STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235700	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Willows at East Lansing	3500 Coolidge Road East Lansing, MI 48823

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to provide written notice of transfer for two (Resident #19 and Resident #37) of two reviewed. Findings include: Resident #19 (R19) Review of the medical record revealed R19 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, anxiety, and diabetes. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/9/24 revealed R19 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R19 was their own responsible party/decision maker. Review of R19's history revealed they were transferred to the hospital on 7/4/24 and returned on 7/5/24, transferred to the hospital on 9/29/24 and returned on 9/30/24, and most recently transferred to the hospital on 10/10/24. R19 had not yet returned to the facility. Review of the medical record revealed no indication that R19 received a written notice of transfer upon transfer to the hospital. In an interview on 10/16/24 at 9:22 AM, Social Worker (SW) E reported they were present when R19 transferred to the hospital on 10/10/24. SW E reported the only paperwork they provided was the petition to psychiatric services. In an interview on 10/16/24 at 10:58 AM, Registered Nurse (RN) G reported they were assigned to care for R19 on 10/10/24. RN G reported the only paperwork that was provided to R19 was the Continuity of Care Document (CCD), face sheet, and code status. RN G was not aware of a written transfer notice. RN G reported if any additional paperwork was completed, Assistant Director of Nursing (ADON) C would have done that. In an interview on 10/16/24 at 11:13 AM, ADON C reported the only paperwork provided to R19 upon transfer to the hospital was the CCD, face sheet, and the petition to psychiatric services. Clinical Support (CS) I was also present during the interview. CS I and ADON C were unable to provide a written notice of transfer. (continued on next page)

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

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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	An email received from Nursing Home Administrator (NHA) A on 10/16/24 at 11:26 AM, revealed The transfer notice can be found in [electronic medical record system] under observations and/or via progress notes. Written transfer notices were not found under observations or progress notes. In an interview on 10/17/24 at 09:16 AM, Director of Nursing (DON) B and CS I reported they were unable to find documentation that R19 was provided with a written notice of transfer for each of the three hospital transfers. 49103 Resident 37 (R37) Review of the medical record revealed R37 was last admitted [DATE]. R37 had been readmitted after a hospitalization beginning on 6/11/24 with a diagnosis of Urosepsis (a life-threating complication of urinary tract infection). R37 had previously been readmitted [DATE] after a hospitalization with a diagnosis of Sepsis. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/10/24 revealed R37 scored 09 out of 15 (indicating moderate cognitive impariment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R37 was their own responsible party/decision maker. Record review further revealed no indication that R37 received a written notice of transfer upon transfer to the hospital. On 10/16/24 a request to the Nursing Home Administrator (NHA) A for the written notice of transfer was made. A notice for a hospitalization in May was submitted, but none for June. 10/17/24 at 10:40 AM the Clinical Support Nurse T and Director of Nursing (DON) B were interviewed concerning the lack of paperwork (transfer notice) for the hospitalization s in June. Clinical Support I explained that around that time (June 2024) some process changes had been going on and administration was trying to sort through and find out what happened. On 10/17/24 no further documents were submitted prior to the survey exit.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to provide written notice of bed hold policy for two (Resident #19 and Resident #37) of two reviewed. Findings include: Resident #19 (R19) Review of the medical record revealed R19 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, anxiety, and diabetes. