STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235663	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notting Hill of West Bloomfield	6535 Drake Road West Bloomfield, MI 48322

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to provide adequate privacy for Resident Council group meetings and addressing grievances for four of 14 Confidential (C) residents (C-4, C-7, C-8, C-10) reviewed for organized monthly Resident Council meetings. Findings include: On 1/15/25 at approximately 10:50 a.m., Activity Director (AD) R reported the Resident Council President, C-4, was unable to be in attendance, despite being invited the day before. On 1/15/25 at 11:04 a.m., the group meeting to review resident council per regulatory guidance was held in the Private Dining room, an enclosed room off the main dining room. It was observed there initially were no signs announcing the meeting; signs were placed on the door just prior to the meeting starting . The State Ombudsman (resident advocate), Ombudsman U, was present for the meeting along with the Surveyor. Residents reported they wanted the Ombudsman present and declined for any other staff to be present. There were 13 residents in attendance, and the President, C-4, was absent from the meeting. The meeting purpose and group meeting process were explained to residents, with all in agreement. The [NAME] President, C-10, reported they would act in the role as President in lieu of C-4 not being there. Residents collectively reported this was not the room where they met monthly for their resident council meetings, and they liked meeting in this room, as the doors were closed and the room was private. The 13 residents, some in wheelchairs, fit in the room, along with Surveyor and Ombudsman U, for 15 person's total. On 1/25/25 at approximately 11:15 a.m., all residents present collectively reported they normally met in the Piano Room, at the end of a hall on the first floor. They shared this room afforded them no privacy, as the room was wide open and had no door, and staff went in and out of the room during their meetings. Residents collectively reported the interruptions were distracting, and they felt as if everyone could hear their concerns. Residents reported AD R posted signs to not enter on two chairs, which was confirmed by C-10, however staff walked right past the signs. Residents reported staff would continually walk into the room during their monthly meetings every month, and there were many interruptions and a lack of privacy, as staff accessed the offices in the area and were coming in frequently to use the beauty shop space. Resident collectively reported this bothered them, as they wanted to meet privately and without interruption. Residents conveyed they reported this to the AD R, and nothing changed. Residents expressed concerns the Resident Council President, C-4, was not at the group meeting on this date and had missed other meetings and wondered if they should be in their role. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents collectively stated their concerns in the resident council meetings were not being followed up on. C-8 stated, I know they are busy (staff) but we need a social worker to come in and be there and listen to us and support us, and not just hear us .We are being shut down (meaning their concerns were not being followed up on). Resident collectively reported they were concerned staff feared retaliation if they follow-up on their concerns, so their concerns were not getting addressed. When asked about the grievance process, only two of 13 residents knew there were grievance forms, and said they were by the facility elevators. The group collectively reported AD R did not follow-up on their concerns, nor any staff, and they wanted follow-up. The residents could not identify who the grievance officer was in the building, and did not know who to file a grievance with. Residents reported they had brought up concerns related to long call light response times, staff attitudes, and other concerns with no follow-up monthly. The residents reported they did not know who the Grievance Officer was, and 11 residents did not know how to file a grievance and with who. An observation on 1/25/24 at approximately 11:30 a.m. yielded there were no grievance forms by either facility elevator/door (on both floors), confirmed by Ombudsman U. On 1/15/25 at 1:40 p.m. (after the group meeting), the Resident Council President, C-7, was asked about missing the group meeting, with Ombudsman U present. C-7 reported they were aware of the meeting and had asked staff to get them up for the meeting. C-7 stated they had asked all morning and no one had gotten them ready. C-7 stated they were upset they were not assisted up out of bed to attend when they asked earlier in the morning. C-7 reported they wanted to remain the Resident Council President. C-7 was alert and oriented x 4, and could read the clock accurately, and knew their schedule, and the time the meeting was scheduled . C-7 asked for Surveyor to return to hear their concerns, as they were still eating lunch. C-7 was alert and sitting up in their wheelchair during the interview and reported they had missed some meetings as they were not told when they were or taken to them, not by choice. Review of the Resident Council Meeting minutes, dated 1/07/25, obtained from the Nursing Home Administrator (NHA), revealed, Old Business: (list follow-up from last month's minutes). Issues not resolved move to new business. New Business: Comments on Administration, Maintenance, Social Services, Housekeeping, Laundry, Nursing and Activities .however there were no comments found, grievance or customer services forms (concern forms) attached, or follow-up. The December 2024, and November 2024 minutes revealed similar comments per department, with no description, grievance forms, customer service forms, or follow-up. On 1/15/25 at 2:30 p.m., the NHA was shown the past three months minutes, reviewed them with Surveyor, and asked if they had any grievance or concern forms for the past five months for resident council meeting concerns. The NHA confirmed they had no concerns or grievances forms found since August 2024, and they would have been found in the grievance book, which was a large white binder on their desk. The NHA reported they were missing and shared there should have been follow-up of resident concerns being addressed for the past five months on grievance forms, per review of the meeting minutes for the past three months. Their expectation was there would be grievance forms. The NHA confirmed they were the Grievance Officer. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25 at 3:33 p.m., AD R was asked to confirm where the residents met for the monthly Resident Council meetings, and if they had expressed any concerns. AD R confirmed the monthly resident council meetings were held in the Piano Dining Room (large dining sitting room adjacent to the beauty parlor). AD R stated, Sometimes they (staff) are walking through (the room). That is correct. They are still coming through . Family ignores this too . It was shared with AD R no grievance or concern forms were provided for the past three months related to residents' concerns per the NHA, and residents' reported concerns, and Surveyor concerns, with none provided by the end of the survey. On 1/15/25 at 3:37 p.m, the Piano Room was observed with the Maintenance Director, Staff Q , and Maintenance Staff R, and confirmed this was where residents met. The room was a large room at the end of a facility hall, with a piano in the room, furniture and tables, and a wide opening, with no doors to close off the room/space. Staff S and Staff T were asked if they could observe and measure the opening. Staff S and Staff T measured the opening, which was 8' wide and 6' tall. Both stated this large opening could not be closed off for privacy. The room was 39' x 36', per their measurements with a tape measure. Both confirmed staff entered and exited the beauty salon at all times of day, and the Piano Room was not a private space for residents to meet. Both reported the private dining room which was the closed-door room off the main dining room would be the best place for meetings in the facility. Review of the resident council meeting minutes showed for the past three months the number of residents who attended the meetings were: 1/07/2025: 12 residents, 1 staff. 12/10/2024: 9 residents, 3 staff. 11/12/2024: 10 residents, 1 staff. Review of the minutes showed the Resident Council President, C-4, had been present at the 1/07/25 meeting, and had missed the prior two months. On 1/16/25 at 9:10 a.m., C-4 was seen for follow-up per their request regarding their concerns since they missed the meeting on 1/15/24. C-4 confirmed the meeting space was not private, which concerned them, as staff walked in and out of the room during their meetings. C-4 stated, I want to go to the resident council meetings, and I am not always told or gotten up out of bed . C-4 reported they wished to remain Resident Council President and attend the meetings regularly, especially since they were President. C-4 stated even if they had been asleep, they would have expected to be awakened to attend, per their expressed wishes to staff to attend the State group meeting on 1/15/25. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy, Guest/Resident Council, revised 8/20/21, revealed, Policy: The Guest/Resident Council provides a formal, organized means of guest/resident input into facility operations. Information: The facility must allow guests/residents to organize into a council group without interference. The facility must provide the group with space, privacy for meetings, and staff support, if requested. Procedure .2. The Activity Director will assist the Guest/Resident Council in electing officers on an annual basis. The officers may include President, [NAME] President, Secretary, Treasurer. 3. Guest's/Resident's may be appointed to council from year to year .5. The Guest/Resident Council President will lead the meeting with assistance from Activity Recreation Director/designees, if requested. In the absence of the President, the leadership role will go to the [NAME] President .8. A private space with sufficient room for all who wish to attend will be provided, if possible, that affords the group full auditory and visual privacy and is free from interruptions .11. The Guest/Resident Council grievances and recommendations will be documented on the Guest/Resident Assistance Form (State only) or the Guest Satisfaction Concern/Suggestion form. The completed forms are brought to the attention of the Administrator who will forward the forms to the respective department head for attention and response. 