STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235705	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helen Newberry Joy Hltcu Golden Leaves Living Ctr	502 W Harrie St Newberry, MI 49868

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 35103 Based on observation, interview, and record review, the facility failed to ensure personal privacy during medication administration for 6 Residents (R7, R23, R9, R22, R15, and R6) of 7 residents observed during medication pass. This deficient practice resulted in the explanation and administration of resident medications within visual and auditory view of fell ow mealtime diners and the absence of personal privacy. Findings include: The following observations of medication pass in the facility dining room identified the following medication administrations in the presence of multiple diners at the same table as the medication was being administered or injected. The medication cart was wheeled into the dining room for medication preparation and administration. 1. 6/24/24 at 4:18 p.m. (dinner served in dining room from 4:00 p.m. to 6:00 p.m.), R7 was administered a quick-acting insulin via insulin pen in her upper left arm while sitting at the dining room table. The insulin injection was given by Licensed Practical Nurse (LPN) D. fell ow diners were sitting to the left and to the right of R7 at the dining room table at the time of administration. On 6/25/24 at 7:30 a.m. LPN E administered oral medications and a long-acting insulin injection via insulin pen to R7. The insulin was injected into R7's left upper arm while R7 was seated at the dining room table with residents to their right and to their left. 2. 6/24/24 at 4:28 p.m., R23's blood glucose level was verified by LPN D using a continuous glucose monitor that scanned a small sensor worn on R23's upper arm. R23 was seated at a small, square dining room table with another resident at the time of the blood glucose check. 3. 6/24/24 at 4:52 p.m., R9 was administered long-acting insulin via an insulin pen in full view and hearing distance of the diners sitting next to her at the dining room table. LPN D stated, [Resident Name], I am going to give you a shot, as LPN D lifted up the front of R9's blouse and pulled down the top of her pants to expose her lower abdomen for the injection. While R9 had been pulled away from the table slightly, she was still in auditory and visual view of other diners. On 6/25/24 at 7:45 a.m., LPN E administered oral medications to R9 while she was seated at a dining room table with other residents. 4. 6/24/24 at 4:36 p.m., R22 was seating at a dining room table with four other residents when LPN D delivered crushed acetaminophen mixed in vanilla pudding to the table. LPN D told R22 the medication was [acetaminophen] in visual and auditory distance of the other four residents. (continued on next page)

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

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. 6/24/24 at 4:42 p.m., R15 was administered three oral medications, crushed, and mixed in chocolate pudding, and a small cup of prepared laxative while seated with fell ow diners. 6. 6/24/24 at 4:47 p.m., R6 was administered three oral medications, crushed, and mixed in chocolate pudding while seating in close proximity to fell ow diners. Review of the facility Pharmacy - Medication Administration policy, reviewed 10/2020 revealed the following, in part: . Explain procedure to residents, position comfortably, and provide appropriate privacy . Procedure for Medication Administration via Injection . All General Procedures for Medication Administration apply . Explain procedure to resident and provide privacy . During an interview on 6/25/24 at 10:22 a.m., when asked about administering oral medications and insulin injections in the dining room the Director of Nursing (DON) stated, We always passed the meds in the dining room. When asked about personal privacy when medications are explained to the resident or injections are given, the DON stated, I agree about privacy (the lack of privacy) during the medication pass in the dining room. It will be corrected.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to complete a discharge summary for one Resident (R24), of one resident reviewed for discharge from the facility. This deficient practice resulted in the potential for compromised continuity of care. Findings include: Review of R24's Progress Notes on 6/26/24 at 7:32 a.m., revealed the following, in part: 4/6/24 13:15 (1:15 p.m.) Resident (R24) discharged from facility to resume care at [Assisted Living Facility]. Belongings were packed and gathered by family. Medications and most recent medication list provided to resident at time of departure. Resident stable at time of d/c (discharge). Review of R24's Minimum Data Set (MDS) Admission assessment, dated 3/7/24, revealed R24 was admitted to the facility on [DATE] with active diagnoses that included: arthritis, malnutrition, anxiety disorder, chronic obstructive pulmonary disease (COPD), and adult failure to thrive. R24 scored 14 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. During an interview on 6/26/24 at 8:05 a.m., the Director of Nursing (DON) was asked for discharge information for R24, including a physician order for discharge, recapitulation of stay, and medication reconciliation and instructions provided to the Resident (R24) and/or the Resident Representative at the time of discharge from the facility. The DON reviewed the entirety of R24's electronic medical record (EMR) and was unable to locate any of the requested discharge documentation for R24. The DON also