Oral Inhalation Administration, November 2021, revealed, .U. Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations, or: 1) Wash pieces (except tubing) with warm, soapy water daily. Rinse with hot water. Allow to air dry completely on paper towel . W. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. X. Change equipment and tubing every seven days or per facility policy/protocol . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility policy titled, Use of CPAP/BIPAP Machine, approved 7/22, revealed, .3. To clean the mask, hand wash in warm water with approved cleanser. Mask to be washed weekly and as needed. 4. Rinse thoroughly. Pat with a towel and air dry completely before use . 6. The headgear should be cleaned weekly and as needed by hand washing. 7. Tubing should be hand washed weekly and as needed and hung to air dry . 49944 Resident #9: Resident #9 is [AGE] years old and most recently admitted to the facility on [DATE] with diagnoses that include anxiety, depression, dementia, hypertension and peripheral vascular disease. Resident #9 has a brief interview for mental status (BIMS) of 5 indicating severe cognitive impairment. On 08/19/24 at 11:19 AM, R9 was observed lying in their bed and their oxygen concentrator was running at 2 liters per minute, oxygen tubing was connected to the concentrator but not on the resident. R9 was asked if they use oxygen and R9 stated sometimes I do and sometimes I don't. R9 was in no distress and very pleasant during the conversation. On 08/20/24 at 12:20 PM, the oxygen concentrator was observed turned off, oxygen tubing was connected to it, the tubing was placed in a bag and there was no date on the tubing. R9 was observed using a small portable tank to get to the dining room for lunch. On 08/21/24 at 11:40 AM, R9's oxygen concentrator was running, oxygen tubing was connected to it, the tubing was on the bed and there was no date on the tubing. R9 was observed eating lunch on her bedside table. On 08/21/24 at 02:45 PM, and interview was conducted with Registered Nurse (RN) 'A', RN 'A' was asked why R9 didn't have any oxygen on and if the tubing should be labeled and dated? RN 'A' stated that the resident will take their oxygen tubing off a lot and the staff will put it back on her. RN 'A' stated that they believe the oxygen tubing should be labeled and dated. On 08/21/24 at 03:44 PM, and interview was conducted with the Director of Nursing (DON). The DON was asked if oxygen tubing should be labeled and dated when in the resident's room. The DON stated they believe that you have to date and label the tubing, but they will check the policy to be sure. Record review of the policy titled Oxygen Administration reviewed 8.2024 revealed: Infection Control Issues: 1. If a resident is using a humidifier, proper cleaning and testing for leaks will be completed. 2. The oxygen delivery device (e.g., nasal cannula, mask) will be changed once a week or as needed. The tubing will be dated to assist with tracking of when tubing should be changed. 3. Instructions will be given to replace the tubing to cannula more frequently if it becomes excessively kinked or discolored. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. If the nasal cannula/mask/tubing is not in use, it must be stored in a clean bag. 5. Wipe down monitoring devices with approved disinfectant as needed.

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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** 37666 Based on interview and record review, the facility failed to assess, monitor, ensure availability of pain medications and provide pain management for one resident (Resident #307) of 2 residents reviewed for pain management, resulting in the resident's verbalizations of unrelieved pain, frustration and helplessness. Findings Include: Resident #307: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #307 was admitted to the facility on [DATE] with diagnoses: Cancer of the lung, liver and bone; Pulmonary edema, respiratory failure, pneumonia, and glaucoma. On 8/19/2024 at 4:23 PM, during a tour of the facility, Resident #307 was observed lying in bed with family at the bedside. The resident's family said he was having pain and was not receiving pain medicine that helped. They said the resident also had a cough and wanted some cough syrup. They said he had pneumonia and received it in the hospital. They said they were told the doctor ordered it, but they were waiting for the medication. Resident #307 spoke up and said he was uncomfortable. On 8/19/2024 at 4:45 PM, Unit Manager E was interviewed about Resident #307's pain medication, she said the physician saw the resident that day and wrote new orders, but they had not been processed yet. She said she thought there was also cough syrup. Reviewed the resident had been at the facility for 2 days and had been having pain. A review of the physician orders indicated the resident had an order for Meloxicam 15 mg (a pain medication for arthritis) dated 8/18/2024 at 9:00 AM; Tylenol 1000 mg as needed every 6 hours, on 8/18/2024 at 5:00 AM; Hydrocodone-Acetaminophen 5-325 mg tablet dated 8/19/2025 at 12:15 PM; Tylenol 325 mg 2 tabs dated 8/19/2024 at 11:45 AM; Morphine 5 mg 8/19/2024 at 3:00 PM, Guaifenesin (cough syrup) dated 8/19/2024 at 4:15 PM. The Morphine, cough syrup/guaifenesin and Hydrocodone-Acetaminophen were ordered 2 days after the resident was admitted . A review of the August 2024 Medication Administration Record/MAR for Resident #307 revealed the resident received a dose of Tylenol 1000 mg at 5:04 AM on 8/18/2024, 12 hours after admission to the facility. He rated his pain level as a 10 on a 0-10 pain scale with 10 being the highest level of pain. The next dose of Tylenol 1000 mg was given at 1:25 PM and the resident rated his pain as a 5 on the 0-10 pain scale. On 8/19/2024 at 3:09 PM the resident was given Lorazepam (Ativan-an anti-anxiety medication that can be sedating) and Morphine 5 mg liquid as needed every hour at the same time. