STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235647	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Okemos	5211 Marsh Road Okemos, MI 48864

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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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure four of 32 Licensed Nurses maintained current cardiopulmonary resuscitation (CPR) certification for Healthcare Providers (HCP), which included a hands-on session, for one (R98) of one reviewed.Findings include: Review of the medical record reflected R98 admitted to the facility on [DATE], with diagnoses that included intraspinal abscess and granuloma, acute respiratory failure with hypoxia, cardiomyopathy, atrial fibrillation, atherosclerotic heart disease, methicillin susceptible staphylococcus aureus and chronic kidney disease. The 5-day Medicare Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], reflected R98 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). According to the medical record, R98 died in the facility on [DATE] and was a full code (desired CPR efforts). A Progress Note for [DATE] at 6:37 AM, authored by Licensed Practical Nurse (LPN) H, reflected they were informed by the Certified Nurse Aide (CNA), at 4:15 AM, that R98 was unresponsive. R98 was observed face down, between the bed and window. The CNA was directed to obtain the crash cart and call a code. Staff assisted with placing R98 on their back. According to the note, CPR was initiated at 4:20 AM, and 911 was called. The automated external defibrillator (AED) was applied at 4:27 AM, and no shock was advised. Compressions resumed at 4:29 AM. At 4:31 AM, CPR was paused, no shock was advised by the AED, and CPR was resumed. Emergency Medical Services (EMS) arrived at the facility at 4:32 AM. R98 was pronounced deceased in the facility at 5:06 AM. LPN H's personnel file included a Basic Life Support (BLS) CPR/AED/First-Aid certificate of completion, dated [DATE], which reflected it was valid for two years, from cprheartcenter.com. The attached provider card, also dated [DATE] from cprheartcenter.com, reflected the course was administered by the National CPR Foundation. There was no evidence that LPN H had completed a hands-on component to their CPR certification. Attempts were made to contact LPN H via phone on [DATE] at 1:10 PM and [DATE] at 8:10 AM. A return call was not received prior to the exit of the survey. In an interview on [DATE] at 9:09 AM, Director of Nursing (DON) B reported Human Resources and nursing monitored CPR certifications. DON B reported nurses were to be Basic Cardiac Life Support (BCLS) certified and were not allowed to complete their CPR certification online. On [DATE] at 11:50 AM, DON B reported she had left messages with LPN H, in attempt to clarify their (continued on next page)

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

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CPR certification and determine if there was an in-person component of their class. Review of CPR certifications for the facility's licensed nurses reflected a National CPR Foundation BLS provider card for Registered Nurse (RN) R, dated [DATE], which was valid for two years. In an interview on [DATE] at 12:53 PM, RN R reported their CPR certification course was completed online, and they did not do a hands-on or demonstration component of the course. Record review reflected a BLS HCP CPR/AED/First-Aid certificate of completion for RN Y, dated [DATE], which was valid for two years and provided by the National CPR Foundation. Record review reflected a National CPR Foundation provider card for Healthcare-CPR/AED, for LPN BB, dated [DATE], which was valid for two years. On [DATE] at 12:39 PM, writer called the cell phone for RN Y, voicemail stated she was unable to accept messages at this time. Unable to leave a message due to mailbox being full. During an interview on [DATE] at 12:40 PM, RN BB, stated she took her CPR recertification online and did not perform a hands-on demonstration, just the online education. RN BB stated she had been a nurse for 30 years and confirmed she did not do a hands-on demonstration for her CPR recertification. According to National CPR Foundation, online courses offered include Standard-CPR/AED, Standard-First Aid, Standard-CPR/AED, First Aid, Standard-Bloodborne Pathogens, Healthcare Professional-CPR/AED, and Healthcare Professional-Basic Life Support. According to the Frequent Asked Questions, CPR Foundation does not offer hands-on training and stated, However, if your employer or licensing board requires a hands-on component or a skills check, or a different provider, please visit CPRNearMe.com (https://nationalcprfoundation.com/support/) According to CPR Heart Center, online courses offered include CPR/AED, First Aid, CPR/AED/First Aid, Bloodborne Pathogens, Healthcare CPR/AED, and Basic Life Support (BLS). The Support