reviewed the attached acute care hospital's EMR and was again unable to locate any physician order for discharge or any other documentation showing the discharge activity conducted with R24 and their Resident Representative. During an interview on 6/26/24 at approximately 8:15 a.m., the Assistant Director of Nursing (ADON) B was asked for the location of R24's discharge documentation. ADON B confirmed she had been present and performed R24's discharge on 4/6/24, but no discharge documentation was completed or retained in the medical record. Both ADON B and the DON acknowledged they were not aware of any discharge requirements that involved retaining or completing discharge documentation for residents. ADON B said that she was unaware of what was needed to document a resident discharge. The DON also acknowledged that she was not aware of what the discharge process was or what documentation was required to be prepared or retained at discharge. Review of the Discharge and Transfer - Resident policy, last revised 12/5/2022, revealed the following, in part: Discharge Home: 1. The attending physician makes the determination and orders the discharge. 2. The Social Work Designee initiates discharge planning for all residents . 5. The LPN Charge Nurse supervises the preparation of the resident for discharge. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. The LPN Charge Nurse will demonstrate a Recapitulation of Stay of the resident utilizing the Discharge Checklist for Nursing. 7. The Discharge Checklist for Nursing will be reviewed with the resident/guardian prior to discharge and be signed by the resident/guardian and Discharging Nurse. A copy of the Discharge checklist for Nursing will be given to the family and a copy made for the residents' chart. Information to be included, but not limited to, medication administration, mobility, cognition, vital signs, current weight, discharge education, care plan resolution. 8. Nursing Staff will utilize the Discharge Documentation Outline as an aide to write their discharge documentation to demonstrate the resident's recapitulation of stay and condition prior to discharge. This form can be found on the Pulse, under Forms . 10. The physician completes the discharge summary. 11. The physician may provide prescriptions for medication. The resident or family may need directions for obtaining the medication. 12. The LPN Charge Nurse assures that personal property list is updated at time of discharge. 13. The Social Work Designee arranges for the disposition of personal possessions and trust accounts . 15. Social Work Designee documents in the Social Work progress notes the preparation and completion of discharge, including family and resident responses. 16. The LPN Charge Nurse obtains all the resident's records and forwards to the RN supervisor. 17. The Social Work Designee completes the LTCU (long term care unit) I-Team (interdisciplinary team) Discharge summary. 18. The Charge Nurse organizes the chart and forwards it to medical records . If resident is going against medical advice, refer to Discharge Against Medical Advice Policy 4.8 .

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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. 34568 Intake Number: MI00145187 Based on observation, interview, and record review the facility failed to follow resident person-centered care plans and Activity's of Daily Living (ADL) policy for two Residents (R3, and R12) of 11 residents reviewed for ADL care. This deficient practice resulted in R3 sustaining injuries and R12 feeling rushed during ADL care and unmet care needs. Findings include: R3 An interview was conducted with R3 on 6/24/24 at 1:17 p.m. R3 stated that he was mistreated by Certified Nurse Aide (CNA) I. R3 was observed to have bruising, scrapes, and bandages to his right and left lower extremities. Review of the facility's investigation read, in part, 6/16/24 - 07:40 a.m., CNAs were is [sic] with (R3) to prepare him for breakfast and noticed multiple skin tears and bruises on right arm. CNA #1 asked what happened to his arm and (R3) responded that b**** from last night grabbed by [sic] arm hard and squeezed, I didn't have time to tell her to stop CNA #2 is a witness to resident's statement. 07:45 a.m. CNA #1 immediately reported this to RN (Registered Nurse) Supervisor, who went to (R3's) room to assess wounds, she noted multiple bruises and skin tears to right arm, which is his functional arm. (R3) told RN supervisor that NOC (night) shift CNA was being mean and when asked if he was made to feel unsafe, he answered yes. (R3) stated to RN Supervisor that (CNA I) had grabbed his arm, squeezed, and then pulled on him, causing a skin tear. She lost grip and grabbed his hand, causing second skin tear .also noted there was no draw sheet or chucks in use. 3:52 CNA I returned DON (Director of Nursing) phone call and was questioned regarding last night's occurrences. She admits to grabbing resident's arm to assist with transfers, she was on the other side of bed and had to go around bed to assist as he was too close to edge of bed. Grabbed arm and it slipped so she grabbed his hand to pull him over so he could assist with holding self on side. (CNA I) states that she did not notice skin tear until after care was provided. Review of R3's Care Plan read, in part, I have an ADL self-care performance deficit r/t (related to) CVA (Cerebrovascular Accident) with left sided weakness .I require assistance from 2 staff members to provide care during the night .My skin is fragile. Please turn and position me in bed using a draw sheet . An interview was conducted with CNA I on 6/26/24 at 7:30 a.m. CNA I confirmed she did not follow R3's care plan regarding turning, repositioning or the number of staff members required to perform R3's ADL care. R12 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with R12 on 6/26/24 at 8:06 a.m., who stated, I do not feel safe with (CNA I). She is too rough with her cares and treats me poorly. She grabs my arms too aggressively. I don't feel safe. Review of the facility's Standards of Care policy revised 6/1/24 read, in part, .Focus on Resident and not the task .Do not rush .For repositioning use draw sheet unless otherwise specified. Prevent shear injuries .