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/2024 at 9:54 AM, during an interview with the Director of Nursing/DON and Unit Manager/UM E about Resident #307's pain management. The Unit Manager said the family and resident requested not to receive the Morphine because it was too sedating. The medication was given at the same time as a sedating medication, Lorazepam. The DON said the resident was admitted from the hospital on 8/17/2024 in the afternoon, with diagnoses lung cancer, with liver and bone metastasis (the cancer spread to the bone). Reviewed the resident was receiving pan medication and cough syrup in the hospital: Morphine 4 mg every 2 hours (a lower dose), hydrocodone-acetaminophen (7.5-325mg-a higher dose), alprazolam (Xanax), and cough syrup to control the residents pain and discomfort. Discussed that the Resident was given Tylenol at 5:00 AM on 8/18/2024 when his pain level was 10. Resident #307 was in pain and uncomfortable. On 8/22/2024 at 8:55 AM, Social Services/SS Manager G was interviewed, and she said Resident #307 was going home with Hospice services that day. A review of the Care Plans for Resident #307 identified the Care Plan was initiated on 8/19/2024- 2 days after the resident was admitted , The resident is at Risk for pain related to Lung Cancer with metastasis to the liver and bone, date created, initiated and revised 8/19/2024 with a Goal: The resident will not have an interruption in normal activities due to pain through the review date, created on 8/19/2024. A review of the facility policy titled, Resident Rights, date created 5/22 and reviewed 10/2023 provided, Employees shall treat all residents with kindness, respect and dignity . choose a physician and treatment and participate in decisions and care planning .

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on interview and record review, the facility failed to ensure dialysis communication forms were complete and included pre-dialysis and post-dialysis assessment, including location and assessment of the dialysis access site, for one resident (Resident #308) of 2 residents reviewed for Dialysis care, resulting in the potential for a decline in condition and the inability for a prompt response to care needs. Findings Include: Resident #308: Dialysis A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #308 was admitted to the facility on [DATE] with diagnoses: Diabetes, chronic kidney disease, requires renal dialysis, Myelodysplastic syndrome, anemia, heart disease and peripheral vascular disease. On 8/20/2024 at 8:55 AM, Resident #308 was observed lying in bed, awake. He said he received dialysis treatments on Mondays, Wednesdays and Fridays in the afternoon. A review of the physician orders identified the following: Hemodialysis . every M-W-F with chair time 3 pm, start date 8/16/2024. Dialysis: check permacath site daily and upon return from dialysis. Include check that caps secure, start date 8/17/2024. Complete dialysis flow sheet, place in dialysis fold and give to resident to take to dialysis, start date 8/21/2024 (5 days after receiving dialysis and written during the survey). There was no mention of the dialysis catheter site location in the physician orders. A review of the progress notes indicated there was mention of the resident's dialysis catheter location on 8/15/2024 at 9:20 PM in an Admission Note: Resident arrived via stretcher (from hospital) . The resident has a right sided permacath being used for dialysis at this time . and 8/20/2024 at 12:17 AM, . Dialysis catheter to right chest wall with dressing intact . There was no additional mention of Resident #308's dialysis catheter location, dressings or additional assessment. A review of the provider note by Nurse Practitioner F dated 8/16/2024 revealed there was no mention of the resident's dialysis catheter or the location. A review of the Care Plans for Resident #308 identified the following: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident receives hemodialysis, date initiated and revised 8/16/2024 with Interventions: If bleeding occurs from the dialysis graft/fistula, apply direct pressure over the site and call for help. Do not leave the resident alone, start date 8/16/2024. The resident did not have a graft or fistula as mentioned in the Care Plan. He has a Permacath IV catheter. The Care Plan had no mention of the Permacath or monitoring to prevent adverse events. A review of the Hemodialysis Communication Forms for Resident #308 dated 8/16/2024 and 8/19/2024, indicated there was no mention of the dialysis access site for the resident. The form had a section for completion by the facility nurse prior to the resident leaving for dialysis and a section for the Dialysis center to complete post dialysis treatment. Neither section asked about the resident's dialysis access site. There was no description of the type of access or location of the access site to ensure monitoring for adverse effects, or infection. On 8/21/2024 at 10:21 AM, the Director of Nursing/DON and RN Unit Manager E