section of the website revealed CPR Heart Center does not offer hands-on training and stated, For those who are required to complete a hands-on component or a skills-check, please visit cprnearme.com. (https://cprheartcenter.com/) Review of the facility's Cardiopulmonary Resuscitation (CPR) & Basic Life Support (BLS) policy dated [DATE] revealed Obtain and/or maintain certification in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) for Healthcare Providers in an adequate number of key clinical staff members who will direct resuscitative efforts, including non-licensed personnel. This certification will be obtained through a CPR provider who evaluates proper technique through in-person demonstration of skills. CPR certification which includes an online knowledge component yet still requires in-person skills demonstrations to obtain certification or recertification is also acceptable.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure call lights were answered timely for nine residents (R2, R3, R17, R26, R28, R43, R58, R90, R101) in a facility census of 92.Findings include: Resident #3 (R3) Review of the medical record reflected R3 was admitted to the facility on [DATE] and was readmitted on [DATE]. Diagnoses of trigeminal neuralgia, multiple sclerosis, chronic pain syndrome, polyneuropathy, muscle weakness and lack of coordination. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/14/2025, revealed R3 had a Brief Interview of Mental Status (BIMS) of 13 out of 15 (cognitively intact) and is dependent of all care. During an observation on 09/02/2025 at 1055 AM, R3 turned her call light on to get someone to put her back to bed after her appointment at the pain clinic. R3 stated she asked staff to make/change her bedding when she left at 900 AM, and it had not been changed, observation of stool smeared on her blue pad that covers her bottom sheet. R3 stated staff would tell her they are too busy, morning and night shifts. R3 stated she has had to wait up to 1.5 hours for somebody to answer her call light and provide care or turn the call light off and tell her they will be back. R3 stated they always had an excuse, she had to end up yelling out for help, the resident next door would yell out for her too. R3 stated the staff call this the yelling hall, because we have to yell for help, because nobody answers our call light and we cannot get out of bed on our own. During an observation on 09/02/2025 at 10:58 AM, 4 other call lights were on as well on the hall 300. No CNA was visible anywhere on the hall. R3 has been waiting in her wheelchair waiting to go back to bed for almost an hour. During an interview on 09/02/2025 at 1109 AM, Licensed Practical Nurse (LPN) CC stated she had 2 CNA's on the 300 hall for 23 residents, she stated she did not know how many residents were a 2-person assist. LPN CC also stated staff would be down to assist R3 when they are done giving another resident a shower. During an observation on 09/05/2025 at 9:25 AM, 300 hall had 3 call lights on, rooms 315, 318 and 323. During an observation on 09/05/2025 at 0940 AM, all 3 lights are still on (315, 318 and 323), plus call light for room [ROOM NUMBER] is on. During an observation and interview on 09/05/2025 at 0940am, CNA DD stated there was 2 CNA's on the 300 hall. Writer asked how many residents on the 300 hall required 2 person assist with care provided. CNA DD stated they have 11 residents that required 2-person assistance with all care and 24 residents in total on the 300 hall. During an observation on 09/05/2025 at 0944 AM- CNA DD walked into room [ROOM NUMBER], (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	carried out a breakfast tray and did not provide any care. room [ROOM NUMBER] call light on. During an observation on 09/05/2025 at 9:47 AM, the call light for 317 was turned off. The other 4 call lights are still on. During an observation on 09/05/2025 at 9:50 AM, room [ROOM NUMBER], the call light was turned off, but they never changed her brief, resident turned light back on once she stated they came in and turned it off saying they would be back. During an observation on 09/05/2025 at 9:51 AM, the call light for room [ROOM NUMBER] turned off and needs are met. During an observation on 09/05/2025 9:53 AM, call light turned off for room [ROOM NUMBER], providing care for her at this time. During an observation on 09/05/2025 at 9:59 AM, call lights were still on for rooms [ROOM NUMBERS]. During an observation on 09/05/2025 at 10:02, room [ROOM NUMBER] light is not on, but CNA DD was in the room providing care but was standing at the door waiting for another CNA to help her transfer resident with the mechanical lift. During an observation on 09/05/2025 at 10:06 AM, room [ROOM NUMBER] and 323 call lights were still on. During an observation on 09/05/2025 at 10:10 AM, CNA EE walked into room [ROOM NUMBER] assisting her back to bed. During an observation