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/9/24 revealed R19 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R19 was their own responsible party/decision maker. Review of R19's history revealed they were transferred to the hospital on 7/4/24 and returned on 7/5/24, transferred to the hospital on 9/29/24 and returned on 9/30/24, and most recently transferred to the hospital on 10/10/24. R19 had not yet returned to the facility. Review of the medical record revealed no indication that R19 received a written notice of the bed hold policy upon transfer to the hospital. In an interview on 10/16/24 at 9:22 AM, Social Worker (SW) E reported they were present when R19 transferred to the hospital on 10/10/24. SW E reported the only paperwork they provided was the petition to psychiatric services. In an interview on 10/16/24 at 10:58 AM, Registered Nurse (RN) G reported they were assigned to care for R19 on 10/10/24. RN G reported the only paperwork that was provided to R19 was the Continuity of Care Document (CCD), face sheet, and code status. RN G was not aware of a written bed hold policy notice. RN G reported if any additional paperwork was completed, Assistant Director of Nursing (ADON) C would have done that. In an interview on 10/16/24 at 11:13 AM, ADON C reported the only paperwork provided to R19 upon transfer to the hospital was the CCD, face sheet, and the petition to psychiatric services. Clinical Support (CS) I was also present during the interview. CS I and ADON C were unable to provide a written notice of bed hold policy. An email received from Nursing Home Administrator (NHA) A on 10/16/24 at 11:26 AM, revealed Residents are provided the bed hold policy upon admission. In an interview on 10/17/24 at 09:16 AM, Director of Nursing (DON) B and CS I reported they were unable to find documentation that R19 was provided with a written notice of bed hold policy for each of the three hospital transfers. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	49103 Resident 37 (R37) Review of the medical record revealed R37 was last admitted [DATE]. R37 had been readmitted after a hospitalization beginning on 6/11/24 with a diagnosis of Urosepsis (a life-threating complication of urinary tract infection). R37 had previously been readmitted [DATE] after a hospitalization for a diagnosis of Sepsis. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/10/24 revealed R37 scored 09 out of 15 (indicating moderate cognitive impariment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R37 was their own responsible party/decision maker. Record review revealed no indication that R37 received a written notice of the bed hold policy upon either transfer to the hospital. On 10/16/24 a request to the Nursing Home Administrator (NHA) A for the written notice of bed hold policy was made. A notice for a hospitalization in May was submitted, but none for June. 10/17/24 at 10:40 AM the Clinical Support Nurse T and Director of Nursing (DON) B were interviewed concerning the lack of paperwork (bed hold policy notification) for the hospitalization s in June. Clinical Support I explained that around that time (June 2024) some process changes had been going on and administration was trying to sort through and find out what happened. On 10/17/24 no further documents were submitted prior to the survey exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review, the facility failed to develop and implement comprehensive Care Plans for one (Resident #5) of 15 reviewed for Care Plans, resulting in the potential for unmet care needs. Findings include: Resident #5 (R5) Review of the medical record reflected R5 was admitted to the facility on [DATE] with diagnosis which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and dysthymic disorder (persistent depressive disorder). The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/03/2024, reflected R5's Brief Interview for Mental Status (BIMS) was coded as a 12, indicating moderate cognitive impairment. On 10/15/24 at approximately 9:15 AM, R5 was observed in her room, going through her dresser drawers. R5 expressed frustration with not being able to locate a clothing item and stated that she gets very frustrated with the facility for keeping her here and with people removing her personal property. R5's roommate, who declined to be interviewed, only wanted to share that she had concerns for R5's wellbeing related to an increase in aggressive behaviors. Review of R5's Physician Order revealed an active order dated 6/26/24 for Escitalopram (Lexapro-an antidepressant) 10 mg (milligrams) once daily. Review of a Progress Note dated 8/08/2024 at 12:40 PM stated R5 was being followed by the Interdisciplinary Team for the use of the psychotropic medication. The same Progress Note stated Nursing will monitor resident q [every] shift for adverse effects r/t [related to] medication use and for behaviors. Plan of care is appropriate and up to date . Review of a Progress Note dated 9/08/2024 at 11:03 AM stated Resident [R5] woke up this morning in an extremely agitated state; staff ensured all needs were met and resident remained agitated. Resident tried leaving the building twice this morning and staff was able to redirect her . A Progress Note dated 9/13/2024 at 9:35 PM At about 1945 (7:45 PM) resident noted carrying one of her blanket, her and her dogs pictures, and a book walking out of her room stating that she has gotten all of her belongings she needed and she is going home. Redirection not effective. Her [family member] was in the building trying to redirect resident and not effective. She became very agitated with [family member]. Resident walked towards the front entrance wanting to leave .Multiple staff members approached resident to have her go to her room and not effective . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note dated 10/10/2024 at 10:39 PM revealed Resident wanted to shut the door and her roommate wanted door open, because it causes her Claustrophobia. resident [R5] became agitated and pull [sic] a chair in front of the door and stared at her resident [sic]. This nurse asked resident if she could move to her chair. Resident stated that I pay enough money to sit where ever I want. Resident remained in chair for approximately 15 minutes, until activities staff help redirect resident and she returned to her recliner . Documentation of a Social Services follow-up could not be located in the electronic medical record (EMR). In an interview on 10/16/24 at 2:04 PM, Licensed Practical Nurse (LPN) K stated that she was working on the day R5 had a disagreement with her roommate regarding the room door. According to LPN K, R5 closed the door to their shared room, but the roommate requested it remain open due to her claustrophobia. R5 became angry, dragged her roommate's chair in front of the door, and stared at her. LPN K made several attempts to redirect R5, but none were successful and only seemed to aggravate R5 further. Eventually, another staff member was able to calm R5. LPN K also mentioned that prior to this incident, R5 had thrown her roommate's shoes in the trash out of anger and during a separate incident, had to have a roommate change back in September due to a conflict with her former roommate. LPN K noted that while R5 typically displays sundown behaviors (the term sundowning refers to a state of confusion that occurs in the late afternoon and lasts into the night. Sundowning can cause various behaviors, such as confusion, anxiety, aggression or ignoring directions. Sundowning also can lead to pacing or wandering), these behaviors had been increasing in frequency over the past few months and R5 was becoming more aggressive. She added that there are no interventions listed to guide staff on how to assist and/or redirect R5 with her aggression. LPN K stated that resident behaviors are documented under the Progress Note's in the EMR. LPN K stated that the Interdisciplinary Team will review the Progress Note's and discuss the behavior concerns in morning meeting. In an interview on 10/16/24 at 3:56 PM, Certified Nursing Assistant (CNA) L stated that she was familiar with R5. CNA L stated that R5 had sundowning behaviors that were more frequent and increasingly aggressive. CNA L stated that she has observed the aggressiveness and that R5 is difficult to redirect. CNA L verified that R5 had to be relocated to a different room last month due to an argument between R5 and her previous roommate. CNA L was unsure of any behavior interventions that were in place for R5. CNA L stated that behaviors are documented under the task section in the EMR. Review of a Physician Order revealed the following active order initiated on 9/18/24 which stated .target behavior-Depression (sadness, tearfulness, and withdrawn). At the end of each shift mark frequent-how often behavior occurred and intensity) . No Physician Order for monitoring any other behaviors and/or behavior related to the increased nighttime delirium were located in the EMR. Review of R5's Care Plan revealed no Care Plan for R5's behavior of increased confusion at night with the potential for aggression and no Care Plan for depression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/17/24 at 9:45 AM, Social Worker (SW) E and SW F explained that when a resident exhibits behaviors, a Physician Order for behavior tracking is implemented, and a referral for psychiatric services is made if necessary. Social Work discusses these behaviors during interdisciplinary team meetings to develop a Care Plan with individualized interventions. Regarding the recent incident between R5 and her roommate on 10/10/24, SW E and SW F mentioned they were both informed about it only yesterday. SW E and SW F are currently following up on the matter, which includes creating a Care Plan for R5 that specifically addresses the behaviors and provides interventions to assist staff in managing them. Both SW E and SW K acknowledged that they should have been notified about the 10/10/24 incident immediately after it occurred to provide appropriate follow-up and develop a timely Care Plan for R5.