12. Responses regarding resolution are to be documented on the Guest/Resident Assistance Form (State only) or the Guest Satisfaction Concern/Suggestion form, reviewed by the Administrator and a copy of completed forms are sent to the [NAME], and kept with the Guest/Resident Council minutes. 13. Action taken and/or considerations given to issues will be reported back to the Guest/Resident Council at the following meeting and documented within the minutes .15. The use of resources to enhance the guest's/resident's understanding of facility functions and/or issues that affect them will be facilitated if unanimously requested by council. This can include utilizing department heads, (the) Ombudsman, etc .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on observation and interview, the facility failed to provide a sanitary homelike environment amongst residential common areas including,the central shower room, first floor dinner, room [ROOM NUMBER] and room [ROOM NUMBER]) resulting in an unkempt environment resulting in potential for resident dissatisfaction with their living conditions and failure to maintain a clean healthcare environment. Findings include: On 1/24/25 at 10:08 AM, An observation of the second-floor resident rooms revealed carpeted floors unkempt, appeared not vacuumed regularly and were observed with paper straw wrappers, and other paper like debris. Passing by residential rooms in the 200 hallway was observed with all rooms having tiled flooring was not mopped and sticky ring marks were noted. room [ROOM NUMBER] floor was observed with a moderate pile of cakelike substance surrounded by a dried sticky ring. The white door facing the residents and entrance to their bathroom area was observed with five moderate sized rings of pink colored dried matter on white colored door and dried food substance on the walls on the left side walls toward the main door. room [ROOM NUMBER] was observed with dried brown colored tube feed (enteral feeding) on dispensing machine, pole, base, and electric cord. Dried brown matter also observed on the corner wall behind the machine. Dried spilled matter also observed on wall above garbage can. Observation of the second floor Central Shower room revealed the following: Floors throughout were visibly soiled with white water marks around the bathtub. [NAME] thick matter identified in between door hinges on the door to toilet room, under the vanity sink was littered with two clear plastic razor caps, white straw wrappers, and disposable gloves. The entrance to the shower was observed having tile base chipped off and the piece of the broken tile revealed a pointed triangle shaped on floor. The lighting into the shower was not functional when the light switch was turned on. The common shower vanity area countertop was dirty with visible strands of hair on top and within the sink basin. The top drawer was opened and contained a clear plastic cup half filled with a white colored milk like liquid, blue comb, black comb, white hairbrush all with moderate amounts of hair and dander in between the bristles. Loose razor blades, nail clippers were on the base of drawer and one can of shaving cream was observed with no dispenser and rust rings around the perimeter of can. A red bottle of body wash was observed with a resident name written in black marker, and one white hand scrub brush was observed at the back of the drawer. The second drawer revealed briefs and washcloths, half used bottle of mouth wash, one gray sock, and clumps of hair lying amongst two bottles of Oxy-Force multipurpose cleaner. The second-floor common sitting area with television and couches identified a computer sitting on top of desk. The first drawer of the computer was opened and revealed three bottles of shampoo/conditioner/body wash and two packs of body shaving razors. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/14/25 at 11:10 AM, the common activity area known at the facility as the Piano Room revealed: Residents and family members/visitors were observed sitting at the dining room tables, the bases of all chairs were observed with a layer of dust and table tops were observed unkempt. On 1/15/25 at 8:30 AM, an observation of the first-floor dining area was observed with dead insects and webs lying on windowsills. The large black round table bases were observed with large amounts of dried food, and liquid matter. Staff was observed setting tables for dining and white table clothes were observed with visible tea/coffee-colored stains. The Main Lobby/Entrance to the facility was observed with moderate amounts of dead insects lying on top of the windowsills. On 1/15/25 at 9:55, An interview and facility tour was commenced with Housekeeping Director D (HD D). HD D confirmed housekeeping was responsible for wiping down, sills, chairs, tables, and bases. All flooring maintenance including vacuuming and mopping including all common areas, residential rooms, and common shower area throughout the facility. While touring the second-floor central shower room, two bottles of Clorox Urine remover was noted on top of the vanity area. The brown thick matter on the door was observed at which time HD D commented that it looked like human matter and acknowledged the bottles of cleaning supplies on vanity should not have been stored in residential area. HD D was informed of the other items observed on 1/14/25 and confirmed the drawers were unkempt and should have not contained items other than clean washcloths, and briefs. The second-floor common sitting area with television and couches identified a computer sitting on top of desk. The first drawer of the computer was opened and revealed three bottles of shampoo/conditioner/body wash and two packs of body shaving razors. HD D immediately removed these items, commented that was not appropriate storage and threw into the garbage. The days previous findings were discussed with HD D and was observed taking notes of findings. HD D acknowledged the observations were unkempt and housekeeping was responsible for maintaining the areas of concern and had not. Review of the facility Policy titled; Housekeeping Services dated 2/2023 documented: .Housekeeping Services play a large role in maintaining a clean healthcare environment .thorough scrubbing will be used for all environmental surfaces that are being cleaned in guest/resident care areas . cleaning of non-carpeted floors and other horizontal surfaces will be done daily and more frequently if spillage or visible soiling occurs .carpeting will be vacuumed regularly .

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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** 30675 Based on interview and record review, the facility failed to develop a comprehensive care plan to address a resident's specific nutritional needs for one (R297) of four residents reviewed for nutritional care planning. Findings include: Review of the closed clinical record revealed R297 was admitted into the facility on [DATE] with diagnoses that included: other complications of gastric band procedure, sepsis, unspecified severe protein-calorie malnutrition, morbid (severe) obesity due to excess calories, metabolic encephalopathy, acute respiratory failure with hypoxia, altered mental status, and encounter for surgical aftercare following surgery on the digestive system. The resident was transferred to a local hospital on 12/17/24 at 12:35 PM and has not returned to the facility. According to the Minimum Data Set (MDS) assessment dated [DATE], R297 had no communication concerns, had intact cognition, weight was 359 pounds, with no weight loss or weight gain, had no parenteral/intravenous feeding on admission, and was on a mechanically altered diet. Review of the care plans included a nutritional care plan that was initiated by the Director of Nursing (DON) on 12/9/24 and a revision date of 1/10/25 by Registered Dietician (RD 'I') that read, Resident is at risk for Nutritional decline r/t (related to): (blank - incomplete). There were no interventions identified that were resident specific to R297's nutritional needs, risks and use of altered diet. Review of the physician/extender progress notes revealed conflicting documentation referencing nutritional care planning and monitoring reviewed as this documentation was NOT available for review in the clinical record and confirmed by the RD during this survey. These progress notes included: An entry on 12/13/24 at 3:27 PM by Nurse Practitioner (NP 'HH') read, .ASSESSMENT/PLAN Risk Malnutrition -continue Mechanical Soft Diet thin liquids -RD eval reviewed, included in plan of care -close monitoring for dietary intake continues . A late entry on 12/15/24 at 9:36 PM by Physician 'GG' for 12/13/24 at 4:35 PM read, The patient's care plan addresses the risk of malnutrition and urinary retention with appropriate monitoring and supportive measures .For the risk of malnutrition, the patient remains on a mechanical soft diet with thin liquids, which they are tolerating well at this time. The registered dietitian's evaluation has been reviewed and incorporated into the plan of care. Close monitoring of dietary intake will continue to ensure the patient maintains adequate nutrition and to identify any potential concerns early . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry on 12/17/24 at 11:39 AM by Physician 'GG' for 12/16/24 at 4:39 PM read, .Regarding the risk of malnutrition, the patient will continue on a mechanical soft diet with thin liquids. A registered dietitian (RD) evaluation has been reviewed and included in the plan of care, with ongoing monitoring of dietary intake. The patient is currently tolerating oral intake well, and this will continue to be closely monitored to ensure adequate nutrition . It is unknown what care plan and RD evaluation the physician is referencing as there was none available for review in the clinical record. Physician 'GG' was unable to be reached for an interview by the end of the survey. On 1/15/25 at 2:40 PM, an interview was conducted with RD 'I'. They reported they were the only RD on staff, was full-time and started at the facility in October 2023. When asked about the lack of nutritional assessments and care planning for R297, RD 'I' confirmed they did not do the evaluation and had been out sick on 12/11/24. When asked who was to provide nutritional monitoring in their absence, RD 'I' reported they were not sure who, but had notified their Regional RD. When asked who was responsible for ensuring the nutritional care plan was completed, RD 'I' reported they were and confirmed R297's nutrition care plan was incomplete. According to the facility's policy titled, Nutritional Services Documentation dated 9/19/2024: .The nutritional evaluation is then used in the development of the resident's individualized care plan to demonstrate the resident's needs, strengths, and priorities .Nutrition and hydration intervention .Goals and approaches that will be addressed on the interdisciplinary plan of care .A care plan will be developed and implemented .