were interviewed related to Resident #308's dialysis access via permacath. It was discussed there was no mention of the permacath site in the physician orders to ensure the resident was assessed properly. Also reviewed there was no mention of the correct dialysis access site in the care plans. Both nurses said they would look into it. A review of the Hospital Discharge Instructions identified, Keep right chest permacath clean and dry. This was not noted in the facility plan of care. A review of the facility policy titled, Dialysis Protocol, dated 1/14, reviewed 9/23 and revised 2/18 provided, General: To provide guidance to the facility on how to care for the dialysis resident . The dialysis site will be checked and monitored every shift for thrill and bruit (this is for a fistula) . The resident's care plan will reflect their dialysis needs . The policy did not address an IV Permacath for dialysis.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 37666 Based on observation, interview and record review the facility failed to ensure that clinical staff postings were 1.) Completed and available for review for multiple days from January 2024- August 2024, including the months of January 2024, February 2024 and July 2024 and 2.) The clinical staff posting was accurate, resulting in the inability for residents and visitors to know what clinical staff were working on those days. Findings Include: FACILITY Sufficient and Competent Nurse Staffing On 8/22/2024 at 9:40 AM, during an interview with the Director of Nursing/DON about nurse staffing, she said the Clinical Staff posting document (Staffing Report) was completed daily by the Scheduler D and posted on the wall by the nurses' desk. The document was used to identify how many RN's (Registered Nurses), LPN's (Licensed Practical Nurses) and CAN's (Certified Nursing Assistants) were staffed on that day on each shift. The document identified how many hours were worked for an RN, LPN and CAN's and listed Total Hours per shift) and also included the Date and Resident Census (number of residents in the building on that day). The document was required to show how many residents were in the facility on a particular day and how many qualified nursing staff were present to care for them; any visitors or residents would then be able to see it after it was posted. The DON said the Scheduler had a binder with copies of the prior daily staff postings. On 8/22/2024 at 11:00 AM, the facility binder was reviewed with the daily posted staffing sheets titled, (Facility) Staffing Report from 1/1/2024- to current 8/22/2024. The July 2024 daily reports were missing except for 7/31/2024. Upon further review of the daily posted Staffing Reports, January and February 2024 had several documents missing and there was no census number on the forms that were present. In addition, several more of the forms were identified to be incomplete with missing staff hours and missing census data. On 8/22/2024 at 11:15 AM, the Scheduler D was interviewed about the daily posted nurse Staffing Report. She said she started the forms with information from the nurses schedule on who was supposed to be working that day and then she would send them to the nursing supervisor. The Scheduler D said on the days she was not working, such as the weekend, she would send the documents in advance to the receptionist for completion prior to posting. The Scheduler D was asked about the discrepancies with missing documents and incomplete information. She said she only starts the forms and the nurses would complete them further. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/2024 at 11:20 AM, during the interview with Scheduler D, the front desk Receptionist was asked about the Staffing Report forms and she said she did not do anything with them. Scheduler D showed the Receptionist that there was a folder on the Receptionists computer desk top, but the Receptionist said was not sure what was in the folders on her computer. She said she usually worked Monday-Friday on the day shift. The Scheduler D said there were 2 folders with staffing report forms, but they were incomplete; she said she could not find the missing posted staffing forms from July, 2024. She said some of the forms were in a binder and some were not. A review of the facility policy titled, Assignment of Nursing Care, date 10/03 and reviewed/revised 8/24 provided, Assignment of nursing care is based on the specific needs of the residents . Assignment of nursing care is based on the number of staff on the units . Nursing assignments are kept as required.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 22348 Based on observation, interview, and record review, the facility failed to ensure that medications were available and administered timely as ordered for two (2) residents, Resident #30 and Resident #103, of nine (9) residents reviewed for medications, resulting in R30 not receiving her Lidocaine 4% Patch topically and R103 was not given her Lantus insulin injection resulting in the potential for adverse reactions or worsening of diabetes condition for R103 and potential for increased in pain and discomfort for R30 related to delayed or interruption of the medication. Findings include: During medication administration observation conducted on 8/20/24 and 8/21/24, There was a total of 32 opportunities observed in halls 100, 200, and 300. Two medication errors were observed out of 32 opportunities. 