STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235719	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Manor Nursing and Rehabilitation Center	13990 Lakeside Circle Sterling Heights, MI 48313

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 This citation pertains to Intake: MI00143142. Based on observation, interview, and record review, the facility failed to answer call lights timely for four residents (R50, R49, R24, and R9) out of five reviewed for call lights. Findings Include: R50 On 7/15/2024 at 9:03 AM, R50's call light was observed activated. A computer screen behind the nurse's station showed that R50's light had been activated for 13:00 minutes. At 9:06 AM, R50's light was observed activated. Two certified nurses' assistants were noted to walk past R50's room and a nurse was noted at their cart down the hallway. At 9:10 AM, R50's light was observed still activated. At 9:12 AM, a nurse was observed going into R50's room and deactivating the call light. R50 was heard stating they wanted a pain pill. On 7/15/2024 at 2:33 PM, R50 was interviewed regarding call light waits. R50 stated sometimes it takes a while to get their call light answered. R50 stated they can wait anywhere from 30 minutes to an hour for help after pushing their light sometimes. A review of the medical record revealed that R50 admitted into the facility on [DATE] with the following diagnoses, Pain in left leg and Cerebral Infarction. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating an intact cognition. R50 also required staff assistance with bed mobility and transfers. On 7/16/2024 at 3:16 PM, an interview was conducted with the Director of Nursing (DON) via phone. The DON stated they had just conducted an all staff education regarding answering call lights and ensuring everyone answers them no matter their discipline. 40330 R49 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235719	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Lakeside Manor Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13990 Lakeside Circle Sterling Heights, MI 48313	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/14/24 at 10:18 a.m., R49 stated they felt, It takes 20 minutes to a half an hour for the call light to be answered (at first). Then they [the nursing staff] say, I will be back, and I sit another what feels like two to three hours, when I have to go to the bathroom. I have sat in my stool a good 2-3 hours .it felt like forever. It was a couple weeks ago .When they come in on third shift, they say, We just got here, you have to wait. I wait an hour for shift change. I want the old people [other residents] to be taken care of [also]. Review of the MDS assessment, dated 6/25/24, revealed R49 was admitted to the facility on [DATE], with diagnoses including heart failure, malnutrition, lung disease, and stroke. The sensory assessment revealed R49 was able to make themself understood and understand others. R49 required moderate assistance with bed mobility and transfers, and maximal assistance with toileting. R49 was always incontinent of bladder and bowel. The BIMS assessment revealed a score of 12/15, which showed moderate cognitive impairment; it was noted a score of 13/15 or above yielded normal cognition. Call light logs were requested for R49 for the past two months on 7/14/24, and per corporate administrative staff, there were no call light logs available by survey exit. R24 During an interview on 7/14/24 at 12:27 p.m., R24 reported they often waited up to one hour to an hour and a half for their call light to be answered when they needed to be changed and cleaned up. R24 explained the nursing staff would come into their room and turned their light off and did not return. R24 stated, When I need to be cleaned up, they [staff] come in and turn the light off every day, and every 15 minutes I turn it [back] on. R24 stated, I wait hours for assistance .I watch the clock. R24 stated this caused them to feel frustrated and upset. R24 was visibly upset when discussing this during the interview, talking with a raised voice and sharp tone. R24 observed the clock in their room and was able to tell the time accurately. R24 was oriented to themself, their surroundings, and their situation. Review of the MDS assessment, dated 4/16/24, revealed R24 was admitted to the facility on [DATE], with diagnoses including heart failure and dementia. The assessment showed R24 received hospice care. The sensory assessment revealed R24 was able to make themselves understood and understand others. R24 required moderate assistance for toileting, hygiene, and bed mobility, and maximal assistance for transfers. The BIMS assessment revealed a score of 14/15, which showed R24 was cognitively intact. Call light logs were requested for R24 for the past two months on 7/14/24, and per corporate administrative staff, there were no call light logs available by survey exit. During a phone interview with the DON on 7/16/24 at 4:06 p.m., they reported the facility was addressing the longer call light times and acknowledged any wait beyond 30 minutes would be a concern. 22960 R9 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/15/24 at 11:50 am, R9's call light was observed activated. A computer screen behind the nurse's station showed that R9's call light had been activated for 30 minutes. Certified Nurse Assistant (CNA) Q was observed sitting at the nurse's station looking at their cell phone while R9's call light was sounding. At that time, R9 was observed in bed. When queried about the call light, R9 stated they had turned on the call light about 30 minutes ago, so that staff could get them out of bed. R9 stated they needed the assistance of staff with a mechanical lift to get out of bed. R9 was visibly upset, and stated they had let staff know at 10:00 am they wanted to get out of bed today. R9 stated it was unacceptable that 2 hours later, they were still waiting for staff to help them. R9 stated, I wouldn't be here if I didn't need the help. I can't do these things without help. On 7/15/24 at 11:55 am, Certified Nurse Assistant (CNA) E was observed entering R9's room to see what they needed. CNA E told R9 they were not their aide, but that they would let their aide know they wanted to get up. CNA E turned off R9's call light, and went back to the nurse's station and sat down. On 7/15/24 at 12:10 pm, CNA E, who was still sitting in a chair near the nurse's station, was queried about R9's call light. CNA E stated R9 was not their resident, and they had told their assigned aide (CNA Q) and they knew that they needed help. CNA E confirmed they had turned off R9's call light, and stated I let their aide know. A review of the medical record revealed that R9 admitted into the facility on [DATE] with the following diagnoses, Cerebral Infarction, Hypoxia, and Morbid Obesity. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R9 also required assistance with bed mobility and transfers. A review of a facility policy titled, Call Lights: Accessibility and Timely Response noted the following, .10. All staff members who see or hear an activated call light are repsonisble for responding.If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38207

This citation pertains to Intake MI00145142.