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 Based on observation, interview, and record review, the facility failed to assess and monitor pressure injuries, develop and implement a plan of care for pressure injuries, and maintain infection control practices during dressing changes for One Resident (R14) of One resident reviewed for pressure injuries. This deficient practice resulted in harm when R14 experienced worsening of wounds and the development of three stage 3 pressure injuries. Findings include: Resident #14 (R14) was interviewed on 6/24/24 at 12:56 p.m. R14 was noted to be lying on his back in bed with the sides of his body pressed against the side rails on the bed. R14 said, they ordered me a new bed - it should have been here by now. R14 said a new bed had been ordered due to wounds on his buttocks. On 6/24/24 at approximately 2:00 p.m., the Director of Nursing (DON) said there were no pressure injuries in the facility. When asked for clarification, the DON reiterated the facility did not have any residents who had pressure injuries. When asked regarding wounds for R14, the DON responded, those are areas of shearing (skin damage that results when tissue layers laterally shift in relation to each other). R14 was readmitted to the facility on [DATE] after eight days of hospitalization due to Sepsis (a potentially life-threatening condition due to infection). A form Skin Observation Tool - Licensed Nurse dated 4/28/24 documented R14 had three pressure injuries when he was readmitted to the facility from the hospital: a stage 2 pressure injury (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) on the posterior right thigh, a stage 2 pressure injury on the left posterior thigh, and a pressure injury to the gluteal area. The documentation did not indicate which side the pressure injury to the gluteal area was located or the stage of the pressure injury in the gluteal area. An admission Minimum Data Set (MDS) assessment dated [DATE] coded R14 as having one or more unhealed pressure injuries at Stage 1 or higher (skin with a localized area of non-blanchable redness). The MDS coded R14 as scoring 15 on a Brief Interview for Mental Status examination indicating R14 was cognitively intact. R14's medical record did not contain any documentation of wound assessments for the month of June 2024. The form Wound - Weekly Observation Tool (Licensed Nurses) was completed weekly for the month of May 2024. The last wound assessment in the medical record was completed on 5/30/24 and documented communication to update the physician on 5/31/24, the day after the document was completed. The assessment documented the wounds as shearing wounds. A wound assessment dated [DATE] described the wounds as shearing. The assessment of 5/3/24 documented the presence of granulation tissue and slough and documented 30% of the shearing was covered with necrosis and/or slough. On 6/25/24 at approximately 1:50 p.m., a different bed was observed in R14's room. The bed was a bariatric bed with a low air loss mattress. R14 said the new bed arrived earlier in the day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/25/24 at 2:06 p.m., the nurse supervisor, Registered Nurse B (RN B), was observed completing wound care and dressing change to R14's wounds. RN B cleansed her hands and donned gloves before removing the existing dressing from R14's bilateral upper buttocks area. When the dressing was removed, three wounds were observed: one on the left intergluteal cleft adjacent to the inferior coccyx (tailbone), and two on the right intergluteal cleft lateral to the coccyx. The wounds were open with adipose (fat) tissue visible in the bases of the wounds. RN B said, this is much worse than the last time I saw [R14] and said R14's wounds had worsened to three stage 3 pressure injuries (full-thickness skin loss with visible subcutaneous fat and granulation tissue). RN B was asked to measure the wounds but responded, We don't measure - only the wound consultant measures. RN B cleansed the wounds wearing the same gloves she had on when removing the soiled dressing, patted the wounds dry, applied skin prep around the wounds then applied an absorbent dressing across the wounds without cleansing her hands or changing her gloves during these tasks. RN B was asked regarding the treatment and responded she would report to the wound care consultant so the consultant would assess the wounds and determine the appropriate treatment. On 6/25/24 at 2:26 p.m., RN B was asked about cleaning her hands and changing gloves when completing treatments. RN B responded she washed her hands after she set up the wound supplies and when she was finished with the treatment. RN B said, I didn't think about it (washing hands and changing gloves) while I was doing it (completing the treatment). The DON was interviewed on 6/25/24 at approximately 4:00 p.m. The DON said RN B had informed her about the worsening of R14's wounds. The DON was asked about wound measurements and assessment. The DON said, There's