2 medications were omitted because they were unavailable for the residents. As a result, the facility had a medication error rate of 6.25%. During the medication administration observation conducted on 8/21/24 at 09:00 AM, Nurse Kprepared R30's morning medication due at 10:00 AM. When Nurse K was getting all R30's medication ready, Nurse K informed the surveyor the Lidocaine Patch was unavailable in the cart and would check if some were in the stock/storage medication rooms. Upon her return, Nurse K stated that there was no Lidocaine Patch 4% in stock, and no backup supply was available in the facility. Nurse K further indicated that she had informed the Director of Nursing DON and would get an order from the doctor to change the medication to an afternoon instead of a morning dose. R30's due medication in AM was administered at 9:15 AM except for the Lidocaine Patch 4%. An order was noted for R30 of Aspercreme Lidocaine External Patch 4% (generic: Lidocaine) topically applied to the lower back once a day, every day. Treatment Administration Record (TAR) revealed a daily schedule to administer at 10:00 AM. The medication was not available. On 08/21/24 at 09:29 AM, Nurse K was observed preparing R103's medication due at 10:00 AM. Nurse K revealed that the resident had just been admitted last night, and the insulin Lantus injection was unavailable. Nurse K went to the medication storage room at 09:30 AM but could not find the medication in the backup kiosk that holds the medication supply. Nurse K went to see the doctor but was not at that doctor's office then. An order for R103 of Lantus Solution 100 unit/ ML (Generic: insulin Glargine) was to give ten (10) units subcutaneously one time daily every day. TAR revealed a schedule to administer at 10:00 AM daily. The medication was not available. 08/21/24 at 11:06 AM, Nurse K was queried if the missed medication for R30 and R103 was administered. Nurse K reported that R30's Lidocaine patch 4% was still unavailable. Nurse K revealed that the last Patch was administered to R30 yesterday (8/20/24) morning. Regarding R103's Lantus insulin injection, it is still unavailable and has not been delivered by the pharmacy. These are missed medications for both residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON), during an interview on 08/21/24 at 12:59 PM, revealed that they use Medline to supply Over-The-Counter (OTC) medications. The DON clarified that the Lidocaine Patch 4% is an OTC. The DON verified R30's Lidocaine Patch 4% was last given topically yesterday, 8/20/24, at 12:50 PM and was taken off at 10:02 PM. It was reordered three (3) days ago from the OTC supplier. The DON commented: It was set to be delivered in yesterday, and they said it was delivered but was not here. The DON also explained R103 R103's insulin did not arrived because the patient was admitted yesterday, 8/20/24, at 6:08 PM and stated: That's why the Lantus was unavailable. It is our policy to find the med's in the backup medication. Pharmacy should be restocking them. The Medication Administration -General Guidelines Policy (not dated) was reviewed on 8/22/24 at 3:45 PM. The policy specified: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on interview and record review the facility failed to obtain consent for the use of an antipsychotic medication for one resident (Resident #303) of 5 residents reviewed for unnecessary medications, resulting in the potential for unidentified adverse effects and the receipt of an unnecessary medication. Findings Include: Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Resident #303: A record review of the Face sheet, assessments and progress notes, indicated Resident #303 was readmitted to the facility on [DATE] with diagnoses: Alzheimer's dementia, depression, anxiety, heart failure, atrial fibrillation, anemia, hypothyroidism and a history of falls. The Minimum Data Set (MDS) assessment was not yet completed. A review of the electronic medical record revealed Resident #303 was a prior resident at the facility between 10/23/2023 and 12/21/2023. On 12/21/2023, the resident discharged to an Assisted Living facility. The resident readmitted to the Long Term Care facility on 8/15/2024. A record review of the physician orders for Resident #303 indicated the resident was receiving Divalproex Sodium 125 mg daily, (a medication for seizures) start date 8/16/2024; Trazadone 25 mg daily, (an anti-depressant) start date 8/16/2024; Risperdal 0.5 mg twice a day (for behaviors), (an anti-psychotic medication) start date 8/15/2024. On 8/21/2024, at 11:46 AM, during a record review of the electronic medical record, a Psychiatric Consultation dated 11/2/23 was identified. The document did not include assessment information. There was no identification of medications, but a box titled, Statement of Consent) was checked next to I do Consent to the treatment designated herein, including necessary recommended psychotropic medication treatment other than (blank). I give consent voluntarily and without coercive or undue influence . The document was signed by the resident on 11/2/23. The Psychiatric Consultation did not say what the resident consented to or if there were any medications consented to. It did not list any psychotropic medications. The document was incomplete and referenced the resident's prior admission to the facility. There was no consent identified for psychotropic medications administered to Resident #303 after she was admitted from the Assisted Living facility on 8/15/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Psychotropic Medications, dated 