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on observation, interview, and record review, the facility failed to ensure nursing services met professional standards for medication administration and documentation for one resident (R55) out of one reviewed for self administration. Findings Include: Clinical record review revealed R55 was admitted to the facility on [DATE] with a medical history of hepatitis (inflammation of the liver), hypertension, and diabetes. Psychiatric history included major depressive disorder, bipolar disorder, and anxiety. A Brief Interview of Mental Status (BIMS) score assessed on 11/14/24 scored 14/15 indicating R55 was cognitively intact. On 1/14/25 at 10:48 AM, During initial interview, an observation revealed nine scabbed, red colored blister/lesions on forehead, bilateral cheeks, nose and chin. R55 voiced concerns since they had developed the sores, Nursing leaves some kind of lotion at the bedside and has no idea what the lotion is. R55 was observed grabbing two medicine cups filled with a white colored lotion from their bedside table and with frustration, threw into the garbage. R55 voiced concern they have asked to see the medication, has no idea what it is, and it is uncovered and not sanitary. R55 commented that dust and particles could get into the open medicine cup and would prefer a covered lotion be left. R55 was asked if the Nurses confirm if they apply the cream and R55 replied that the Nurses just leave it there. On 1/15/25 at 3:00 PM, a second observation/interview with R55 revealed another white colored cream in a medication cup on the bedside table. R55 acknowledged they had not applied the lotion. R55 confirmed all nurses just leave it and tell them it is for your face. When asked if their assigned nurse confirmed if it was applied today, R55 replied no, they never ask. Record Review of the Medical Administration Record (MAR) for R55 revealed ordered Benzoyl Peroxide External Gel 5 % Apply to Forehead and nose topically one time a day for topical infection/acne was documented as given on 1/15/25 at 9:00 AM by Licensed Practical Nurse (LPN) M. On 01/15/25 at 3:08 PM, an interview conducted with (LPN) M acknowledged R55 had a medicated lotion for their face. When asked what the medication was, LPN M was observed removing the medication labeled Benzoyl Peroxide External Gel 5% (antibacterial cream medication). When LPN M was asked if they applied the medication to R55, LPN M replied they left it at the bedside and further inquired to this surveyor if R55 had applied it. When asked if R55 had orders to self-administer and leave at bedside, further questioning was terminated as LPN M ignored the question and walked away from the surveyor. On 1/15/25 at 3:18 PM, The Nursing Home Administrator (NHA) was informed of the above interaction with LPN M, confirmed the nurses name and apologized for the interaction. No further explanation was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48680 Based on observation, interview, and record review the facility failed to provide timely toileting/brief care for three residents (R78, R31, and R55) of three reviewed for incontinence care, resulting in the resident being left wet for extended periods. Findings include: On 1/15/25 at 2:36 PM, R78 was observed in their room asking an unknown staff member to change them. At that time, R78 was told that they would find someone to help them and exited the room. At 2:45 a nurse entered the room and turned the call light off and exited the room without helping the resident. At 3:10 PM, a certified nurse assistant (CNA) went into the room and assisted R78. On 1/16/25 at 10:30 AM, an observation of the nurse's station revealed a view of the call light board to see how long the call lights had been on. R31's light had been on since 9:51 AM, R78's call light had been on since 10:03 AM. At 10:32 AM, R31 was observed in their room and asked what they needed. R31 asked to be changed and stated that they had been waiting for some time now. At 10:33 AM, R78 was observed in their room and asked if this Surveyor was there to change them. There was a smell of ammonia and a visible ring of urine around the fitted sheet and blue pad in R78's bed. On 1/16/25 at 10:45 AM, Ceritified Nursing Assistants (CNAs) were observed in the hallway together upset because with their assignments because they had to be changed because a CNA had not showed up as of 11:00 AM. At 11:15 AM R31 was changed and cleaned. On 1/16/25 at 2:00 PM the Director of Nursing (DON) was asked what a reasonable wait time for a call light was to be answered and stated, No more than 30 minutes. When notified of the above observations, the DON stated she would look into it. No additional information was provided by the exit of the survey. 40330 R55 On 1/16/25 at 9:50 a.m., R55 was interviewed in their room. R55 was in their bed, and reported their aide did not change their sheets all night, and they sat in wet urine. R55 reported they could change themselves sometimes to remove their brief but could not put on new sheets. R55 reported they had told their midnight aide, who had not returned to change them when asked, so they laid on dirty sheets all night. R55 reported their aide peeked in their room, said they would return, and did not, and turned off their call light. R55 stated this made them feel upset and uncomfortable. R55 reported they had told staff this occurred occasionally but nothing changed. R55 was alert and oriented x 4 spheres, could tell time and knew their daily schedule. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at approximately 9:55 a.m., Certified Nurse Aide, (CNA) V, assisted R55 to show Surveyor their wet sheets. Their top and bottom sheets were soaked from their shoulders to ankles, with some feces smears and dried blood. CNA V stated, This happens all the time. When asked to clarify, CNA V reported when they arrived for their morning shift as R55's nurse aide, they found the prior shift had left them wet or with wet sheets. When asked who their prior aide was, R55 reported they did not know, as the nurse aides frequently did not wear name tags or had them turned. R55 reported this bothered them, as staff did not generally give them their name when they asked them. On 1/16/25 at approximately 10:00 a.m., it was observed CNA V was not wearing a name badge, either an official badge or a sticker badge on their scrubs. On 1/16/25 at approximately 3:18 p.m., CNA V was observed wearing scrubs, with no name badge, including an official badge or a sticker badge identifying their name. On 1/16/25 at approximately 3:22 p.m., CNA V was asked about R55 being found this morning with soaked sheets, and if they had confirmed this was urine when they changed R55. CNA V reported they frequently found R55 soaked in urine when they arrived for their shift, at least four times during their pay period and this was a current concern. CNA V reported R55 needed assistance with self-care at times and needed assistance fully changing their sheets. On 1/16/25 at approximately 3:26 p.m., CNA V was asked why they were not wearing a name badge, as none was observed twice on 1/16/24 by Surveyor. CNA V confirmed they were not wearing a badge and had left their name badge in their car and felt bad. CNA V reported they forgot to wear their badge, as staff were generally not wearing name tags on their resident floor (second); and many only wore them when the State was in the building. CNA V reported they understood why they should wear a name badge, so residents could identify them and for personalized care. Review of R55's Care Plan, accessed 1/16/25, revealed R55 was occasionally incontinent of bladder or bowel due to an overactive bladder. The intervention was to check R55 every two hours for incontinence, and to wash, rinse, and dry them, and change them as needed, to prevent skin breakdown and urinary tract infections. The ADL (activities of daily living) Care Plan further revealed R55 required assistance with ADL's due to weakness. Review of R55's Minimum Data Set (MDS) assessment, dated 11/30/24, revealed R55 required moderate assistance with toileting, and was frequently incontinent of bowel and bladder. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 14/15, which showed R55 was cognitively intact.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 Based on observations, interviews, and record reviews, the facility failed to ensure that a physician was notified of a change in condition for one resident (R78) of one resident reviewed for change in condition. Findings include: On 1/14/25 at 10:12 AM, an interview was conducted about the care in the facility with R78 and their family member. R78 stated, It's been fine but, they take a long time to change me. R78 further went on to explain that he felt that 40 minutes to an hour or 2 is too long to be sitting with mess on your bottom. R78 also explained they needed some type of antibiotic for their skin and that it had been itching and burning for a while and told the nurses. Family member II explained that R78 had been calling them for the past month asking if they could take them to the doctor so they can get antibiotics because the spot on their back was hurting and they were afraid it may be an abscess forming. Family member II tried to explain to R78 that they couldn't do that because they had doctors in the facility to do that. R78 when on to state that the area had been hurting for a while and that no one had done anything about it. A review of the record revealed that R78 was admitted to the facility on [DATE] with a diagnosis of nontraumatic subdural hemorrhage, major depressive disorder, and muscle weakness with a Brief interview for mental status score(BIMs) of 13. A further review of the record showed that there were skin assessments and none of them indicated the rash area on the back. There was an order for hydrocortisone cream and a wound care consult put in shortly after the interview was conducted for R78. On 1/16/25 an interview with the Director of Nursing (DON)was completed. She was asked when a physician should be notified about a change in condition and replied, Once the change had been Identified. The DON was notified of what R78 had stated about their skin condition, the weekly skin assessments showing no issues, yet orders were put in after the resident was interviewed by this Surveyor. The DON stated she had no knowledge of the skin issue, and sent the wound care nurse to assess the area. No additional information was provided by the exit of the survey.