no reason we can't measure wounds - we're registered nurses. The DON said she did not know why there were no documented wound assessments for June 2024 and said the wound consultant had been in the facility and should have documented on R14's wounds. The DON said she had assessed R14's wounds and determined the wounds were not shearing. The DON said the wounds had advanced to three stage 3 pressure injuries but admitted she did not know when the three pressure injuries were initially identified. The DON said she had contacted R14's physician to change the treatment order due to necrotic tissue in the wound beds. When asked why a low air loss mattress had not been provided to R14 prior to today, the DON said she had not been made aware of the wound consultant's recommendation for a low air loss mattress until the previous week. She said the bed and mattress were immediately ordered when it came to her attention, and it was delivered on 6/25/24. The DON said the wound consultant would be in the facility to assess R14's wounds the following day, on 6/26/24. The DON was asked to inform the surveyor when the wound consultant arrived so the surveyor could interview the consultant. R14's care plan included a care plan for being at risk for skin breakdown but did not include actual skin breakdown or mention of pressure injuries. The care plan documented I am at risk for skin breakdown d/t (due to) previous history of cellulitis and diabetic ulcers. The bariatric bed was not included in the care plan interventions nor were a low air loss mattress or related interventions to prevent the development of pressure injuries or promote the healing of existing pressure injuries. On 6/26/24 at approximately 9:00 a.m., the DON conveyed the wound consultant would not be in the facility due to being on sick leave. The DON produced an email chain between herself and the wound consultant. An email from the DON to the wound consultant on 6/25/24 at 3:01 p.m. read in part: .the wounds have deteriorated. Now stage III. Are you or anyone else able to come today and assess? . The response from the wound consultant dated 6/25/24 at 6:11 p.m. read, in part: .I am out for several weeks due to injury, meaning no wound services to LTC (long term care) during that time . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/26/24, a weekly wound assessment was noted in R14's medical record dated 6/11/24. The assessment documented shearing to the buttocks with epithelial tissue, granulation tissue, and odor. The form was dated 6/11/24 but displayed as created and locked on 6/25/24. On 6/26/24, skin assessments were observed in R14's record dated 6/24/24 and 6/25/24. The assessment dated [DATE] documented two stage 2 sacral pressure injuries measuring 2.5 cm x 2.0 cm x 0.1 cm. The skin assessment on 6/25/24 documented three stage 3 pressure injuries: a stage 3 on the proximal right buttock measuring 2.7 cm x 1.0 cm x 0.1 cm, a stage 3 on the distal right buttock measuring 2.0 cm x 0.5 cm x (no depth documented), and a stage 3 on the left buttock measuring 4.5 cm x 4.0 cm x 0.1 cm. A nursing progress note dated 6/25/24 at 2:22 p.m. documented, Wound care performed today per orders. Resident's wounds classified as sheer [sic] in OT/WC (occupational therapy/wound consultant) documentation. Upon assessment, res has 1 stage 3 decub (pressure injury) on his left inner buttock and 2 stage 3 decubs on his right buttock. Wounds have slough to > (greater than) 90% of wound bed . A skin and wound progress note dated 6/25/24 at 7:02 p.m. documented No formal wound care services will be provided this week (6/24 - 6/28) as staff member out of office. Do not anticipate staff return until week of 7/15/24. Nursing staff to continue wound care management plan. The policy Skin and Wound assessment dated ,d+[DATE] [sic] read, in part: .Purpose: 1. To maintain and/or improve the skin integrity of all residents .b. ALL [sic] residents that do have skin breakdowns and/or pressure ulcers receive necessary treatment and services to promote healing, prevent infection, and prevent the breakdown from recurring . A preventative care plan will be developed .4. All ulcers will be measured weekly and PRN (as needed) .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 Based on observation, interview, and record review, the facility failed to accurately assess, develop and revise care plan interventions, provide adequate supervision, and investigate falls for root cause, to minimize the risk of fall recurrence for one Resident (R23) of two residents reviewed for falls. This deficient practice resulted in R23 experiencing multiple falls with numerous injuries including transfer to the emergency department for facial suturing. Findings include: Resident #23 (R23) was admitted to the facility on [DATE] with a diagnosis of severe Dementia with agitation. An admission Minimum Data Set (MDS) assessment dated [DATE] documented R23 as having a history of falls prior to admission to the facility. Section J1700 of the MDS documented R23 had a fall within the month prior to admission to the facility and had falls within 2-6 months prior to admission to the facility. On 6/24/24 at 2:10 p.m., a position change alarm box was observed on the head of R23's bed. R23 was observed ambulating in the hallway, occasionally leaning into the wall as he walked and entering other residents' rooms. An incident report dated 4/3/24 at 11:04 p.m. documented R23 fell in his room. There were no interventions documented on the incident report, baseline care plan, or nursing progress notes to identify and minimize risk of fall recurrence. An admission nursing assessment