on 09/05/2025 at 10:18 AM room [ROOM NUMBER] call light is still on while residents continued to wait for care. During an observation on 09/05/2025 at 11:00 AM, some residents had to wait over an hour and half for care to be provided to them. R28Review of the medical record revealed R28 was admitted to the facility on [DATE] with readmission date of 8/4/25 with diagnoses that included: pain, difficulty walking and anxiety. According to the Minimum Data Set (MDS) assessment dated [DATE], R28 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).On 9/2/25 at 10:02 AM, R28 was observed sitting up in bed. R28 reported that sometimes it takes over an hour for staff to answer her call light and one time she waited 3 hours. R28 reported that the day she waited 3 hours, her sister spoke with the Director of Nursing (DON) and that she (R28) had spoken to nursing staff about her concerns with long call light response times. R101Review of the medical record revealed R101 was admitted to the facility on [DATE] diagnoses that included: transient ischemic attack and nondisplaced fracture of upper end of humerus. According to the Minimum Data Set (MDS) assessment dated [DATE], R101 scored 15/15 on the Brief Interview for Mental Status (BIMS) exam (which indicated intact cognition). On 9/2/25 at 9:51 AM, R101 was observed sitting up in her bed. R101 reported that it takes anywhere (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from 5 minutes to an hour and a half for staff to respond to her call light and that certified nursing assistants (CNA) have reported to her that they don't have enough staff to take care of what they need to do each shift. R101 added that she believed that the meals arrive cold due to a lack of staff. R26: Review of the medical record reflected R26 admitted to the facility on [DATE], with diagnoses that included Parkinsonism. The Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/3/25, reflected R26 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 09/02/2025 at 10:38 AM, R26 was observed in bed, wearing a night gown. R26 stated the facility needed to hire more help so they didn't have to wait so long to go to the bathroom. R26 reported sometimes call lights were answered right away and other times took up to one hour. On 09/02/2025 at 10:43 AM, an observation of a call light system device, located at the nurse's station, reflected the call light for R43 had been on for 19 minutes, while the call light for another room had been on for 42 minutes. R43 had been overheard calling out, hello. Both call lights were turned off at 10:44 AM. R43: Review of the medical record reflected R43 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included heart failure. The Quarterly MDS, with an ARD of 8/21/25, reflected R43 scored 15 out of 15 (cognitively intact) on the BIMS. On 09/02/2025 at 10:58 AM, R43 was observed up in a chair, in their room. R43 reported it took up to two hours for their call light to be answered, at times, but not daily. R43 reported they sometimes had to holler because they were not sure if their light was on. R58: Review of the medical record reflected R58 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included cerebral palsy. The Quarterly MDS, with an ARD of 7/2/25, reflected R58 scored 15 out of 15 (cognitively intact) on the BIMS. On 09/02/2025 at 12:01 PM, R58 was observed lying in bed. R58 reported they needed more than two Certified Nurse Aides (CNAs), as a lot of residents required two-person assist for care and mechanical lift transfers. R58 reported at times, they were wet for four to eight hours before being changed. According to R58, it was occurring a couple times per week, including on third shift. R58 reported it was important for them to get changed due to a history of urinary tract infections. R58 reported staff would tell them they were not changed due to her being off the unit or asleep, however, R43 stated they were ok with being awaken or being brought back to the unit to be changed. R2: Review of the medical record reflected R2 admitted to the facility on [DATE], with diagnoses that included senile degeneration of the brain and dementia. The Significant Change in Status MDS, with an ARD of 5/30/25, reflected R2 scored two out of 15 (severe cognitive impairment) on the BIMS. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview with R2's family member on 09/02/2025 at 12:44 PM, they reported using R2's call light for assistance a couple weeks prior. A CNA responded and said they would get the nurse. It then took three hours for the nurse to come. R2's family member did not specifically recall what the need was but stated it may have been for pain medication. R17: Review of the medical record reflected R17 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included cholecystitis. The Quarterly MDS, with an ARD of 7/21/25, reflected R17 scored 15 out of 15 (cognitively intact) on the BIMS. On 09/02/2025 at 2:07 PM, R17 was observed seated in a wheelchair, in their doorway. R17 reported they required two-person assist with care and a mechanical lift for transfers. R17 reported when they needed something, they were sometimes told there were five people ahead of them. On 09/05/2025 at 11:17 AM, R58's room door was closed, and their call light was observed to be on. The call light system, at the nurse's station, reflected R58's call light had been on for 25 minutes. The call light was responded to at 11:25 AM. Review of the medical record revealed R90 was admitted to the facility on [DATE] with diagnoses that included vascular dementia without behavioral disturbance/psychotic disturbance/mood disturbance, anxiety, insomnia, major depressive disorder, and psychotic disorder with hallucinations. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/2/25 revealed R90 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), was frequently incontinent of urine and bowel, and was dependent on staff for activities of daily living (ADLs). On 9/2/25 at 10:51 AM, R90 was observed seated in a Broda chair in the dining room on the unit. R90 reported on second shift, they were often left soiled for hours. R90 reported he told staff when he needed to be changed, and staff responds with in a minute or in a second. R90 stated, a second turns into an hour and a minute turns into five hours. R90 reported staff frequently told him they have 25 residents to care for. In an interview on 9/5/25 at 9:51 AM, Director of Nursing (DON) B reported the facility discussed staffing needs in morning stand up meeting, throughout the day, and a the end of the day stand down meeting. DON B reported they reviewed census and acuity of each unit. DON B reported they were unaware of any call light concerns from residents.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain respect and dignity to one resident (Resident #3) of one resident's care and services.Resident #3 (R3)Review of the medical record reflected R3 was admitted to the facility on [DATE] and was readmitted on [DATE]. Diagnoses of trigeminal neuralgia, multiple sclerosis, chronic pain syndrome, polyneuropathy, muscle weakness and lack of coordination.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/14/2025, revealed R3 had a Brief Interview of Mental Status (BIMS) of 13 out of 15 (cognitively intact) and is dependent of all care.During an observation and interview on 09/02/2025 at 11:52 AM, R3 stated some of the staff are not very kind, this writer asked if she has told anyone, and R3 stated no not yet, she was going to wait and see if her attitude got any better. Stated the staff are ruff with repositioning her, due to her chronic pain and Multiple Scleroses. Writer passed this information on to the LNA A.During an interview on 09/05/2025 at 10:10 AM, R3 stated that LNA A came into her room yesterday to talk to her about staff being rude and disrespectful. R3 stated she was concerned about the night staff because they are the problem. R3 stated LNA A left a card for her to call if she had any more concerns. R3 stated that the other night, she called CNA by name, stated she would not change her brief after R3 told her she was wet. R3 stated she had to change herself in the night, because nobody would change her. R3 stated she pulled her brief off from the side and washed herself off with a wet wipe the best she could. R3 pointed to the pack of wet wipes on her over the bed table and a pack of briefs in the corner sitting on her chair. R3 stated that CNA would come into her room, look at the front of her brief and say she was not wet, and leave the room. R3 stated she told her she was soaked underneath, and she would be told she was not wet, and then left the room. She had to pull her own brief off and try to clean herself up 2 times last night. R3 stated her call light was on over an hour last night and they came in and turned it off without providing care. Discussed the need for staff to leave her call light on until care is provided. R3 stated they turn it off all the time without helping her, telling her they would be back.During an interview on 09/05/2025 at 10:56 AM, DON B writer reported R3's concerns about having her call light on and turned off without care provided. This writer reported that this happened twice last night. DON B pulled up the documentation from last night's shift and reported there was documentation throughout the night on check and change. DON B stated she would go down and talk to R3 now.