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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** 40330 Based on observation, interview, and record review, the facility failed to provide restorative therapy services for one (R25) of one resident reviewed for restorative services and range of motion. Findings include: On 1/14/25 at 3:29 p.m., R25 was observed in their hospital bed, with their knees bent partially, and their heels pressing on the bed mattress. Their knees appeared to be lacking in full extension, by about 20 to 30 degrees. On 1/14/25 at 3:31 p.m., R25 was asked if they received restorative therapy services due to their bilateral leg range of motion deficits. R25 reported they were receiving restorative therapy prior to their hospitalization and were unsure why restorative therapy was not doing range of motion, since their legs felt tighter. R25 reported they wanted restorative therapy services to resume and clarified they were not receiving therapy services (physical or occupational therapy) recently. On 1/14/25 at 3:45 p.m., the Restorative Aide, Certified Nurse Aide (CNA) X, was asked if R25 was on their caseload. CNA X explained R25 was not receiving restorative therapy since their hospital stay, and they were unsure why restorative services had not resumed. Review of R25's facility census revealed they were last hospitalized on [DATE] and returned to the facility on [DATE]. Review of R25's restorative log, retrieved 1/16/25, range of motion was ordered for R25's upper and lower extremities three times weekly, for eight weeks, to maintain range of motion, skin integrity and function. The log revealed there was no restorative therapy completed during the 30-day look back. On 1/16/25 at 12:57 p.m., the Rehabilitation Director, Occupational Therapist (OT) W, was asked if R25 was receiving restorative or therapy services since their hospital stay. OT W reported R25 had contractures, and they were unsure of why there was a gap in restorative care between their hospital stay and resumption of restorative therapy and reported this had come to their attention yesterday (1/15/25). When asked who oversaw restorative therapy (i.e. referral to the program), OT W reported this was a shared responsibility between nursing and therapy, and ultimately the Director of Nursing was in charge at this time. OT W was asked if R25 was screened after their hospital stay. R25 reported R25 was screened and picked up for speech therapy services on 12/27/24, but no other services (OT or PT - Physical Therapy), and there was no screening for therapy services prior. OT W was asked for R25's therapy records, specifically PT. They were unclear why R25 was not continuing with restorative therapy. Review of R25's therapy records revealed R25 was last seen for PT services and discharged [DATE], per records received. Review of the notes showed R25 had range of motion limitations in both legs actively at the knees (-30 degrees) and had no contractures. OT had seen R25 during 2/2024, however had not addressed leg range of motion. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 1:36 p.m., the Director of Nursing (DON) was asked about R25 not being referred to restorative therapy after their hospital stay, per their expressed wishes. The DON stated they did not really have a fully functioning restorative program, stating they had a restorative program but was not all put together, and explained they did not have a restorative nurse. The DON reported they had newly assigned the ADON to take over the restorative therapy program. The DON was asked if R25 should have been on restorative services, given therapy was reporting some contractures beginning. The DON responded R25 should have been screened, and they saw no therapy screening before 12/27/24. The DON reported they understood the concern, and clarified they needed a restorative nurse to watch over restorative so they could keep tract of residents who need restorative care. The DON explained residents' received range of motion during cares but it was not the repetitive movements which they needed. The DON was asked about R25's heels being observed pressing on the mattress. The DON acknowledged their heels should be offloaded on their mattress. On 1/16/25 at approximately 1:50 p.m., R25 was observed in their bed with the DON and wound care nurse. R25's heels were observed pressing on their mattress. R25 reported they preferred a pillow verse offloading devices, although they did not always like the pillow either. R25's knees and legs were observed mostly extended, with some flexion at the knees. The DON attempted range of motion with R25's legs, with their permission. It was observed R25's right leg had about 30 degrees flexion at the knee and their legs were stiff. The DON was unable to range R25's left knee/leg fully, so there appeared to be contracture possibly, per the DON. It was noted some range of motion was present in both legs, and there had not been a recent PT assessment for comparison. The DON confirmed R25 would be seen by therapy and their restorative program would likely be resumed. Review of R25's Minimum Data Assessment (MDS), dated [DATE], revealed R25 was admitted on [DATE], with diagnoses including Parkinson's disease, bradycardia (slow heart rate), anxiety, depression, and hemiparesis (one-sided weakness). The assessment showed range of motion limitations in their arms and legs, however there was no contracture diagnosis. R25 was dependent for toileting, transfers, and bed mobility. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed they were cognitively intact at that time. Further review revealed R25 had not received therapy services during the look-back period or restorative therapy. There was no documentation of a contracture diagnosis. Review of R25's Care Plan, accessed 1/16/25, revealed no documentation of a contracture or contractures. Review of the Electronic Medical Record (EMR) showed no documentation of a contracture or contractures. Review of the policy, Restorative Nursing, effective 5/01/24, revealed, The facility strives to enable the resident to attain and maintain the highest practicable level of physical, mental, and psychosocial well-being. The Interdisciplinary team (IDT) works with the resident and family to identify measurable restorative goals and practical interventions that can be implemented and achieved with nursing support. A licensed nurse will help manage the restorative nursing process with assistance of nursing assistants trained in restorative care . 2. Determine with the IDT, if the resident meets criteria for a restorative program. Criteria include but are not limited to: a. Resident requiring i. Contracture prevention and management (including passive range of motion (PROM), active range of motion (AROM), splint/brace assistance .Restorative quarterly evaluation is completed at least quarterly .Person-centered care plan .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to ensure timely/completed assessments and investigations into multiple falls, and identify and implement appropriate fall interventions for one (R85) of three residents reviewed for accidents. Findings include: On 1/14/25 at 1:25 PM, R85 was observed laying in bed, positioned halfway down the bed with their right leg positioned in the air and resting on a large pillar in the middle of the room, next to their bed. R85 was observed to have a perimeter mattress in place (edges of mattress raised) and was lightly hitting themselves and saying No, no, no. On 1/14/25 at 1:30 PM, a Nurse was observed asking the Nurse Aide to reposition the resident in bed. On 1/15/25 at 7:51 AM, R85 was observed laying in bed, positioned on their back. The perimeter mattress was observed to have additional pillows to the side centers of the mattress on both sides and the bed was positioned lower, but not all the way to the floor. The wheelchair next to the bed was observed to have a pommel cushion (a wheelchair cushion that has a raised center section to keep the resident's legs separated and prevents sliding forward in wheelchair seat). Review of the clinical record revealed R85 was admitted into the facility on [DATE] with diagnoses that included: hemiplegia and hemiparesis and vascular dementia moderate with mood disturbance, adjustment disorder with mixed anxiety and depressed mood, According to the Minimum Data Set (MDS) assessment dated [DATE], R85 had severe cognitive impairment, had no psychosis or behavior concerns, had one fall without injury, and two or more falls with injury (except major) since admission or prior assessment. Review of the care plans included: A fall care plan initiated 8/27/24, revised last on 1/7/25 read, [name of R85] is at risk for fall related injury and falls R/T (related to): poor vision, cognitive loss, gets up with out assistance, has lt field deficit, multiple CVAs (Cerebrovascular Accidents). Interventions included: Bed in lowest position. (Initiated 11/22/24) Concave Mattress (Initiated 12/2/24) Pommel cushion will be added to wheelchair. (Initiated 12/17/24) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put the call light within reach and encourage her to use it for assistance as needed. (Initiated 12/13/24, revision on 1/3/25) Review information on past falls and attempt to determine the root cause of the falls. (Initiated 1/7/25) An Activities of Daily Living (ADL) care plan initiated 10/18/24, revised 11/15/24 documented, [name of R85] has a functional ability deficit and requires assistance with self care/mobility R/T: decreased mobility, confusion. Interventions included: Use of pommel cushion in w/c (wheelchair) when oob (out of bed). (Initiated 11/25/24) Review of R85's evaluation for physical device (pommel cushion) was initiated on 11/25/2024 but not locked (completed) until 1/9/25. On 1/15/25 at 11:01 AM, the facility was requested to provide all incident/accident (I/A) reports for R85 since admission, including documentation of the facility's investigations into these incidents. Review of the documentation provided by the facility identified R85 had 10 falls from 9/19/24 - 12/20/24 (most recent). Further review of the documentation revealed documentation on the I/A's were incomplete, had multiple missing documentation of interviews with staff, recall of what/when/where the resident was prior to the fall, interventions to prevent future fall occurrences, and lack of notification to the facility staff, physician, and/or responsible party. R85's I/A documentation for a fall on 12/20/24 at 12:15 PM from Nurse 'Y' documented, in part: .resident was found on the floor by aide - was lying on left side and wrapped in blankets .resident assisted back into bed, assessed for injury. Neuro checks initiated within normal limits .No injuries observed at time of incident . The section of the I/A that identified Injuries Report Post Incident documented, .Left antecubital, Left trochanter (hip), Left shoulder (rear). There was no further documentation into any details of these areas, such as if an x-ray had been completed, or if there was a change in condition. The section for Agencies/People Notified read, No Notifications found. The Post Fall Evaluation completed by Nurse 'Y' noted time of fall was 7:10 PM and further read, .Resident was observed lying on left side wrapped in a sheet. No furniture or tables in vicinity . The section for Re-Creation of Last 3 Hours Before Fall, Root Cause of this Fall which included describe initial intervention to prevent future falls and if care plan/kardex was updated was left blank. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The section for New Interventions after IDT (Interdisciplinary) review noted medication review. This document was not dated by Nurse Y and the section for IDT signature which indicated this had been discussed/reviewed by the IDT included only 1 person (illegible name). R85's I/A documentation for a fall on 12/16/24 at 6:23 PM from Nurse 'Z' documented, in part: .Resident slide <sic> slowly from wheelchair into a sitting position onto the floor . The section for notifications only identified the Director of Nursing (DON) and Physician/Nurse Practitioner. There was no identification that the responsible party had been notified. The section for root cause of this fall and initial interventions to prevent future falls read, Screen for pummel <sic> cushion. The section for New Interventions after IDT review read, Therapy to give pummel <sic>. However, this intervention was already identified as initiated on the ADL care plan on 11/25/24. R85's I/A documentation for a fall on 12/14/24 at 2:09 PM from Nurse 'AA' documented, in part: .CNA (Certified Nursing Assistant) entered client's room and witnessed client on the floor on her knees .no wounds or bruising to body .Client states I was on my knees. It's like praying.Client was helped into her wheelchair and taken to the dining area . The section for Agencies/people notified read, No Notifications found. There was no documentation the facility, physician, or responsible party had been notified of this fall. The section of the Post Fall Evaluation noted for Re-Creation of Last 3 Hours Before Fall read, Resident in w/c resting. The section of this report to identify the root cause of the fall and prompted the staff to describe initial intervention to prevent future falls read, Assisted back to chair. The section for if care plan/kardex had been updated and what new interventions had been identified and implemented after the IDT review were left blank (incomplete). R85's I/A documentation for a fall on 12/13/24 at 12:15 PM from Nurse 'BB' documented, in part: .WRITER WAS NOTIFIED THAT STAFF OBSERVED RESIDENT ON FLOOR ON THE SIDE OF THE BED HEAD FACING THE FOOT OF THE BED. RESIDENT APPEARED TO ATTEMPTING TO CRAWL . Resident Unable to give Description .No Injuries observed at time of incident . The section for Agency/people notified only included the resident's responsible party (son) and the DON. There was no documentation that the physician had been notified. The section for the post fall evaluation noted prior to fall documented the resident was resting in bed in lowest position. The section for the root cause of the fall had a mark next to Mood or mental status. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The section to Describe initial intervention to prevent future falls read, Put call light within reach & encourage her to use it. The section for updating the care plan/kardex was marked and the section for New intervention after IDT review only read, Follow facility fall protocol. R85's I/A documentation for a fall on 12/12/24 at 6:19 PM from Nurse 'N' documented, in part: .nurse was called into residents room, to find the resident laying on the floor next to the bed .No injuries observed at time of incident .oriented to person . The section for Post fall evaluation documented the fall description details as, Resident couldn't describe what she was doing .Resident was observed laying on her side . The section for Re-Creation of last 3 hours before fall identified only a staff name. The section for root cause of this fall had a mark next to Mood or mental status. The section for Describe initial intervention to prevent future falls read, Assisted back to bed. The section for whether the care plan/kardex had been updated was blank (incomplete). The section for New interventions after IDT review read, Maintenance to assess bed and mattress .for prior falls to determine unmet need. R85's I/A documentation for a fall on 12/2/24 at 12:07 AM from Nurse 'Y' documented, in part: .Resident had an unwitnessed fall. she was found laying on her left side .Resident is unable to give Description .No injuries observed at time of incident .Oriented to Person .Injury Type .Left antecubital .Left trochanter (hip) .Left shoulder (rear) . The section for statements read, No statements found. The section for Agencies/people notified read, No Notifications found. The section for post fall evaluation read, .1 hour before fall was laying in bed .root cause of this fall .amount of assistance in effect, mood or mental status - describe initial intervention to prevent future falls: assisted back to bed .New interventions after IDT review: neurochecks . The section for the IDT review contained only two signatures, and the section for the date and nurse signature was left blank (incomplete). The section for Agencies/people notified and Statements were blank (incomplete). There was no documentation that the facility, responsible party, or physician had been notified of this fall incident. R85's I/A documentation for a fall on 11/30/24 at 10:52 AM from Nurse 'CC' documented, in part: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Resident observed on L (left) side of bed on the floor with nightstand drawer open .Resident was assessed and placed back into bed .No injuries observed at time of incident . The section for Agencies/people notified only included the DON and Physician. There was no documentation the responsible party had been notified. The section for the Post fall evaluation read, .Date of Fall: 11/30/24 Time of Fall: 3:10 PM .Resident found on ground next to bed . The section for new interventions identified after the IDT review read, concave mattress. R85's I/A documentation for a fall on 11/23/24 at 6:15 PM from Nurse 'DD' documented, in part: .Writer was informed by resident cna at about 5:35 pm that resident was on the floor. Writer went and observed resident lying on her left side on the floor .Resident said she was trying to move around .No injuries observed at time of incident . The section for post fall evaluation after IDT review identified an evaluation for a gerichair. There was no documentation available for review if this had been completed. R85's I/A documentation for a fall on 11/22/24 at 5:49 PM from Nurse 'EE' documented, in part: .resident was witnessed rolling out of bed, on to the floor, hitting head on to side of wall of bed left side . initiate neuro-checks, monitor for change in condition, update care plan . The section for Post fall evaluation - describe initial intervention to prevent future falls documented, assisted back to bed, ensured gripper socks on. The sections for new interventions after IDT review and if the care plan/kardex updated were both left blank (incomplete). The IDT review section contained only two staff signatures (one of which was Nurse 'EE' who completed the report, the other was the DON. R85's I/A documentation for a fall on 9/19/24 at 5:00 PM from Nurse 'FF' documented, in part: .resident was observed laying on her right side on the side on her bed . The section for Agencies/people notified documented the DON and physician were notified. The document further identified they had attempted to contact the resident's responsible party but didn't get an answer. There was no further documentation of any further attempts to notify had been attempted. The section for Post fall evaluation documented for Root cause of this fall .Amount of assistance in effect . The section for staff to describe initial intervention to prevent future falls documented, Assisted back to bed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notting Hill of West Bloomfield	6535 Drake Road West Bloomfield, MI 48322

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The sections for whether the care plan/Kardex had been reviewed or updated and what new intervention after the IDT reviewed were left blank (incomplete). On 1/16/25 at 11:01 AM, an interview was conducted with the Director of Nursing (DON). When asked if the facility had identified any issues with the lack of complete incident/accident reports such as the physician, facility, or responsible party not being notified, or lack of fall investigations and implementing interventions to prevent further falls, the DON reported they had not. At that time, the DON was informed of the concerns with R85's documentation and investigation of multiple falls. The DON was requested to provide any additional documentation as the documents provided for review were incomplete (missing pages and blank pages). The DON reported they may not have been scanned properly and would attempt to rescan for review. When asked if they had identified any concerns in reviewing the incident/accident reports, the DON reported sometimes they felt the nursing documentation needed to be more thorough and upon reviewing the I/As completed by Nurse 'Y' they reported that was a newer nurse and has had a few re-educations about documentation. When asked about the evaluation for the pommel cushion, the DON reported that was done by the therapist and confirmed the assessment had not been completed until 1/9/25. When asked about the conflicting interventions of when that was identified and implemented as the care plans indicated conflicting dates, the DON reported they were not aware of the documentation on the ADL care plan, but indicated they were aware of the intervention added on 12/17/24. When asked about the interventions identified to encourage the resident to call for assistance and whether that was an appropriate intervention for someone that had severe cognitive impairment, the DON reported they felt that was appropriate. On 1/16/25 at 2:25 PM, a follow-up interview was conducted with the DON. Upon reviewing the additional documentation provided of R85's fall occurrences, similar concerns were identified with lack of documentation, incomplete assessments and follow-up, including notification to the facility, physician and responsible party. The DON acknowledged the concerns as well. When asked about who was responsible to initiate and complete the I/A's, the DON reported the Nurse assigned to the resident at the time of the fall was responsible for completing that information, including the sections for post fall interventions. The DON further reported those reports were then reviewed in morning meetings with the IDT. When asked about the lack of multiple IDT members on several of the incident reports and how that was considered IDT review, the DON identified several with only their signature and the nurse that completed the report and was unable to offer any further explanation. According to the facility's policy titled, Fall Management dated 9/22/2023: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.If a fall occurs, the interdisciplinary team conducts an evaluation to ensure appropriate measures are in place to minimize the risk of future falls. The Director of Nursing/designee is responsible for coordination of an interdisciplinary approach to managing the process for prediction, risk evaluation, treatment, evaluation, and monitoring or resident falls .The licensed nurse will complete .Incident/Accident Report in (name of electronic medical record system) .Review and/or revise care plan and link to the resident Kardex .The licensed nurse will notify the attending physician and the responsible party of the fall, and document the notification in the medical record .The IDT will review all resident falls within 24-72 hours at the stand-up/clin-ops meeting to evaluate/investigate the circumstances and probable cause for the fall, review/modify the plan of care to minimize repeat falls and link to the resident's Kardex as needed .