was not found in the medical record of R23. According to nursing progress notes on 4/4/24, R23 experienced another fall on 4/4/24 at 1:15 p.m. The fall resulted in multiple injuries including lacerations to the left eyebrow and left cheek, skin tears to the left elbow and left wrist, and a swollen, painful right ankle. R23 was sent to the emergency department and received 5 sutures to the facial laceration on the left eyebrow. An incident report was not located for the fall on 4/4/24. The baseline care plan was not updated with fall hazards or interventions to minimize the risk of fall recurrence. Documentation regarding causal factors or the root-cause of the fall was not located in the medical record. A care conference progress note on 4/10/24 at 3:09 p.m. documented R23 was at low risk for falls despite having 2 falls with injury within the previous 7 days and a history of falls prior to admission to the facility. The note read, in part: .Res low fall risk but subsequently had 2 falls days 1 and 2 after admission . A Physician progress note dated 5/8/24 at 11:46 a.m. documented, in part: .He is at high risk for falls, which he has had 2 since admission to LTC (long term care). One of which required stitches to his forehead . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R23 fell again on 5/17/24 at 1:15 a.m. According to the incident report, R23 was found by staff on the floor in the bathroom of another resident. The incident report documented R23 sustained an abrasion injury to the top of the scalp. No other injuries were documented on the incident report. Nurses' notes on 5/17/24 at 1:13 p.m. documented R23 sustained an abrasion to the center of the forehead as a result of the fall. There were no nurses notes to clarify the location(s) of the injuries. Documentation regarding the causal factors of the fall was not located in the medical record. A fall re-assessment using a Morse Fall Scale was completed on 5/17/24. R23 scored 75 indicating high risk for falls. R23 had an unwitnessed fall in his room on 5/18/24 at 3:52 a.m. According to the incident report, the fall resulted in a skin tear injury to the left elbow. The incident report documented R23 was in bed sleeping when staff heard the bed alarm go off. The incident report read, in part: . Resident fell earlier this day shift, he has some bruising to his face/head. Writer observed a bruise earlier in his hair line. After the fall on night shift he had a bruise to his R [right] side of face and his nose . There was no incident report located for a fall on day shift on 5/17/24 or 5/18/24. Documentation regarding the potential hazards or causal factors of the fall was not located in the medical record. R23 fell in his room on 5/19/24 at 1:40 p.m. The incident report documented the resident was observed attempting to sit down and lost his balance. A care plan intervention was added on 5/20/24 for (brand name) alarm to bed to alert staff when I am up out of bed. The intervention was resolved on 5/27/24 with no other intervention implemented, and no documentation explaining the rationale for the discontinuance of the intervention on the care plan. R23's care plan was reviewed on 6/25/24 and documented, in part: I am at low risk for falls (Morse 15) r/t (related to) confusion. The care plan was not updated with the completion of the fall risk assessment on 5/17/24 to reflect R23's high fall risk. The falls care plan was dated as developed on 4/11/24. The interventions on the care plan for falls were all dated 4/11/24 except for an intervention initiated on 5/20/24 for a position change alarm. The Director of Nursing (DON) was interviewed on 6/25/24 at 9:23 a.m. The DON said a Risk Management Report (incident report) is completed after each fall, and care plans are updated after fall occurrences. The DON was asked if any investigations had been conducted for R23's falls. The DON admitted investigations had not been completed for R23's falls. The DON was asked if there was an incident report for the fall with injury requiring transfer to the emergency department on 4/4/24. The DON reviewed R23's medical record and said an incident report had not been completed. The DON was asked if there was an incident report for the day shift on 5/17/24 or 5/18/24 as referenced in the incident report of 5/18/24. The DON reviewed the record and said there were no additional incident reports on 5/17/24 aside from the fall on 5/17/24 at 1:15 a.m., and there were no additional incident reports on 5/18/24 aside from the one at 3:52 a.m. (continued on next page)

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	235705	A. Building B. Wing	06/26/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON was asked why a position change alarm box was on the head of R23's bed despite being discontinued on 5/27/24. The DON replied, There shouldn't be an alarm box. The DON explained R23 was a prison guard for years and responds quickly to the sound of alarms. The DON said the sound of an alarm is more likely to increase the chance of R23 falling. The DON was told the incident report of 5/18/24 documented the resident had a bed alarm, but the bed alarm wasn't added to the care plan until 5/20/24. When asked when the bed alarm was placed on the bed, the DON said, I'm not really sure. When asked about care plan updates, interventions, and root-cause of fall occurrences, the DON reviewed R23's record and said the care plans and interventions were not updated after falls. The DON and Nursing Supervisor (RN B) were interviewed on 6/26/24 at 10:45 a.m. RN B said she enters a progress note from the Fall Committee into a resident's medical