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain resident's personal privacy for one resident (resident #6) of one resident reviewed. Review of the clinical record revealed R6 was admitted to the facility on [DATE] with diagnoses that included: multiple sclerosis and Type 1 Diabetes Mellitus. According to the Minimum Data Set (MDS) assessment dated [DATE], R6 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).On 9/2/25 at 2:36 PM, R6 was observed in her room, sitting up in a power wheelchair. When interviewed in her room with the door closed, two staff members (at different times), knocked on the door and entered before R6 was able to provide permission to enter her private room. R6 became upset and stated that this happens routinely (staff not respecting her privacy). R6 added that staff had entered her room in the past, while she was having a private conversation with her attorney and that she had previously had a sign requesting privacy on her door which was ignored by staff. On 9/4/25 at 12:25 PM, during an interview with Director of Nursing B, when asked what the expectation was for staff prior to entering a resident room, DON B stated that staff should knock on the door, announce who they are, ask if they can come in (for people that are able to invite them in) prior to entering a resident room.Nursing Home Administrator (NHA) A was asked for a policy regarding personal privacy and on 9/4/25 at 2:25 PM, responded via email that the facility does not have a policy specifically for personal privacy and provided the facilities Resident Rights policy. A review of the Resident Rights policy provided revealed no mention of personal privacy.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide justification for not performing a gradual dose reduction (GDR) for one (R90) of five reviewed. Findings include:Review of the medical record revealed R90 was admitted to the facility on [DATE] with diagnoses that included vascular dementia without behavioral disturbance/psychotic disturbance/mood disturbance, anxiety, insomnia, major depressive disorder, and psychotic disorder with hallucinations. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/2/25 revealed R90 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 9/2/25 at 10:51 AM, R90 was observed seated in a Broda chair in the dining room on the unit. Review of the Physician's Orders revealed R90 was admitted to the facility with an order for Seroquel 200 milligrams (mg) daily. On 6/2/25, the Seroquel was decreased to 150 mg at bedtime for major depressive disorder with psychotic features. Review of the OBRA assessment dated [DATE] revealed [R90] does appear to be in a depressive episode and has also been presenting with psychotic features such as hallucinations. However, these psychotic features could also be a result of his stroke/neurocognitive changes. Review of the Behavior Management Monthly Note dated 8/20/25 revealed Continue with [name of psychiatric services provider] evaluation for GDR of Seroquel. Cymbalta has been helpful with making statements about pain and how to end things. Possible increase of Cymbalta in the future as we continue to decrease Seroquel may be helpful as well with mood/pain. Review of the Psychiatry Follow up note dated 8/21/25 revealed Social Worker [SW] requested evaluation regarding patient's increased symptoms of ongoing moderate depression, insomnia and anxiety with medication review. Per SW, clinical team [discontinued] his Lexapro and started him on Cymbalta 30 mg daily for depression and to help aid in his pain. A GDR of Seroquel was not implemented as they were adding a new medication and did not want to do multiple med [medication] changes at once .No new or worsening behaviors noted .He denies any a/v [auditory/visual] hallucinations. Nursing staff also deny any behaviors. The note further revealed Seroquel 150 mg nightly, with recommendation for GDR to 125 mg nightly as patient has had no a/v hallucinations and no negative behaviors .A GDR will be attempted with 50 mg dose, total dose of 150 mg will be reduced to 125 mg. Review of R90's behavior documentation for the last 30 days revealed no documentation of any hallucinations or delusions. The medical record revealed R90 remained on Seroquel 150 mg at bedtime. There was no documentation as to why R90's GDR from 150 mg to 125 mg was not implemented. In an interview on 9/5/25 at 8:40 AM, Social Worker (SW) J reported psychiatric services emailed their recommendations to her and the facility conducted behavior management meetings weekly which included discussing psychiatric services recommendations and GDRs. SW J reported R90 was last discussed in the behavior management meeting on 8/20/25. SW J reported they did receive an email from psychiatric services regarding the recommendation to GDR R90's Seroquel to 125 mg. SW J reported usually there was documentation in the medical record if a recommendation was not implemented. SW J was unable to locate documentation. In an interview on 9/5/25 at 9:43 AM, Director of Nursing (DON) B reported behavior management meetings were conducted weekly, with each resident being reviewed monthly. DON B reported if psychiatric services made recommendations, an Interdisciplinary Team meeting was usually conducted. DON B was unable to provide any documentation as to why R90's further GDR was not implemented.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Okemos	5211 Marsh Road Okemos, MI 48864