10/12 and reviewed and revised 8/24 provided, The purpose is to promote the safe and effective use of psychotropic medications . The second purpose of this process is to ensure that the resident is evaluated and the indication for the medication is documented . Also, the resident and or significant other are aware of the potential side effects and the facility obtains an informed consent for the use of the psychotropic medication . If an order is obtained for a Psychotropic medication, the resident/responsible party must be informed of the risks and benefits of the medication. The facility must obtain informed consent . This documentation will be placed in the medical record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 This Citation pertains to Intake Number MI00133932. Based on observation, Interview, and record review, the facility failed to ensure a medication error rate of less than five percent (5%) when two medications were omitted for Resident #30 (R30)when the Lidocaine 4% patch was not available and for Resident #103 (R103) when a scheduled Lantus insulin injection was not available from a total of 32 opportunities resulting in a medical administration error rate of 6.25% with the potential for adverse reactions, increased in pain and suffering, and exacerbation of conditions related to omission of the medication or medication not given timely. Findings include: FACILITY Medication administration observation was conducted on 8/20/24 and 8/21/24. A total of 32 opportunities were observed at Halls 100, 200, and 300. Two medication errors were observed out of 32 opportunities, resulting in a 6.25% (over 5%) error rate. During the medication administration observation conducted on 8/21/24 at 09:00 AM, Nurse K prepared R30's morning medication due at 10:00 AM. When Nurse K was getting all R30's medication ready, Nurse K informed the surveyor the Lidocaine Patch was unavailable in the cart and would check if some were in the stock/storage medication rooms. Upon her return, Nurse K stated that there was no Lidocaine Patch 4% in stock, and no backup supply was available in the facility. Nurse K further indicated that she had informed the Director of Nursing DON and would get an order from the doctor to change the medication to an afternoon instead of a morning dose. R30's due medication in AM was administered at 9:15 AM except for the Lidocaine Patch 4%. Resident #30 (R30): R30 was admitted to the facility on [DATE] with a diagnosis of difficulty in walking, essential hypertension, and a Motor Vehicle Accident (MVA) requiring surgical intervention. R30's Brief Interview of Mental Status (BIMS) score, performed on August 5, 2024, was 15/15. A score of 15 indicated that the person is cognitively intact. The order was noted for Aspercreme Lidocaine External Patch 4% (generic: Lidocaine) topically applied to the lower back once a day, every day. Treatment Administration Record (TAR) revealed a daily schedule to administer at 10:00 AM. R103 was admitted to the facility on [DATE] with the diagnosis of difficulty in walking with repeated falls, diabetes mellitus, mild protein calorie malnutrition, essential hypertension, and vertebrogenic low back pain in addition to other diagnoses. R103's order for Lantus Solution 100 unit/ ML (Generic: insulin Glargine) was to give ten (10) units subcutaneously one time daily every day. TAR revealed a schedule to administer at 10:00 AM daily. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/24 at 09:29 AM, Nurse K was observed preparing R103's medication due at 10:00 AM. Nurse K revealed that the resident had just been admitted last night, and the insulin Lantus injection was unavailable. Nurse K went to the medication storage room at 09:30 AM but could not find the medication in the backup kiosk that holds the medication supply. Nurse K went to see the doctor but was not at that doctor's office then. 08/21/24 at 11:06 AM, Nurse K was queried if the missed medication for R30 and R103 was administered. Nurse K reported that R30's Lidocaine patch 4% was still unavailable. Nurse K revealed that the last Patch was administered to R30 yesterday (8/20/24) morning. Regarding R103's Lantus insulin injection, it is still unavailable and has not been delivered by the pharmacy. These are missed medications for both residents. R30's Blood sugar was taken this morning at 148mg/dL (Normal blood sugar level is 80-130 mg/dL). The Director of Nursing (DON), during an interview on 08/21/24 at 12:59 PM, revealed that they use Medline to supply Over-The-Counter medications. Lidocaine Patch 4% is an OTC. R30's Lidocaine Patch 4% was last applied yesterday, 8/20/24, at 12:50 PM and was taken off at 10:02 PM. It was reordered three (3) days ago from the OTC supplier. The DON commented: It was set to come in yesterday, and they said it was delivered but was not here. The DON further explained that R103 was admitted yesterday, 8/20/24, at 6:08 PM and stated: That's why the Lantus was unavailable. It is our policy to find the meds in the backup. Pharmacy should be restocking them. The Administrator, on 8/21/24 at 1:30 PM, was made aware of the Lidocaine patch, the Lantus insulin injection, and the medication administration error of over 5%. The Medication Administration Policy was requested. The Medication Administration -General Guidelines Policy (not dated) was reviewed on 8/22/24 at 3:45 PM. The policy specified: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. Procedures: Administration .2) Medications are administered in accordance with written orders of the prescriber. .6) Medications are administered without unnecessary interruptions . .12) Medications are administered within 60 minutes of the scheduled time, except before, with, or after meal orders, which are administered based on mealtimes, unless the facility has adopted a different medication administration schedule, such as a patient-centered, block-style approach. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 Based on observation, interview, and record review, the facility failed to prevent significant medication errors for one resident (Resident #103) of 9 residents reviewed for medication errors, resulting in the potential for serious adverse effects for insulin omission and pain control management as ordered by the physician, and decline or worsening of medical condition. Findings include: Resident 103 (R103): A review of the Electronic Medical Record on 8/21/24 at 11:00 AM revealed that R103 was admitted to the facility on [DATE] with the diagnosis of difficulty in walking with repeated falls, diabetes mellitus, mild protein calorie malnutrition, essential hypertension, and vertebrogenic low back pain in addition to other diagnoses. R103's order for Lantus Solution 100 unit/ ML (Generic: insulin Glargine) was to give 10 units subcutaneously one time daily every day. TAR revealed a schedule to administer at 10:00 AM daily. On 08/21/24 09:29 AM, Nurse K was preparing R103's medication due at 10:00 AM. Nurse K revealed that the resident was recently admitted last night, and the insulin Lantus injection was unavailable. Nurse K went to the medication storage room at 09:30 AM but could not find the medication in the backup kiosk that holds the medication supply. Nurse Ksearched for the facility doctor but was not at that doctor's office then. On 08/21/24 at 09:41 AM, R103 was observed sitting on the chair in her room as she took her morning medication given by Nurse K. No Lantus injection was available. Lantus injection was not administered as prescribed. R103 had facial discomfort and slight movement while sitting and talking to the nurse. After the nurse had given the medications, she immediately attempted to leave the room. The nurse was by the door when the surveyor asked R103 if she was experiencing pain. R103 said yes. The surveyor requested R103 to rate her pain from zero to ten (0-10). A score of zero (0) means no pain, and 10 indicates the worst pain felt. R103 replied saying: It is a six (6). Nurse K heard and stated that she had included one Tylenol in the medicine R103 had just taken. R103 immediately said, I could have used two(2) tablets right now or anything stronger. Nurse K' on 8/21/24 at 9:45 AM, commented that R103 did not state that she was in pain earlier. A review of R103's medication order on 8/21/24 at 9:46 AM revealed: Lantus Solution 100 Unit /ml inject 10 units subcutaneously one time a day for DM. Insulin Glargine-yfgm 100 unit/ml Solution pen-injector. Give 10 units by mouth at bedtime related to diabetes mellitus due to underlying condition with diabetic polyneuropathy (E08.42) 2100 Tylenol Extra Strength (ES) Oral Tablet 500 mg: Give 1 tablet by mouth every 4 hours as needed (PRN) for pain. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Norco Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every six(6) hours as needed for pain. Pain Level every 8 hours. On 8/21/24 at 10:00 AM, The following errors were observed for R103: 1. The Lantus Solution injection due at 10:00 AM was not received by R103 as ordered. On 8/21/24, at 11:09 AM, the surveyor verified with Nurse K (assigned to R103) that R103 had not received the Lantus this morning as ordered. R103's blood sugar was 182, done at 11:30 AM. 2. Staff obtained a new order of Insulin Glargine-yfgm 100 unit/ml Solution pen-injector to be administered at 2100. However, it wrote: To give 10 units by mouth at bedtime at 2100. After reviewing the facility's Medication Administration Guideline and the 5 Rights of Medication Administration, 10 insulin solution pen injector units to be given by mouth indicate an error by route. 3. During the morning med pass on 8/21/24, Nurse K was observed to have omitted to ask R103 about her pain level and had given R103 one tablet of Tylenol. After taking the single tablet, R103 made the nurse and surveyor aware that her pain level was 6/10, and she wished to have more than one tablet of ES Tylenol. R103 had an order for Norco that was active for moderate to severe pain, but the nurse did not assess her pain level before giving the resident the Tylenol. During an interview on 08/21/24 at 11:06 AM, Nurse K verified that Lantus was a missed medication. Nurse K reported that R103's Lantus insulin injection is still unavailable and has not been delivered by the Pharmacy. On 8/21/24 at 12:59 PM, the Director of Nursing (DON) revealed that R103 was just admitted yesterday, 8/20/24, at 6:08 PM and stated: That's why the Lantus was unavailable. It is our policy to find the meds in the backup. Pharmacy should be restocking them. On 8/21/24 at 1:30 PM, the Administrator was made aware of the Lantus insulin injection, Five Rights, pain management concerns for R103, and the medication administration error of over 5%. On 8/22/24 at 3:45 PM, the facility policy for Medication Administration -General Guidelines Policy (no date) was reviewed. The policy specified: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.Failed to ensure insulin was available as ordered for R103.