records when a resident falls to document the cause of falls and the interventions implemented for the resident. A response was not received when asked why there was no documentation for root-causes or interventions for R23. The DON was asked the location of R23's admission nursing assessment. The DON looked in R23's medical record and said an admission nursing assessment had not been completed for R23. The DON said an admission nursing assessment is expected to be completed for all residents when admitted to the facility. The policy Falls and Suspected Falls dated as revised 12/5/23 read, in part: .Purpose: Establish care plans that provide a safe environment that minimizes risk for falls .A Care Plan will be developed with goals and interventions to decrease the potential for falls . The Fall Team Committee (FTC) will review all falls on a weekly basis. Falls with injuries requiring hospitalization will be reviewed by the Fall Team Subcommittee within 24 hours of the fall. Interventions and recommendations will be addressed by the attending physician and care plan will be reviewed and revised as needed .Investigation includes implementing any interventions deemed necessary to prevent recurrence. The Supervisor will investigate the fall .the Supervisor will update the care plan . A Care Plan will be developed with goals and interventions to decrease the potential for falls. Areas of focus will include, but are not limited to fall history, external factors, and internal factors that may contribute to falls and/or potential falls .The Nurse/LPN (Licensed Practical Nurse) shall complete a Clarity Report and Accidents & Injuries Report and Risk Management Assessment for each fall or suspected fall . Investigation includes implementing any interventions deemed necessary to prevent recurrence .The Supervisor will investigate the fall .Based on that review, the Supervisor will update the care plan and notify staff of changes and / or trends in falls .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on observation, interview, and record review, the facility failed to complete assessments to determine the need for bed rails for one Resident (R5) of two Residents reviewed for bed rail assessments. This deficient practice resulted in the potential of entrapment, serious injury or harm, and/or death for all facility residents using bed rails without assessment of safety and appropriateness for medical conditions. Findings include: Review of R5's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including dementia and hemiplegia affecting left nondominant side. R5's 4/8/24 Minimum Data Set (MDS) assessment section P revealed she was not marked for the use of bed rails. On 6/24/24 at 1:03 p.m., an observation revealed R5 had bilateral (right and left side) bed rails attached and in the upright position on her bed. R5 was lying in her bed resting. On 6/25/24 at 1:41 p.m., an observation revealed R5's bed still had bilateral side rails attached and in the upright position. On 6/26/24 at 10:24 a.m., an observation of R5's bed was conducted with the Director of Nursing (DON). The DON confirmed that R5's bed did have bilateral side rails attached. The DON stated that R5 bed rails were to be zip tied to the bed and not in use as per R5's care plan. Review of R5's June 2024 physician orders revealed she did not have an order for the use of bed rails. Further review showed that R5 did not have a consent from her or her representative for the use of bed rails. Review of R5's care plans read, in part, I am at high risk for falls and become shaky when standing during transfers .I do not use bed rails . Review of the facility's Bed Rail Guidelines and Assessments revised on 1/18/23 read, in part, .If the IDT (interdisciplinary) team recommends the need for a bed rail to be implemented, the MDS Coordinator/Social Service Designee will obtain a physician order for the use of the bed rail .The MDS Coordinator/Social Service Designee will care plan the need for bed rail placement .The MDS Coordinator/Social Service Designee will utilize the Resident Bed Rail Consent Form if bed rails are to be implemented and maintain these records in the EMR/medical record .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 35103 Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than 5 percent, with 8 errors identified, out of 25 medication administration opportunities observed. This deficient practice resulted in a medication error rate of 32 percent, and the potential for the administration of non-therapeutic doses of medication, and preparation of medication not according to manufacturer's instructions. Findings include: The following medication errors were observed: Error 1. R7 - During observation of preparation of a fast-acting insulin pen for R7 on 6/24/24 at 4:18 p.m., Licensed Practical Nurse (LPN) D placed the insulin pen needle on the pen hub (rubber seal) without cleansing the hub with alcohol. Error 2 and 3. R7 - During observation of preparation of a long-acting insulin pen for R7 on 6/25/24 at 7:30 a.m., LPN E placed the insulin pen needle on the pen hub without cleansing the hub with alcohol. LPN E primed the long-acting insulin pen by dialing the insulin pen to 40 units, while LPN E attempt to hold the injection button to expel only two units of the 40 as a primer. LPN E then administered the remaining insulin to R7. Error 4. R7 - During the 6/25/24 7:30 a.m., medication pass, a physician order for Januvia 100 mg (milligram) Tablet, give 1 tablet orally one time a day related to Type 2 Diabetes Mellitus Without Complications was not administered. LPN E looked in all of the medication