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on observation, interview and record review the facility failed to update a care plan to include detailed person centered needs for one resident (#35) of 15 residents reviewed for care planning. Findings include: Review of the clinical record reflected Resident # 35 (R35) was admitted to the facility on [DATE], Review of the Minimum Data Set (MDS) dated [DATE] reflected a Brief Interview Status Score of (7) severe indicating severe cognitive impairment. The MDS also reflected R35 had a history of falls. On 10/15/24 at 9:30 am, R35 was observed sitting in their room up in a wheel chair, R35 was observed to have a golf ball size abrasion to the top left side of the forehead. R35's family member D was present and reported R35 has had a few falls since admission and aside from the abrasion on the head, R35's left knee also sustained an abrasion. Family member D reported all of R35 falls were from the bed. One floor mat was observed in R35's room. On 10/15/24 at 02:50 pm, R35 was observed resting in bed, a floor mat was observed on left side of bed, family member D in room sitting in chair on left side , R35's bed was observed approximately knee height. Record review reflected R35 fell on [DATE] sustained an abrasion above the left eyebrow, left cheek and temple, left knee abrasion. An unwitnessed fall was documented to have occurred on 09/20/24 at approximately 11:30 pm, R35 sustained a right knee abrasion 1.5 centimeter by 1.5 centimeter. R35's third fall was documented as an unwitnessed fall that occurred on 10/08/2024, the incident and accident report revealed R35 rolled out of bed hit his head and was transferred to the emergency department for further evaluation. Review of R35's fall care plan dated 09/16/24 reflected R35 was at risk for falls and the intervention Fall mat to floor was added on 9/24/24. The care plan was not individualized and did not specify if the floor mat should be placed on the left side or the right side of R35's bed. On 10/16/24 11:42 am, during an interview with Director of Nursing (DON) B, R35's falls and interventions were reviewed. R35's care plan was reviewed with DON B acknowledged R35's fall care plan was not updated to R35's specific need of which side of the bed the floor mat was to be placed. On 10/16/24 at 12:01 pm, during an interview with Certified Nursing Assistant (CNA) H, she reported care was driven by the care plan, CNA H when queried how she knew where/what side of the bed to place a floor mat for a resident she said you have to look at the care plan. When CNA H was queried if the care plan read Fall mat to floor , CNA H stated she wouldn't know where to place the mat, and hoped it was mentioned in report or you would have to guess.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on observation, interview and record review the facility failed to provide a meaningful, diverse and engaging activity program for one resident (#41) of one reviewed for activities. Findings include: Review of the clinical record reflected Resident # 41 (R41) was admitted to the facility on [DATE] with diagnosis that included neurocognitive disorder with Lewy body. Review of the Minimum Data Set (MDS) dated [DATE] reflected R41 scored 00 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). Review of R41's activity assessment dated [DATE] reflected R41 enjoyed pet visits, being read to and easy listening music, and family visits. Review of R41's activity care plan dated 8/28/24 revealed R41 enjoyed pet therapy, (which the facility does not offer), catholic services, going outside, bingo, socials and happy hour, easy listening and bluegrass music. Review of the October Calendar revealed catholic services, bingo, bible study, reading groups and socials. Review of R41's activity participation record for October reflected R41 attended 2 sensory activities and one lunch time trivia. Septembers activity participation record reflected 4 activities (no dates) trivia, 1:1, and 2 group readings. The month of August reflected R41 had participated in 2 activities which were 2 episodes of watching television. On 10/15/24 at 10:06 AM, R41 was observed sitting in 100 hall activity/TV area, R41 was sitting, MTV playing on the television but R41 was not watching it. On 10/15/24 at 02:53 PM R41 was observed sitting in front of the television on the 100 hall activity/TV area, R41 was sitting, MTV playing on the television but R41 was not watching it. The volume on the television was low and not audible over the noise of the nearby fish tank motor and alarms sounding on hall. On 10/16/24 at 09:20 AM, R41 was brought into the 100 hall activity/TV area, R41 was instructed by unknown staff to sit on the couch, located in front of the television where MTV was playing a reality show. At 936 AM R41 was observed looking around the room, 2 other unidentified residents were present, sitting in reclining wheel chairs, one whom was asleep the other staring at the ceiling. At 9:47 am an unidentified Certified Nursing Assistant took R41 back to her room without explanation. On 10/16/24 at 11:22 AM R41 was observed in the 100 hall activity/ TV area sitting in a wheelchair in front of the television, head down looking at the floor. MTV playing on the television. The same 2 peers from the 9:20 am observation were present and also not watching MTV. R41 was again observed on 10/16/24 at 12:05 PM and again at 3:01 PM, sitting in front of the television with MTV on. On 10/17/24 at 9:28 am R41 was observed in the 100 hall activity/ TV area sitting in a wheelchair in front of the television, R41's head was down looking at the floor. MTV playing on the television. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 9:30 am during an interview with Nursing Home Administrator (NHA) A and Clinical Support Life Enrichment J R41's activity assessment and activity care plan was reviewed. NHA A reported the facility no longer offers pet therapy with the exclusion of some hospice residents receiving pet therapy (R41 is not a hospice resident). NHA A reported the facility has books, and music programs, socials etc . but did not offer any explanation as to why R41 was not invited or encouraged to attend, as there is no documentation that R41 had refused any invitations to group activities.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review the facility failed to ensure one out of one resident (Residents #5) received the necessary behavioral health care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being, resulting in the potential for unmet emotional and/or mental well-being care needs. Resident #5 (R5) Review of the medical record reflected R5 was admitted to the facility on [DATE] with diagnosis which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and dysthymic disorder (persistent depressive disorder). The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/03/2024, reflected R5's Brief Interview for Mental Status (BIMS) was coded as a 12, indicating moderate cognitive impairment. On 10/15/24 at approximately 9:15 AM, R5 was observed in her room, going through her dresser drawers. R5 expressed frustration with not being able to locate a clothing item and stated that she gets very frustrated with the facility for keeping her here and with people removing her personal property. R5's roommate, who declined to be interviewed, only wanted to share that she had concerns for R5's wellbeing related to an increase in aggressive behaviors. Review of R5's Physician Order revealed an active order dated 6/26/24 for Escitalopram (Lexapro-an antidepressant) 10 mg (milligrams) once daily. Review of a Progress Note dated 8/08/2024 at 12:40 PM stated R5 was being followed by the Interdisciplinary Team for the use of the psychotropic medication. The same Progress Note stated Nursing will monitor resident q [every] shift for adverse effects r/t [related to] medication use and for behaviors. Plan of care is appropriate and up to date . Review of a Progress Note dated 9/08/2024 at 11:03 AM stated Resident [R5] woke up this morning in an extremely agitated state; staff ensured all needs were met and resident remained agitated. Resident tried leaving the building twice this morning and staff was able to redirect her . A Progress Note dated 9/13/2024 at 9:35 PM At about 1945 (7:45 PM) resident noted carrying one of her blanket, her and her dogs pictures, and a book walking out of her room stating that she has gotten all of her belongings she needed and she is going home. Redirection not effective. Her [family member] was in the building trying to redirect resident and not effective. She became very agitated with [family member]. Resident walked towards the front entrance wanting to leave .Multiple staff members approached resident to have her go to her room and not effective . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note dated 10/10/2024 at 10:39 PM revealed Resident wanted to shut the door and her roommate wanted door open, because it causes her Claustrophobia. resident [R5] became agitated and pull [sic] a chair in front of the door and stared at her resident [sic]. This nurse asked resident if she could move to her chair. Resident stated that I pay enough money to sit where ever I want. Resident remained in chair for approximately 15 minutes, until activities staff help redirect resident and she returned to her recliner . Documentation of a Social Services follow-up could not be located in the electronic medical record (EMR). In an interview on 10/16/24 at 2:04 PM, Licensed Practical Nurse (LPN) K stated that she was working on the day R5 had a disagreement with her roommate regarding the room door. According to LPN K, R5 closed the door to their shared room, but the roommate requested it remain open due to her claustrophobia. R5 became angry, dragged her roommate's chair in front of the door, and stared at her. LPN K made several attempts to redirect R5, but none were successful and only seemed to aggravate R5 further. Eventually, another staff member was able to calm R5. LPN K also mentioned that prior to this incident, R5 had thrown her roommate's shoes in the trash out of anger and during a separate incident, had to have a roommate change back in September due to a conflict with her former roommate. LPN K noted that while R5 typically displays sundown behaviors (the term sundowning refers to a state of confusion that occurs in the late afternoon and lasts into the night. Sundowning can cause various behaviors, such as confusion, anxiety, aggression or ignoring directions. Sundowning also can