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent a fall for one (R5) of two reviewed. Findings include:Review of the medical record revealed R5 admitted to the facility on [DATE] with diagnoses that included epilepsy, and morbid obesity. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/24/25 revealed R5 scored 12 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was dependent on staff for activities of daily living (ADLs). On 9/2/25 at 10:45 AM, R5 was observed lying in a bariatric bed with a perimeter mattress and a fall mat on the right side of the bed. A Broda chair was observed in R5's room. R5 reported she fell out of her Broda chair and fractured her leg. Review of the Witnessed Fall incident report dated 6/9/25 at 10:45 AM revealed R5 had fallen out of her wheelchair outside of the building in the parking lot. The incident report revealed an Activity Aide was propelling the Broda chair and the chair slid sideways, and he could not straighten it out in time before the wheel got stuck in a crack in the blacktop and the chair tipped to the left and the resident fell out to the side and the chair tipped on top of her. The incident report revealed R5 reported 9 out of 10 right hip/thigh pain and that R5 sustained a fracture. Review of the hospital documentation revealed R5 sustained an acute nondisplaced distal femoral fracture and was discharged with a right knee brace. In a telephone interview on 9/4/25 at 9:02 AM, Certified Nursing Assistant (CNA) T reported they were in the parking lot in their vehicle when they witnessed Activities Aide (AA) U pulling R5 in the Broda chair in the parking lot, using one hand. In an interview on 9/4/25 at 9:58 AM, AA U reported R5 used a Broda chair which was larger and difficult to push. AA U reported pushing Broda chairs on the sidewalk did not seem safe as the Broda chairs almost fell off the sidewalk. AA U reported because of this, they pushed Broda chairs in the parking lot around the building. AA U reported while pushing R5 in her Broda chair, the Broda chair started to swerve right, and he could not get it to go straight. AA U reported as he was trying to straighten out the Broda chair, they hit a big crack in the pavement, the wheel went into the crack and R5's whole chair tipped over. According to a witness statement from Vendor V that was included in the facility's investigation, Vendor V was in their van in the parking lot at the time of the incident. Vendor V witnessed a staff member propelling R5's Broda chair with one hand, hit a bump, and the chair tipped over. In an interview on 9/4/25 at 11:57 AM, Director of Nursing (DON) B reported while AA U propelled R5's Broda chair, they hit a crack in the blacktop where the wheel got stuck and the chair tipped over. DON B reported most Broda chairs in the facility, including R5's, had a green pedal that could be engaged for easier control/movement of the chair. The parking lot was observed with a repaired crack/gap that appeared to be approximately two inches wide. DON B reported the facility had identified noncompliance and implemented corrective actions. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included ad hoc QAPI meeting, all Broda chairs in the facility were inspected, education that only CNAs and nurses are to propel Broda chairs, and weekly audits for compliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235647	A. Building B. Wing	09/05/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff utilized personal protective equipment (PPE) for one (R70) of one reviewed for Transmission-Based Precautions (TBP). Findings include: Review of the medical record reflected R70 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included Crohn's Disease. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/21/25, reflected R70 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 09/02/2025 at 12:29 PM, a sign was observed, outside R70's room door, which had two STOP signs and read, CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit . On 09/02/2025 at 12:29 PM, Staff Member (SM) C was observed to pass a lunch tray to R70's room, without the use of PPE. When asked about the sign for contact precautions and what it was for, SM C reported the sign indicated if they needed to wear a gown or mask if going in to do care on R70. R70's Physician's Orders reflected contact isolation was implemented for vomiting on 8/30/25 and discontinued 9/3/25. In an interview on 09/04/2025 at 9:38 AM, Infection Preventionist (IP) D reported R70 was placed on contact precautions over the previous weekend, as a precaution, for nausea, vomiting and diarrhea, until they were seen by a provider. IP D reported anyone entering R70's room, for any reason, should have worn a gown, mask and gloves.