cart drawers and could not find the prescribed medication. LPN E said the Januvia would be pulled from back-up because the medication was not in the cart. LPN E was asked to verify the administration status of the Januvia on 6/25/24 at 9:20 a.m., R7's Medication Administration Record (MAR) documented the Januvia was administered. When asked if the Januvia had been pulled from back-up and administered, LPN E acknowledged they had not retrieved the medication from back-up, and the MAR was check as administered in error for R7. Review of the facility Medication Administration policy, reviewed 10/2020, revealed the following, in part: . Documentation: - Document all medications administered including the dose, date, time, route, as applicable . Document if a medication is withheld or omitted for any reason . Errors 5, 6, and 7. R9 - During medication pass observation on 6/24/24 at 4:34 p.m., LPN D prepared a long-acting insulin pen for R9. LPN D placed the insulin pen needle on the hub without cleansing the hub with alcohol, the insulin pen was not primed prior to administration of insulin to R9, and the long-acting insulin pen injection button was held for approximately 5 seconds prior to removal of the insulin pen needle from the injection site. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the [long-acting insulin pen name] instructions, revealed the following, in part: .Wipe the pen tip (rubber seal) with an alcohol swab . Dial a test dose of 2 Units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times . Keep the pen straight, insert the needle into your skin. Use your thumb to press the injection button all the way down. When the number in the dose window returns to 0 as you inject, slowly count to 10 before removing. (Counting to 10 will make sure you get your full insulin dose. Release the button and remove the needle from your skin . Error 8. R15 - During medication pass observation on 6/24/24 at 4:42 p.m., LPN D prepared 17 grams of a powdered laxative in a small, paper cup. The cup was filled with approximately three ounces of water. Additional water would have not allowed for stirring of the laxative to combine with the water. Review of the [powdered laxative name] manufacturer's instructions for preparation, revealed the following, in part: .Stir and dissolve in any 4 to 8 ounces of beverage (cold, hot or room temperature) then drink . During an interview on 6/25/24 at 10:22 a.m., when asked about the above medication pass observations, the Director of Nursing (DON) stated, It is not proper procedure if they do not (cleanse the insulin pen) alcohol the hub. Priming is dialing (the insulin pen) to two (units of insulin), push to prime, and then turn to the prescribed amount of insulin. Nurses should be holding the pen for 10 seconds before removing it from the resident (per long-acting insulin pen manufacturer instructions) . At this same time the DON verified that the small, paper cup used for the powdered laxative preparation could not have four ounces placed in the cup without overflowing during stirring. The DON agreed the powdered laxative should be prepared according to manufacturer's instructions and said the facility would be getting larger cups so residents could drink eight ounces of water with the [powdered laxative].

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 The deficiency has two parts: A and B. Part A: Based on observation, interview, and record review the facility failed to implement appropriate infection prevention and control practices during medication administration for five Residents (R7, R23, R9, R22, and R6) of seven residents observed during medication pass. This deficient practice resulted in the potential for cross-contamination of infectious organisms and the spread of infectious diseases within the facility population. Findings include: The following medication pass infection control concerns were observed: On 6/24/24 at 4:18 p.m., Licensed Practical Nurse (LPN) D used a continuous blood glucose monitor placed in contact with R7's clothing, over the inserted blood glucose sensor in R7's right upper arm. LPN D returned to the medication cart and placed R7's continuous blood glucose monitor on the top of the medication cart with no barrier to prevent cross-contamination between R7's clothing and the medication cart. The monitor was not disinfected. LPN D began preparation of a fast-acting insulin pen but did not cleanse the pen hub with alcohol prior to placing the insulin pen needle on the pen. On 6/24/24 at 4:28 p.m., LPN D used a continuous blood glucose monitor placed in contact with R23's clothing, over the inserted blood glucose sensor in R23. LPN D returned to the medication cart and placed R23's continuous blood glucose monitor on the top of the medication cart with no barrier to prevent cross-contamination between R23's clothing and the medication cart. The monitor was not disinfected. On 6/24/24 at 4:34 p.m., LPN D, with bare hands, used a continuous blood glucose monitor placed in contact with R9's clothing, over the inserted blood glucose sensor in R9's upper arm. LPN D returned to the medication cart and placed R9's continuous blood glucose monitor on the top of the medication cart with no barrier to prevent cross-contamination between R9's clothing and the medication cart. The monitor was not disinfected. LPN D returned to prepare a long-acting insulin pen. The insulin pen needle was placed on the insulin pen with no cleansing with alcohol prior to placement on the insulin pen hub. LPN D donned gloves, without the performance of hand hygiene, administered R9's insulin and returned to the medication