lead to pacing or wandering), these behaviors had been increasing in frequency over the past few months and R5 was becoming more aggressive. She added that there are no interventions listed to guide staff on how to assist and/or redirect R5 with her aggression. LPN K stated that resident behaviors are documented under the Progress Note's in the EMR. LPN K stated that the Interdisciplinary Team will review the Progress Note's and discuss the behavior concerns in morning meeting. In an interview on 10/16/24 at 3:56 PM, Certified Nursing Assistant (CNA) L stated that she was familiar with R5. CNA L stated that R5 had sundowning behaviors that were more frequent and increasingly aggressive. CNA L stated that she has observed the aggressiveness and that R5 is difficult to redirect. CNA L verified that R5 had to be relocated to a different room last month due to an argument between R5 and her previous roommate. CNA L was unsure of any behavior interventions that were in place for R5. CNA L stated that behaviors are documented under the task section in the EMR. Review of a Physician Order revealed the following active order initiated on 9/18/24 which stated .target behavior-Depression (sadness, tearfulness, and withdrawn). At the end of each shift mark frequent-how often behavior occurred and intensity) . No Physician Order for monitoring any other behaviors and/or behavior related to the increased nighttime delirium were located in the EMR. No Progress Notes or Social Work Assessments could be located in the EMR regarding the recent incident with the roommate or the increase in nighttime agitation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235700	A. Building B. Wing	10/17/2024

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/17/24 at 9:45 AM, Social Worker (SW) E and SW F explained that when a resident exhibits behaviors, a Physician Order for behavior tracking is implemented, and a referral for psychiatric services is made if necessary. Social Work discusses these behaviors during Interdisciplinary Team meetings to develop a Care Plan with individualized interventions. Regarding the recent incident between R5 and her roommate on 10/10/24, SW E and SW F mentioned they were both informed about it only yesterday. SW E and SW F are currently following up on the matter, which included conducting psychosocial well-being visits with R5 and the roommate. Both SW E and SW K acknowledged that they should have been notified about the 10/10/24 incident immediately after it occurred to provide appropriate follow-up.

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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** 32064 Based on observation, interview, and record review, the facility failed to justify the increase in an antipsychotic medication for one (Resident #18) of five reviewed. Findings include: Review of the medical record revealed Resident #18 (R18) was admitted to the facility on [DATE] with diagnoses that included anxiety, major depressive disorder, and vascular dementia with psychotic disturbance. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/16/24 revealed R18 scored 2 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and had no behaviors, hallucinations, or delusions during the look back period. On 10/16/24 at 7:33 AM, R18 was observed asleep in bed. On 10/16/24 at 9:17 AM, R18 was observed sitting in the dining room, drinking tea. Review of the Physician's Order dated 12/19/23 revealed an order for Risperidone 0.25 milligrams (milligrams) once a day for hallucinations/delusions. The medication was scheduled to be administered between 6:00 AM and 10:00 AM. Prior to this, R18 was prescribed Risperidone 0.25 mg twice a day. Review of the CAR Review Psychotropic Medication progress note dated 12/26/23 revealed Resident has had a successful GDR [gradual dose reduction] to risperidone [antipsychotic medication] on 6/30/23 and 12/19/23. Review of the Progress Note dated 1/30/24 revealed Resident presents with the following dx's [diagnoses] of Psychotic disorder with hallucinations due to known physiological condition, Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and Major Depressive Disorder. She is currently taking Sertraline [Zoloft/antidepressant medication] 100mg once daily along with Risperidone .25mg once daily. She was last seen by [psychiatry services] on 1/17/2024 stating Plan: continue Zoloft 100mg PO daily. Plan: Continue Risperdal 0.25mg PO q. HS [every day at bedtime] at this time as she had a recent GDR. Evaluate in the next quarter for further GDR. The Risperidone continued to be administered between 6:00 AM and 10:00 AM, despite the note indicating the plan was to administer Risperidone at bedtime. Review of the medical record revealed R18 was transferred to the hospital on 3/21/24 for concerns not related to behaviors or psychiatric well-being. Review of the hospital records revealed the hospital was giving R18 Risperidone 0.25 milligrams twice a day based on an order they had in their