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	235646	A. Building B. Wing	08/22/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37771 Based on observation, interview and record review, the facility failed to ensure that a medication cart and a treatment cart were secured, ensure proper labeling of medication and ensure that topical treatments were not stored with oral medications, of two medication carts and one medication room reviewed for medication storage and labeling, resulting in the potential of medications administered with decreased efficacy, improper labeling of medications, ingestion of medications and drug diversion. Findings include: On 8/20/24 at 9:10 AM, an observation was made of the treatment cart that was positioned in the 300-hall entrance and dining area entrance, that was unlocked and not under supervision of a nurse. There was no nurse in the vicinity of the treatment cart and no nurse in the 300 hall or in the dining area. A staff member comes by, and they are asked to get the nurse for the 300 hall. Nurse K approached the treatment cart, and the contents were reviewed with the Nurse. The treatment cart included supplies for dressing changes and treatments and prescription topical medications. The Nurse was asked about the securement of the cart and the Nurse stated, It should be locked. On 8/22/24 at 1:29 PM, a review of the 200-hall medication cart was reviewed with Nurse N. An observation was made of Fluticasone nasal spray not labeled with an open date. When asked the Nurse reported it should be labeled with the Resident on the bottle and there should be a date of when it was opened and stated, We usually keep them for 30 days once opened. An observation was made of nasal spray that was labeled with a room number and not a resident's identifying information and did not have an open date on the bottle. When queried about facility policy on labeling, the Nurse indicated the Resident's name should be on it not just the room number and it should be labeled with an open date. An observation was made of Artificial Tears, marked with a room number, no resident name and not dated with an open date. The Nurse indicated it should have a Resident name and an open date on it. On 8/22/24 at 2:07 PM, a review of the 300 Hall medication cart was reviewed with Unit Manager, Nurse E. An observation was made of the glucose monitoring test strips to be open and not dated. When queried, the Nurse reported there should be a date on the bottle when opened. An observation was made of capsaicin topical cream, hydrocortisone cream, estradiol cream, and another hydrocortisone cream stored in the drawer with medication for breathing treatments and oral medications. The Nurse was asked about storage of the topical medications with oral medication and breathing treatments. The Nurse stated, They should not be storing these in here. I take them out and someone puts them back in, and indicated a reoccurrence. The Nurse indicated they should be stored in the treatment cart and not the medication cart. A review of facility policy titled, Preparation and general guidelines: IIA2: Medication Administration-General Guidelines, dated November 2021, revealed, .16) During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide . The cart must be clearly visible to the personnel administering medications . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled, Medication Storage in the Facility ID1: Storage of Medication, dated November 2021, revealed, .B . Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access . D. Orally administered medications are kept separate from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc . D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated, if applicable for medications requiring a shortened expiration date . 22348 300 Hall On 8/22/24 at 12:30 PM, the medication cart (MedCart) in the 300 Hall was observed unlocked and unattended. Several residents were nearby, including one ambulatory resident wandering around, asking what today's date was. It was also observed that the computer screen on top of the MedCart was uncovered, and the resident's information, including the medications and other personal information, was also exposed. At approximately 12:33 PM on 8/22/24, Registered Nurse E (RN E) returned to the MedCart in 300 Hall and acknowledged that she had left the cart unlocked and the Resident's information was exposed. RN E then commented: I swear I lock it every time. The only time I didn't is when you are here watching me. On 8/22/24 at 12:35 PM, The Administrator was notified of this observation. The facility policy for medication storage was requested for review. On 8/22/24 at 2:30 PM, the policy entitled Medication Storage in the Facility (dated November 2021) was reviewed. It was noted in the: Policy: The Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: .B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on interview and record review the facility failed to ensure proper communication and documentation of hospice services for one resident (Resident #39) of two residents reviewed for hospice services, resulting in the absence of progress notes in the medical record. Findings include: Resident #39: Resident #39 is [AGE] years old and most recently admitted to the facility on [DATE] with diagnoses that include dysphagia, cerebral infarction, traumatic brain injury and pressure ulcers. R39 has a brief interview for mental status score (BIMS) of 6, indicating severe cognitive impairment and R39 is currently receiving hospice services. On 08/20/24 at 12:50 PM, record review revealed that the most recent hospice note in the electronic medical record (EMR) was from 06/03/24. R39 admitted to hospice care on 04/23/24. On 08/20/24 at 12:58 PM, an interview was conducted with the medical records (MR) 'C'. MR 'C' was asked when the most recent hospice note was from, for R39. MR 'C' stated the most recent note was from 06/03/24. MR 'C' stated that R39 is currently receiving hospice services. MR 'C' stated they would contact the hospice company and get the most recent notes. MR 'C' was asked why the notes weren't uploaded from this hospice company. MR 'C' stated that this specific hospice company is new to the facility. MR 'C' was asked how often hospice companies should be sending notes to the facility. MR 'C' stated that the other hospice companies that contract with the facility usually send them within one week. On 08/21/24 at 03:26 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked how often hospice companies send notes to the facility. The DON replied that receiving progress notes weekly is the goal and they send them when they complete their Interdisciplinary team (IDT) meeting. The DON reiterated that the goal is to receive them weekly. The DON was informed that the most recent uploaded note in R39's EMR was from 06/03/24. Record review of the policy titled, Hospice, reviewed 10/21 revealed: 4. The hospice agency retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions, which includes: a. Designation of a Hospice Registered Nurse to coordinate the implementation of the plan of care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Provision of all core services (e.g., physician, nursing, medical social work, and counseling services) that must be routinely provided directly by the hospice employees, and cannot be delegated to the facility as outlined in current hospice regulations at Section 418.112; c. Provision of drugs and medical supplies as needed for palliation and management of the terminal illness and related conditions. d. Identification of the specific services that will be provided by each entity and the information that will be communicated in the plan of care; and e. Communication between the hospice and the facility will take place if any changes are indicated or made to the plan of care.