cart. LPN D doffed the gloves and began preparing R22's medication without the performance of hand hygiene. On 6/24/24 at 4:42 p.m., LPN D said she was getting hot. LPN D removed the black scrub jacket they had been wearing during the day, opened the third drawer down on the medication cart, where resident medications were stored, and tossed her scrub jacket on top of the resident medications. On 6/24/24 at 4:47 p.m., LPN D offered prepared crushed medications mixed in chocolate pudding for R6. LPN D touched R6's clothing protector with bare hands and offered R6 a drink of water and the prepared medications. LPN D returned to the medication cart and touched the computer mouse to document the medication administration without the performance of hand hygiene. LPN D opened the medication cart and began medication preparation for the next resident (unidentified) without hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/25/24 at 7:30 a.m., LPN E placed an insulin pen needle on a long-acting insulin pen without cleansing the insulin pen hub with alcohol. No hand hygiene was performed following preparation of the insulin pen, contact with the medication cart/handles, and computer mouse, prior to administration of the insulin to R7. During the preparation of R7's oral pills, LPN E opened the second drawer down on the medication cart to reveal her personal phone in a hot pink case. The phone appeared to be turned on and operational, as observed in the medication cart with resident medications. Review of the [long-acting insulin pen name] instructions, revealed the following, in part: .Wipe the pen tip (rubber seal) with an alcohol swab . Review of the Hand Hygiene policy, reviewed 7/7/23, revealed the following, in part: .All personnel at [Facility Name] will follow the hand hygiene policy. The premise of this policy is based on the CDC (Center for Disease Control) recommendations and will include plain soap and water hand washing, the use of anti-microbial soap and water hand washing and alcohol-based hand rubs and foams . Hand Decontamination is Required (using alcohol-based hand rubs or foam, or anti-microbial soap and water or plain soap and water hand washing): 1. (With) Routine decontamination of hands in all clinical settings. 2. Before contact with patients . 7. After removing gloves. 8. After contact with potentially contaminated surfaces . During an interview on 6/25/24 at 10:22 a.m., when asked about the above infection control concerns, the Director of Nursing (DON) stated, I heard about the lab coat in the medication cart. The DON confirmed placing used, worn clothing in the medication cart with resident medications was not acceptable. When asked about potential cross-contamination between resident clothing, the continuous blood glucose monitor and the top of the medication cart, the DON stated, You can't do that. You have to clean the sensor before you put it back on the medication cart. When asked about hand hygiene concerns the DON stated, She should be performing hand hygiene before donning clean gloves or preparing the next medication. The DON also confirmed that it was proper procedure in preparation of the insulin pen to clean the insulin pen hub with alcohol, and personal phones were not to be kept in the medication cart. 13791 Part B: Based on interview and record review, the facility failed to implement the developed water management plan for the control of legionella. This deficient practice has the potential to result in the spread of Legionella bacteria in the water supply system and respiratory infection in all 21 residents. Findings include: On 6/24/24 and 6/25/24 a review of the facility's Water Management Plan (WMP), dated December 08, 2023 was reviewed. The following control measures were specified in the WMP: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1A. 1. Confirm source water safety 2. 1. Confirm source water quality 1E. 1. Disinfectant 4A. 1. Heat 140 F at the water heaters 6A. 1. Flushing unoccupied Rooms; 2 Disinfectant; 3. Drain Shower Hoses. The section of the WMP identified as Program Control Summary Table identified the following monitoring method and frequency for the validation of the implementation of the plan's controls: Perform free chlorine test with [NAME] colorimeter, Monthly. For ice machines in the distribution system, change the filter, quarterly. Flushing unoccupied rooms; target flush time: 5 minutes at the fixtures. Weekly Disinfectant Free Residual oxidant (FRO): 0.2-4.0 ppm as Cl. (chlorine) monthly A document for water testing was reviewed in which a analysis for bacteria identified as Validation Test THAB analytical Report Summary dated indicated a positive result greater than 102. A retest was indicated on the sample result. On 6/25/24 at approximately 8:30 AM, an interview was conducted with the Director of Facilities (DOF) A regarding the collection of data identified in the WMP. DOF A was requested to provide documentation related to the above controls and monitoring. DOH A stated these were held by the facility's contractor and would provide them. A request for these documents was also made to the director of nursing on 6/25/24 at 3:00 PM. A document which monitored scald prevention and demonstrated temperatures less than 120 F was provided. No documentation related to the control measures, testing and frequency were provided to the survey team prior to the end of the survey. When the follow up sample result for the positive bacterial same was requested, DOH A stated the facility had not yet received the results. No evidence of corrective action regarding the positive bacterial sample was provided.