system that was dated 8/25/23. The hospital records did not reveal why they did not implement R18's current order of Risperidone once per day. R18 was readmitted to the facility on [DATE] with diagnoses that included urinary tract infection and sepsis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Order dated 4/4/24 revealed an order for Risperidone 0.25 mg twice a day for behavioral disorders associated with dementia. Review of the Progress Note dated 8/7/24 revealed She is currently taking Sertraline 200mg once daily along with Risperidone .25mg once daily. Plan: Continue Risperdal [Risperidone] 0.25mg and Sertraline 200mg. Evaluate in the next quarter for further GDR. The note indicated R18 was receiving Risperidone once per day, but she was received the medication twice per day. Review of Behavior Analysis Report dated 10/1/23 to 10/16/24 revealed the following behaviors documented: 12/22/23- Rejection of care; Tried to get resident out of bed 4 times, multiple people also tried to get her out, but she refused all activity for the day. 2/5/24- False beliefs/misperceptions; There were no details documented; redirection was successful 3/10/24- Other behavior; Resident woke up confused thinking it was 1pm rather than 1am. days and nights mixed up. 8/21/24- Other behavior; attempted to change resident but was interrupted. I informed the hairdresser that she will need to be changed before her appointment. The hairdresser stated that she was overdue for a appointment and had the available slot at 9:45 AM and will be quick with her, then wheeled her away. Review of the Progress Note dated 9/18/24 revealed This resident's daughter approached this nurse at this time with concern due to the resident's increased hallucinations. Resident is currently seeing dogs in my room. Resident's daughter concerned with infection due to ureter stents being removed yesterday (09/17/24) . A message was passed on to the rounding providers for evaluation and potential treatment. No new orders at this time. The note did not indicate that the hallucination was distressful to R18. In an interview on 10/16/24 at 9:22 AM, Social Worker (SW) E and SW F reported the behavior tracking was documented in progress notes. When asked why risperidone was increased during and after R18's hospitalization , SW E and SW F were not able to provide a rationale. SW E and SW F were asked to provide any documentation they find. Documentation was not received prior to survey exit. In an interview on 10/17/24 at 9:16 AM with Director of Nursing (DON) B and Clinical Support (CS) I reported R18's Risperidone dose was changed while at the hospital from 3/21/24 to 4/3/24. Documentation was requested to show the rationale for the increase in Risperidone. Documentation was not received prior to survey exit.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to offer an updated COVID-19 immunization to two (Resident #7 and Resident #18) of five reviewed. Findings include: Resident #7 (R7) Review of the medical record revealed R7 was admitted to the facility on [DATE] with diagnoses that included diabetes, sleep apnea, and vascular dementia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/2/24 revealed R7 scored 10 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R7 had a guardian. Review of R7's immunization history revealed R7 received their last COVID-19 immunization on 11/11/22. There was no record that R7 was offered the COVID-19 booster for 2023/2024. Resident #18 (R18) Review of the medical record revealed R18 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, heart failure, and dementia. The MDS with an ARD of 8/16/24 revealed R18 scored 2 out of 15 (severe cognitive impairment on the BIMS). R18 had a guardian. Review of R18's immunization history revealed R18 received their last COVID-19 immunization on 11/11/22. There was no record that R18 was offered the COVID-19 booster for 2023/2024. In an interview on 10/16/24 at 3:53 PM, Infection Preventionist (IP) C agreed R7 and R18's last COVID-19 immunization was given on 11/11/22. On 10/16/24 at 4:26 PM, IP C reported R7 and R18 both had a COVID infection in November of 2023 and therefore were not eligible for their COVID-19 immunization at that time. On 10/16/24 at 10:22 AM, IP C reported she spoke with the facility's physician who reported R7 and R18 would have been eligible to receive the COVID-19 immunization 90 days after testing positive for COVID. IP C reported the facility did not have documentation that R7 and R18 were offered the COVID-19 immunization in 2023/2024. People who already had COVID-19 and do not get vaccinated after their recovery are more likely to get COVID-19 again than those who get vaccinated after their recovery .If you recently had COVID-19, you still need to stay up to date with your vaccines, but you may consider delaying your vaccine dose by 3 months. (https://www.cdc.gov/covid/vaccines/getting-your-covid-19-vaccine.html#:~:text=When%20you%20can%20wait%20to,vaccine%20dose%20by%203%20months.)