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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** 30675 This citation pertains to intake # MI0048767. Based on interview and record review, the facility failed to complete a comprehensive nutritional assessment and ongoing evaluation per physician order for one (R297) of four residents reviewed for nutrition. Findings include: Review of a complaint filed with the State Agency included allegations that R297 had not received adequate nutritional assessment and monitoring in accordance with hospital recommendations following a gastric sleeve revision surgery with complications. Review of the closed clinical record revealed R297 was admitted into the facility on [DATE] with diagnoses that included: other complications of gastric band procedure, sepsis, unspecified severe protein-calorie malnutrition, morbid (severe) obesity due to excess calories, metabolic encephalopathy, acute respiratory failure with hypoxia, altered mental status, and encounter for surgical aftercare following surgery on the digestive system. The resident was transferred to a local hospital on 12/17/24 at 12:35 PM and has not returned to the facility. On 1/15/25 at 11:51 AM, a request for medical records was made with the local hospital R297 discharged to on 12/17/24. There were no further records provided by the end of the survey. According to the Minimum Data Set (MDS) assessment dated [DATE], R297 had no communication concerns, had intact cognition, weight was 359 pounds, with no weight loss or weight gain, had no parenteral/intravenous feeding on admission, and was on a mechanically altered diet. Review of the care plans included a nutritional care plan that was initiated by the Director of Nursing (DON) on 12/9/24 and a revision date of 1/10/25 by Registered Dietician (RD 'I') that read, Resident is at risk for Nutritional decline r/t (related to): (blank - incomplete). There were no interventions identified that were resident specific to R297's nutritional needs, risks and use of altered diet. Review of R297's physician orders included: Mechanical Soft Diet thin liquids NO STRAWS with a start date of 12/6/24. Regular diet Level 1 Puree texture, Thin consistency with a start date of 12/8/24. Ensure Plus (nutritional supplement) four times a day for Supplement Ensure plus 8 oz QID (four times a day) or any available nutritional supplement, Dietary to provide. Prefers Chocolate with a start date of 12/10/24. Consult to registered dietician STAT (Immediately) for inadequate dietary intake with a start date of 12/10/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's clinical record for nutritional evaluation/documentation by the Registered Dietician (RD) revealed there were no comprehensive nutritional assessments completed, or progress notes available for review in the electronic clinical record. The only nutrition assessment available for review was dated 12/13/24 which identified only the resident's diet history and food preference evaluation. There was no mention of the specific nutritional needs, including protein, or TPN (total parenteral nutrition). Review of the discharge summary upon R297's admission for discharge recommendations included: .Diet instructions: 1. Continue IDDSI level 5/Minced & moist (International Dysphagia Diet Standardisation (sic) Initiative - a mechanically soft diet, not purred (sic)), 6 small meals, with no straws oral diet as tolerated. 2. Encourage oral intake and protein-rich foods. Provide assistance with meals as needed. 3. RD ordered strawberry [name of supplement] oral supplement TID (Three times a day) (provides 100 kcal (kilocalorie) and 21 gm (grams) protein per serving) to help meet nutrition needs orally per patient preference . Review of the physician/extender progress notes revealed conflicting documentation referencing nutritional evaluations and monitoring reviewed as this documentation was NOT available for review in the clinical record and confirmed by the RD during this survey. These progress notes included: An entry on 12/13/24 at 3:27 PM by Nurse Practitioner (NP 'HH') read, .ASSESSMENT/PLAN Risk Malnutrition -continue Mechanical Soft Diet thin liquids -RD eval reviewed, included in plan of care -close monitoring for dietary intake continues . A late entry on 12/15/24 at 9:36 PM by Physician 'GG' for 12/13/24 at 4:35 PM read, The patient's care plan addresses the risk of malnutrition and urinary retention with appropriate monitoring and supportive measures .For the risk of malnutrition, the patient remains on a mechanical soft diet with thin liquids, which they are tolerating well at this time. The registered dietitian's evaluation has been reviewed and incorporated into the plan of care. Close monitoring of dietary intake will continue to ensure the patient maintains adequate nutrition and to identify any potential concerns early . A late entry on 12/17/24 at 11:39 AM by Physician 'GG' for 12/16/24 at 4:39 PM read, .Regarding the risk of malnutrition, the patient will continue on a mechanical soft diet with thin liquids. A registered dietitian (RD) evaluation has been reviewed and included in the plan of care, with ongoing monitoring of dietary intake. The patient is currently tolerating oral intake well, and this will continue to be closely monitored to ensure adequate nutrition . It is unknown what care plan and RD evaluation the physician is referencing as there was none available for review in the clinical record. Physician 'GG' was unable to be reached for an interview by the end of the survey. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 2:40 PM, an interview was conducted with RD 'I'. They reported they were the only RD on staff, was full-time and started at the facility in October 2023. When asked about the lack of nutritional assessments and care planning for R297, RD 'I' confirmed they did not do the evaluation and had been out sick on 12/11/24. When asked who was to provide nutritional monitoring in their absence, RD 'I' reported they were not sure who, but had notified their Regional RD. RD 'I' further reported they had recently identified the nutritional assessment had been initiated on 12/14/24, but not completed. They confirmed the assessment that was completed on 12/13/24 was only a diet history and food preference evaluation. There was no mention of the specific nutritional needs, including protein, or TPN. When asked if they could identify who initiated that assessment, they reported they were not familiar with that name. When asked when a nutrition assessment would be expected to be completed, they reported they had seven days to do the evaluation. When asked if a resident was admitted with significant nutritional needs, would an assessment be completed earlier, RD 'I' reported they had met with the resident but there was no documentation of that. When asked if they were aware of the STAT order for a RD evaluation, they reported they were not. RD 'I' then reported they still intended to complete the nutritional assessment despite the resident not returning to the facility. They further reported they had discussions with the physicians via text on their phone, but they had not completed an actual nutritional assessment/evalution. According to the facility's policy titled, Nutritional Services Documentation dated 9/19/2024: .Each resident will receive a comprehensive nutritional evaluation upon admission .The nutritional evaluation is then used in the development of the resident's individualized care plan to demonstrate the resident's needs, strengths, and priorities .Once the evaluation is complete, a narrative note is written to include . Nutrition and hydration intervention .

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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** 30675 Based on observation, interviews, and record review, the facility failed to consistently ensure sufficient nursing staff was provided for residents who resided in the facility, resulting in verbalized complaints of delayed care and services, lack of supervision of residents with wandering behaviors, and the likelihood for further delayed care and unmet care needs. This deficient practice has the ability to affect all 101 residents in the facility, including resident# (R86). Findings include: According to the facility's policy titled, Nursing Staffing dated 11/4/2024: .Nursing service is provided by number and type of personnel to ensure that each resident .Receives rehabilitative nursing care as needed; Receives proper care to maintain their highest level of functioning (prevent decline in function or poor clinical outcomes); Is kept clean, comfortable, and well-groomed; Is protected from accidents, injury, and infection .Nursing assistants are expected to carry out their daily assignments in a professional manner and in accordance with established nursing procedures The facility will staff to meet the needs of the residents at the facility .Refer inquiries concerns nursing services to the Director of Nursing . Review of the staffing plan documentation referenced in the Facility Assessment included: .Core Staffing & Personnel Audit Consider the overall needs of your resident population based on your Facility Assessment, MDS Resident Population Profile and any additional sources when indicating the number, average, range, or ration needed for day-to-day operations and Emergencies . Page 33 of 48 of the Facility Assessment referenced a Staffing Plan - [facility name] - July 2024.xlsx that had been uploaded on 8/6/2024. Review of this staffing plan documented there would be 16 Licensed Nurses (6 on days, 6 on evenings, and 5 on nights); and there would be 24 Nurse Aides (10 on days, 8 on evenings, and 6 on nights). Review of the daily staff postings titled, REPORT OF NURSING STAFF DIRECTLY RESPONSIBLE FOR PATIENT CARE since January 2025 identified the following concerns with not having either the appropriate number of nurses or nurse aides as identified in the facility's direct care staffing plan. The documentation provided identified: On 1/1/25 census = 93. Day shift - 4 nurses; 9 nurse aides Afternoon shift - 4 nurses; 8 nurse aides Midnight (night) shift - 5 nurses; 6 nurse aides (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/2/25 census = 94. Day shift - 4 nurses; 10 nurse aides Afternoon shift - 4 nurses; 10 nurse aides Midnight shift - 4 nurses; 6 nurse aides On 1/3/25 census = 95. Day shift - 6 nurses; 10 nurse aides Afternoon shift - 6 nurses; 10 nurse aides Midnight shift - 4 nurses; 6 nurse aides There was no documentation provided for 1/4/25 and 1/5/25. On 1/6/25 census = 99. Day shift - 6 nurses; 10 nurse aides Afternoon shift - 6 nurses; 10 nurse aides Midnight shift - 4 nurses; 6 nurse aides On 1/7/25 census = 95. Day shift - 7 nurses; 10 nurse aides Afternoon shift - 6 nurses; 10 nurse aides Midnight shift - 4 nurses; 6 nurse aides On 1/8/25 census = 95. Day shift - 7 nurses; 10 nurse aides Afternoon shift - 6 nurses; 10 nurse aides Midnight shift - 4 nurses; 6 nurse aides On 1/9/25 census = 99. Day shift - 6 nurses; 10 nurse aides Afternoon shift - 6 nurses; 10 nurse aides (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Midnight shift - 4 nurses; 6 nurse aides On 1/10/25 census = 99: Day shift - 7 nurses; 10 nurse aides Afternoon shift - 6 nurses; 10 nurse aides Midnight shift - 4 nurses; 6 nurse aides There was no documentation provided for 1/11/25 or 1/12/25. On 1/13/25 census = 99. Day shift - 7 nurses; 10 nurse aides Afternoon shift - 6 nurses; 10 nurse aides Midnight shift - 4 nurses; 6 nurse aides On 1/14/25 census = 99. Day shift - 7 nurses; 10 nurse aides Afternoon shift - 6 nurses; 10 nurse aides Midnight shift - 4 nurses; 6 nurse aides On 1/15/25 census = 99. Day shift - 7 nurses; 10 nurse aides Afternoon shift - 6 nurses; 10 nurse aides Midnight shift - 4 nurses; 6 nurse aides R86 On 1/14/25 at 10:03 AM, R86 was observed walking in the hallway and a wanderguard bracelet (electronic device that sets off an alarm) was secured to their right ankle. R86 then walked into another male resident's room who yelled out Get outta here, go!. There was no staff observed providing supervision, or to witness the resident going into this room. On 1/15/25 at 8:05 AM, R86 was observed standing at the nursing station holding onto the ledge. The resident was observed with a sad facial expression and repeatedly talking, but speech was intelligible. There were three other residents in the surrounding lounge area but no staff were present. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 8:16 AM, a visiting hospice nurse came near the desk and after briefly saying hello, told the resident they would find their nurse and left the area. There was no other facility staff nearby until 8:19 AM when an activity staff member came over towards the resident, waved, then walked away. A this time, R86 was sobbing, repeatedly talking, and grabbing at their pubic area. Review of the clinical record revealed R86 was admitted into the facility on [DATE] with diagnoses that included: dysthymic disorder, down syndrome, and unspecified intellectual disabilities. According to the Minimum Data Set (MDS) assessment dated [DATE], R86 had clear speech, was sometimes understood and sometimes understands others, had no mood concerns, rejected care and had wandering behaviors which occurred one to three days during this assessment period of seven days. On 1/15/25 at 9:04 AM, an interview was conducted with the Director of Nursing (DON) regarding concern with R86's observations throughout the survey and lack of supervision. When asked if the facility had discussed and/or considered the resident's need for increased supervision due to wandering behaviors and risk of resident-to-resident incidents, especially given the resident's behavior and vulnerability risk, the DON reported they did not and didn't feel the resident needed anything such as a one to one and felt that wouldn't stop the resident from having a outbursts. The DON further reported sometimes families hired one to one or if they had frequent falls or if it was detrimental, but didn't feel that was needed for R86. When informed the concern was not with the resident's outbursts, but with the lack of supervision to potentially redirect the resident away from potential harmful situations such as entering other resident rooms, wandering in/near nursing stations that had unsecured treatment and medication carts and improperly stored biologicals. The DON reported they didn't feel that would help and the facility was working on finding an alternate placement. When asked what was being done in the meantime if they felt the resident's wandering and behaviors were no longer appropriate for this facility, the DON reported staff try to give the resident activities and were normally good at keeping their eyes on her since she normally sits in the dining room or where the tv was. The DON was asked how they staff could adequately supervise on all shifts when they were providing care to other residents, the DON reported activities provided the resident with some items. When asked about what occurred on the other shifts, especially when staffing levels decreased on the night shift, and the DON reported they didn't feel there was a concern with staffing. On 1/16/25 at 7:56 AM and 2:43 PM, the facility was requested to provide documentation of the daily nursing (for Nurse and Nurse Aides) assignments by room for 1/10/25 - 1/13/25 and 1/3/25 - 1/6/25. This was not provided for review by the end of the survey. It should also be noted that the Administrator was not available for the last day of the survey. The DON informed the survey team they were the point of contact for the remainder of the survey. 40330

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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** 22960 Based on interview and record review, the facility failed to ensure appropriate indication for use, ensure non-pharmacologic interventions were attempted and identify behaviors exhibited prior to the administration of as needed (PRN) psychotropic medication (anxiolytic) for one (R85) of six residents reviewed for unnecessary medications. Findings include: Review of the clinical record revealed R85 was admitted into the facility on [DATE] with diagnoses that included: hemiplegia and hemiparesis, generalized anxiety disorder (12/4/24), dysthymic disorder (12/4/24), vascular dementia moderate with mood disturbance, adjustment disorder with mixed anxiety and depressed mood. According to the minimum data set (MDS) assessment dated [DATE], R85 had severe cognitive impairment, had no psychosis, no behaviors, and did not receive any antianxiety medication. Further review of the clinical record revealed R85 was started on Alprazolam (Xanax) oral tablet 0.5 MG (Milligrams) by mouth every 12 hours as needed for agitation on 12/21/24. This order was to discontinue on 1/7/25. Review of the Medication Administration Records (MARs) and electronic medical record (EMR) revealed R85 received the PRN (as needed) Alprazolam on: January 2025 (5 doses) on: 1/1 at 9:18 AM, 1/1 at 9:45 PM; 1/4 at 9:44 AM, 1/5 at 10:00 AM, and 1/7 at 8:41 AM. December 2024 (10 doses) on: 12/21 at 10:54 PM, 12/23 at 1:39 PM, 12/24 at 4:51 PM, 12/25 at 11:04 AM, 12/27 at 9:50 AM, 12/28 at 9:37 AM, 12/29 at 2:49 PM, and 12/31 at 5:07 PM. It should be noted that there was an additional physician order and section of the MAR that directed Nurses to Document non-pharmacological interventions prior to PRN psychotropic med (medication) administration . that had a start date of 12/20/24. These were all left blank (incomplete) for December and January, despite the documented administrations. Additionally, review of the interdisciplinary progress notes revealed no corresponding entries at the time of the PRN anxiolytic administrations. The direct care staff's documentation on the TASK section of the EMR (Electronic Medical Record) identified several behavior(s) of yelling, grabbing, and refusal of care. These entries did not correspond to the times of the PRN administrations. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 2:25 PM, an interview was conducted with the Director of Nursing (DON). When asked about the resident's use of PRN anxiolytic medication, the DON reported the resident was very restless and had frequent falls. Upon review of the documentation of the PRN administrations and lack of documentation, the DON confirmed the nurses should be documenting that on the MAR. When asked if there was any other location they might document, the DON reported that would be the progress notes. When asked why the medication was ordered for agitation and if that was appropriate, the DON confirmed that was not and would have to follow up with the contracted psych provider as they put in the orders. According to the facility's policy titled, Psychoactive Medication Management dated 8/30/2024: .Non-pharmacologic interventions are the first choice in management of behavioral symptoms .When pharmacological interventions are indicated, the licensed staff will verify that the physician order includes the appropriate clinically supported diagnosis and/or behavior symptom .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on observation, interview, and record review, the facility failed to ensure appropriate medication storage and labeling for medications and biologicals in one of six medication carts and one of one treatment cart. This deficient practice has the potential to affect multiple residents throughout the facility, including R70. Findings include: On 1/15/25 at 8:54 AM, Observation of the first-floor central shower room revealed one pink colored oblong sized pill lying on the floor bordering the back corner next to the tub. Licensed Practical Nurse (LPN) C was asked to retrieve and while picking up with their bare hand, said oh that's an omeprazole When inquired how medication is found in the central shower area, LPN C replied that it must have fallen off the medication cart and rolled into the common shower area. On 1/15/25 at 10:15 AM, One small round white pill was lying in common hallway in front of room [ROOM NUMBER]. LPN F commented that should not be there and was observed picking up the pill off the floor with their bare hand. On 1/15/25 at 10:18 AM, an observation of two intact blue and gray colored capsules were observed lying in common hallway in front of room [ROOM NUMBER]. LPN E remarked the capsules did not contain medication and must have missed the trash bin. On 1/15/25 at 10:26 AM, A light pink colored semi-formed pill like object with crushed powdered substance was observed in common hallway in front of the first-floor common dining area. The Assistant Director of Nursing (ADON) B approached as the observation was being documented, and said it was not medication, must be candy, and proceeded to pick up the pill with their bare hand. On 1/15/25 at 10:30 AM, The Director of Nursing and Nursing Home Administrator were made aware of the above observations and comments by nursing and acknowledged medications should not be found on the floor. 30675 R70 On 1/14/25 at 10:28 AM, R70 was observed laying in bed. At that time, the resident reported they didn't speak much English and proceeded to attempt to call family members without any response. During this observation of the resident, there was a blue bottle of eye drops observed on the resident's overbed tray table. When asked about the contents on the table, R70 stated they didn't speak English. On 1/15/25 at 8:07 AM, the eye drop container remained in the same place as observed on 1/14/25. Review of the clinical record revealed R70 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: biliary acute pancreatitis without necrosis or infection, urinary tract infection legal blindness, dementia and schizoaffective disorder. (continued on next page)

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	235663	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Minimum Data Set (MDS) assessment dated [DATE], R70 had severe cognitive impairment. Further review of a Self Administration of Medication Assessment - V2 evaluation dated 5/25/23 documented, .Resident has order for eye drops for every hour. Resident would not return demostrate <sic> putting in eye drops, just kapt <sic> saying no see, no see. Resident was able to open bottle and understood what the eye drops were for, how many drops and how often. At this time resident is not able to self administer medication due to refusal. There were no further assessments that indicated R70 could have eye drops at bedside. On 1/15/25 at 9:05 AM, an interview was conducted with the Director of Nursing (DON). When asked about the observation of eye drops at R70's bedside, the DON reported they had previously discussed the eye drops in the past and reported family brought in a lot of stuff. The DON reported they would review the clinical record to see if they were able to self-administer and confirmed the same assessment from 5/25/23 which indicated they were not. When asked if other staff had observed that at bedside, why wasn't that identified, the DON was unable to offer any further explanation. On 1/15/25 at 10:02 AM, the DON was observed retrieving the container of eye drops from R70 and reported those should not be kept at bedside and was able to remove from the resident's bedside. The DON further reported they would have to contact the family to let them know not to bring in anymore. 2nd Floor Nursing Station: On 1/15/25 at 8:49 AM, observation of the 2nd floor nursing station - no staff observed with residents walking around/by - was observed to have 25 boxes of COVID-19 Rapid Tests stored on an open shelf area near the shred bin which was not locked/secured. On 1/16/25 8:16 AM, observation of the 2nd floor nursing station revealed an unlocked medication cart and treatment cart. There was no nurse in the vicinity. The Infection Control Nurse (Nurse 'A') was observed coming out of the med room and when asked about the unlocked medication and treatment carts, they confirmed the carts were unlocked and reported they weren't assigned and wasn't sure who was. Nurse 'A' then pointed out Nurse 'N' who was approaching the nursing desk and stated that was the nurse assigned to the medication cart. Nurse 'N' was asked about the unlocked medication cart and they reported they weren't sure how it was opened because they had counted off with the previous nurse and had locked it. They were then asked about the unlocked treatment cart and they reported they didn't know about that. On 1/16/25 at 8:26 AM, the DON was informed of the observations of the unlocked medication and treatment carts and reported that should not have occurred and had been informed by Nurse 'A'. According to the facility's policy titled, Storage and Expiration Dating of Medications and Biologicals dated 8/1/2024: .Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors .

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review the facility failed to obtain and/or coordinate timely radiology services for an X-Ray for one (R63) of one resident reviewed for radiology/other diagnostic services, resulting in the potential for delayed identification of any abnormalities which may require additional medical/treatment intervention. Findings include: Review of the resident's incident/accident reports provided by the facility for the past three months included a fall incident from 1/11/25 which documented R63 was .lying on the side of the bed on left side . Review of the physician orders following this fall incident included an order for the facility to obtain an X-Ray of R63's Left Shoulder. As of this review on 1/15/25, there was no radiology report available in the electronic medical record. Additional review of the radiology log at the nursing station revealed the most recent entry was on 1/11/25 for another resident and R63's request had not been completed despite the order from 1/13/25. Review of a physician progress note on 1/13/25 at 6:10 PM documented, .Date of Consultation: 1/13/2025, Reason for consultation: Fall on 1/11/2025 .PM&R (Physical Medicine and Rehabilitation) is requested to see patient today in regards to a recent fall that occurred on 1/11/2025 .patient was found in her room on the floor lying on her left side. No injuries noted .She complains of pain to L (Left) shoulder. Difficult to assess the quality of pain, but states it is terrible. On examination, facial grimacing is noted on palpation to anterior shoulder .Limitations with passive ROM (Range of Motion) .Assessment/Plan: #Fall with L shoulder pain . Obtain L shoulder XR (X-Ray) out of abundance of caution . On 1/14/25 at 2:48 PM, R63 was observed laying in bed and agreed to an interview. When asked about their fall from 1/11/25, they reported they weren't sure how it happened. When asked if they had received an x-ray since the fall, R63 reported No. When asked on a scale of zero to ten, with zero being no pain and ten being the worst, how would they rate their left shoulder pain currently, R63 reported Seven. Further review of the clinical record revealed R63 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: idiopathic normal pressure hydrocephalus, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, neurologic neglect syndrome, and cerebral aneurysm nonruptured. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R63 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated just on the side of moderate impairment (13-15 was intact cognition), had impairment on upper and lower extremity on one side, received scheduled pain medication regimen, reported occasional pain over the last 5 days, and occasional limited day-to-day activities in the past 5 days because of pain. Numeric Rating Scale for pain was noted as 02 for the worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine; no falls since prior assessment. On 1/15/25 at 9:05 AM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for obtaining x-rays and when those would be expected to be completed, the DON reported x-rays would usually take about 24 hours depending on the status of x-ray company. The DON reported they would look to see if they had been completed and further reported if it wasn't ordered STAT, it should be within 24 hours. On 1/16/25 at 9:16 AM, review of the documentation provided by the facility revealed the x-ray for R63's left shoulder and left wrist was not completed until 1/15/25 (after it was identified as a concern during the survey). There was no further follow-up by the DON and at 5:11 PM, the DON reported there was no facility policy addressing x-rays.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 1/14/25 between 9:00 AM-9:30 AM, during an initial tour of the kitchen with Dietary Manager (DM) Q, the following items were observed: In the walk-in cooler, there was an undated container of salad, an opened undated bag of diced chicken, and an opened, undated bag of polish sausage. DM Q confirmed the items should have been dated. According to the 2017 FDA Food Code section 3-501.17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. In the dry storage room, there were scoops and Styrofoam bowls stored inside bins, with handles resting in the sugar, thickener and corn starch. DM Q confirmed the scoops and Styrofoam bowls should not be stored inside the bins. According to the Food & Drug administration (FDA) 2017 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (A) Except as specified under (B) of this section, in the FOOD with their handles above the top of the FOOD and the container; (B) In FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD with their handles above the top of the FOOD within containers or EQUIPMENT that can be closed, such as bins of sugar, flour, or cinnamon;. There was a shelving unit next to oven, with storage of clean pots, with a heavy accumulation of grease and food debris on the shelves. DM Q Stated staff usually do a thorough cleaning on Saturday or Sunday. According to the Food & Drug administration (FDA) 2017 Model Food Code, Section 4-602.13 Nonfood-Contact Surface, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 48680

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review, the facility failed to ensure effective infection control practices (hand hygiene) during medication pass and implementation of Enhanced Barrier Precautions (EBP) for one (R60) of one resident reviewed for a urinary catheter, resulting in the potential for cross-contamination and the development and spread of infection and disease. Findings include: R60 On 1/14/25 at 10:15 AM and 1/15/25 at 7:58 AM, R60 was observed in bed with a urinary catheter drainage bag observed secured to the side of the bed. At each of these observations, there was no signage posted to indicate the resident was on any precautions such as Enhanced Barrier Precautions (EBP) and there was no Personal Protective Equipment (PPE) available for use. On 1/14/25 at 12:57 PM, the Certified Nurse Aide (CNA 'O') who was assigned to R60 was observed holding a bag of linens just inside the resident's room. When asked about whether they were aware of R60 being on any infection control precautions such as EBP, CNA 'O' reported they were not aware of any, but then stated they might be due to the catheter but were not aware of any and confirmed there was no signage or PPE available. CNA 'O' did confirm there were several other residents in the hallway and indicated those rooms had the PPE carts. Review of the clinical record revealed R60 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: neuromuscular dysfunction of bladder. According to the Minimum Data Set (MDS) assessment dated [DATE], the resident had severe cognitive impairment, was always incontinent of bowel and bladder, and did not have a urinary catheter at the time of this assessment. Review of the resident's physician orders included orders for an indwelling urinary catheter, including EBP due to resident's use of a urinary catheter. On 1/14/25 at 1:07 PM, Nurse 'P' was observed placing an EBP sign on the resident's door. When asked about why they were just now putting the signage on the door, Nurse 'P' reported the resident had a foley catheter and needed to be on EBP. This was not implemented until after it was identified as a concern during the survey. On 1/14/25 1:24 PM, an unidentified staff was observed placing a PPE cart outside R60's room. According to the facility's policy titled, Enhanced Barrier Precautions (EBP) dated 4/2/2024: .Enhanced Barrier Precautions are indicated for residents with any of the following .a wound or indwelling medical devices .indwelling medical devices include .urinary catheters . 48680 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25 at 8:30 AM, a medication pass was conducted with Nurse FF. All medications were pulled, and a nurse entered the room, knocked on the door, introduced themselves, and did the five rights to medication administration. Medications were given to the resident. Upon completing the medication pass, Nurse FF was asked if they had completed the administration, and they replied yes. After observing the medication pass, no hand hygiene was performed before or after administering the medications. On 1/15/25 at 8:43 AM Nurse F a medication pass was conducted with Nurse F. All medications were pulled, and a nurse entered the room, knocked on the door, introduced themselves, and did the five rights to medication administration. Medications were given to the resident. Upon completing the medication pass, Nurse F was asked if they had completed the administration, and they replied yes. After observing the medication pass, no hand hygiene was performed before or after administering the medications. On 1/15/25 at 9:00 AM Nurse M a medication pass was conducted with Nurse M. All medications were pulled, and a nurse entered the room, knocked on the door, introduced themselves, and did the five rights to medication administration. Medications were given to the resident. After observing the medication pass, no hand hygiene was performed before or after administering the medications. On 1/15/25 at 9:23 AM Nurse E a medication pass was conducted with Nurse E. All medications were pulled, and a nurse entered the room, knocked on the door, introduced themselves, and did the five rights to medication administration. Medications were given to the resident. Upon completing the medication pass, Nurse E was asked if they had completed the administration, and they replied yes. After observing the medication pass, no hand hygiene was performed before or after administering medications. On 9/15/25 at 1:32 PM, the Director of Nursing (DON) was interviewed and asked if it is expected that hand hygiene is performed when administering medications, the DON stated, Yes, hand hygiene should be performed before and after each resident. There was no additional information provided at the exit of the survey.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on interview and record review, the facility failed to ensure pursuing and administration of the pneumococcal and influenza vaccine for one resident (R3) of five reviewed for immunizations. Findings include: Clinical record review revealed R3 was admitted to the facility on [DATE] with a medical history of influenza, pneumonia, heart failure, osteoarthritis, and gastrointestinal hemorrhage. R3's primary language is Arabic/Chaldean and translation was provided by family, specifically their daughter. A Brief Interview of Mental Status (BIMS) assessed on 11/14/24 scored 15/15 indicating R3 was cognitively intact. On 1/16/25, a clinical record revealed R3 consented on 11/16/24 (via their daughter who is their translator) to receive the influenza and pneumonia vaccinations. Review of the Electronic Medical Record (EMR) revealed no documentation that R3 received the elected vaccinations. On 1/16/25 at 9:49 AM, an interview was conducted with the facility Infection Control Preventionist (ICP) A. During record review, ICP A recalled R3 did not receive the vaccines and the orders to administer were discontinued on 11/25/24 by the physician. ICP A was unable to locate documentation of the physician's rationale of discontinuing, and confirmed no follow up with R3 or the daughter was provided. On 1/16/25 at 11:51 AM, A Phone interview with R3's daughter revealed the daughter had recalled consenting for the vaccines and replied, They (R3) got them. When questioned if the facility contacted them that the vaccines were discontinued and not administered, the daughter responded No and was under assumption R3 had received the vaccines. On 1/16/25 at 1:30 PM, ICP A acknowledged the the vaccines were not administered after consenting and the resident and daughter were not informed why the elected vaccines were not administered.