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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** 37771 This Citation pertains to Intake Numbers MI00143075 and MI00144896. Based on observation, interview and record review, the facility failed to ensure a safe and sanitary environment in resident care areas and in the kitchen area. This deficient practice has the potential to affect all 55 residents who reside in the building, resulting in the potential for injury, dissatisfaction of living conditions and foodborne illness. Findings include: On 8/21/24 at 10:45 AM, an observation was made in room [ROOM NUMBER] of an open door near Bed B by the window. The door was opened to a furnace and piping that was just inside the door. Housekeeping Staff P was asked about the opened door. The Housekeeping Staff was unsure how long the door had been opened and indicated it should not be left open. Upon pushing on the door, the door did not move and was not able to be shut. The Housekeeping Staff indicated they would call Maintenance Staff. On 8/21/24 at 10:58 AM, the Administrator responded to the Housekeeping Staff request and an observation was made with the Administrator (NHA) of the opened closet door that housed a furnace. The NHA indicated the door should not have been left open and was able to close it shut. The Resident in Bed 214-B was not in the room at the time. On 8/21/24 at 1:53 PM, an interview was conducted with Maintenance Director M regarding the opened closet door in room [ROOM NUMBER]. The Maintenance Director reported the door is usually kept shut and locked and explained that the pest control company had recently been out to inspect that area for mice and the door was opened during pest control visit and was unaware the door had not been shut or locked. The Maintenance Director had the service inspection report from the pest control company that had a service date on 8/19/24. 22348 Kitchen On 08/21/24 at 10:15 AM, during the kitchen observation with the Dietary Manager, the following was observed: 1. Drain #1, located directly underneath the three-compartment sink, had stagnated water and a constant drip coming from the drain. The Dietary Manager revealed that the water was constantly there. The company installed a machine that automatically released a chemical to treat the stagnated water. The stagnated water was dirty (brownish) and smelled like sewage, with accumulated brownish bubbles on top of the stagnated water of the drain. The Dietary Manager further revealed that the machine must not be working because it did not remove the bubbles. The machine is timed and should release a chemical every so often. The Dietary Manager denied smelling the sewage smell coming from drain #1. Drain flies underneath the sink were observed when the Dietary Manager and surveyor inspected drain #1. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It was observed that the installed machine to treat the accumulation of dirty water did not show that it was turned on. The Dietary Manager revealed she did not know how to turn the power on. She further explained that it has C batteries; the last time they were replaced was in June 2024. When the Dietary Manager was asked how one could tell if the machine was on, the Dietary Manager did not reply. 2. Drain # 2: found where the steam machine was observed to be left half open and half covered. A strong sewage odor coming from Drain #2 was observed. The Dietary Manager stated on 8/21/24 at 10:25 AM, indicated that the drain was used for the steam machine, which we don't have anymore, so it is not currently being used. The Dietary Manager admitted that they were not doing anything with it. We forgot it was there. 3. Drain #3 was located by the High Temp dishwasher. The dishwasher was not in use during the observation on 8/21/24 at 10:28 AM. It was not in use but had a water leak, causing a puddle on the floor, which was observed coming from the dishwasher pipes. On 8/21/24 at 10:30 AM, the Maintenance Manager observed the leak from the dishwasher and stated that he had not seen or heard anyone had reported this leak. The Maintenance Director agreed that the leak was coming from the dishwasher pipes. It should not have water leaks and should have been reported for repair. 4. Drain #4: A dry drain with a strong sewage odor was located across the high-temperature dishwasher. The Maintenance Manager and Surveyor saw a drain fly from the dry drain. The Maintenance Manager indicated that he comes in once a week to flush the drain with an accelerator, but maybe doing it more than once a week will help eliminate the smell. No maintenance logs or records of the weekly drain flush or weekly drain checks were presented to the surveyor upon request. No maintenance work orders or maintenance repair records were submitted to the surveyor for review. 49944 On 08/19/24 at 10:00 AM, observation revealed the main dining room floor was sticky, and this was observed before meals, after meals and during an activity. This was observed for the duration of the survey. On 08/19/24 at 12:11 PM, observation revealed room [ROOM NUMBER] had a strong smell of urine and the carpet between bed one and bed two was stained. This was observed for the duration of the survey. On 08/20/24 at 2:45 PM observation revealed the 100, 200 and 300 unit hallways need to be vacuumed. There was paper and other debris noted to be on the floors.