Based on interview and record review, the facility failed to ensure that a (name of) total assistance mechanical lift was available for two residents (R2 and R9) of two residents reviewed for accommodation of needs/choices, resulting in residents not being able to get in and out of bed safely and as desired. Findings include:

R2

A review of a complaint submitted to the state agency (SA) revealed the following, On 6/14/24, staff had to call the Fire Department to come and put [R2] in bed because the lift wasn't working properly and had been out for repairs.

A review of R2's electronic medical record (EMR) revealed the following progress note dated 6/22/24 5:03 AM, Resident called the fire department [four] times. The fire department some how was in the building and stating that the resident was on the floor. Writer followed the fire department passed the resident room the resident was in the room sitting in the chair. Resident was asked on several occasions by the previous shift to go to bed. Resident refused at that time, [Resident] stated [they] wanted to go to bed at [2:00 AM]. At the time that the resident started requesting to go to bed the [Certified Nursing Assistant's] [CNA's] on North were doing [their] round.

Further review of R2's EMR revealed that R2 was admitted to the facility on [DATE] with diagnoses that included Muscular dystrophy (Neuromuscular disease) and Anxiety disorder. R2's most recent minimum data set assessment (MDS) dated [DATE] revealed that R2 had an intact cognition, required use of a mechanical lift for transfers, and was totally dependent on staff for activities of daily living (ADLs) other than eating and oral care.

On 7/14/24 at 2:38 PM, R2 was interviewed regarding the availability of a mechanical lift at the facility. R2 indicated they were unable to get out of bed as desired for four consecutive days sometime during the middle of June 2024 due to the facility's lift being out of the building for repairs. R2 further indicated the facility currently had a temporary mechanical lift provided by the lift company while the facility's mechanical lift continues to be repaired.

On 7/15/24 at 9:45 AM, Maintenance Supervisor (MS) D was interviewed and asked about the status of the facility's mechanical lift and indicated they thought the lift went out for repairs on/around 7/4/24 but was not certain, and the lift company provided the facility with a temporary mechanical lift which is currently in use at the facility. MS D was further interviewed about the lift being out of the building on/around 6/14/24 and stated, I know nothing about that. MD D was asked to provide documentation regarding lift repairs and indicated they had no documentation regarding repairs done to the lift.

On 7/16/24 at 10:18 AM, Licenced Practical Nurse (LPN) P was interviewed regarding the facility's mechanical lift and the progress note they wrote involving R2 dated 6/22/24. LPN P stated, We could not find the mechanical lift. The fire department arrived and we got [R2] back into bed.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 11:00 AM, the Director of Nursing (DON) was interviewed by phone and asked about details regarding the facility's mechanical lift repair. The DON was unable to provide any details and confirmed the facility was without a mechaical lift on and around 6/14/24. The DON was unable to provide any verbal or written information regarding the duration of the facility being without a mechaical lift in the building. On 7/16/24 at 11:30 AM, the [NAME] Nursing Home Administrator (RNHA) was interviewed and asked about any details or documentation related to the facility's mecahical lift repairs. The RNHA indicated the facility Administrator (NHA) was on vacation and no documentation and/or information could be located regarding mechaical lift repairs. 22960 R9 On 7/15/24 at 11:50 am, R9 was observed in bed waiting for staff to answer their call light so that they could get up and out of bed. R9 explained that they needs a mechanical lift to get out of bed, and that the facility only has 1 lift for all the residents. R9 stated that approximately 2 weeks ago, the facility did not have a functioning mechanical lift. R9 stated they were ready to go out with family for their granddaughter's graduation party. R9 stated staff told them they couldn't get her up, because the mechaical lift was broken. R9 stated staff then proceeded to lift them up out of bed manually, to transfer them to the wheelchair. R9 stated, That was very dangerous. They could have really hurt me. A review of the medical record revealed that R9 admitted into the facility on [DATE] with the following diagnoses, Cerebral Infarction, Hypoxia, and Morbid Obesity. A review of the Minimum Data Assessment set revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R9 also required assistance with bed mobility and transfers. A facility policy titled Safe and Homelike Environment Date Implemented: 11/1/22 was reviewed and revealed the following, Policy: In accordance with residents' rights, the facility will provide a safe . comfortable, and homelike environment .This includes ensuring that the resident can receive care and services safely .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 38207 Based on observation, interview, and record review, the facility failed to maintain carpet throughout the facility in a clean, sanitary, and safe condition affecting all 58 residents residing at the facility. Findings include: 200 Unit Carpet On 7/14/24 at 9:01 AM, during an initial tour of the 200 unit at the facility, the carpet on the unit was observed to be stained, worn, with missing spots of carpet observed next to the walls on the unit. On 7/16/24 at 8:32 AM, a further inspection of the carpet on the 200 unit revealed many large stains on the carpet and the carpet to be buckled in some areas. On 7/16/24 at 8:32 AM, an interview regarding the condition of the carpet on the 200 unit was conducted with Housekeeper R. Housekeeper R stated, The carpet needs a deep clean. On 7/16/24 at 8:35 AM, an interview regarding the condition of the carpet was conducted with Housekeeping/Laundry supervisor (HLS) S. HLS S stated, We have shampoo' d it and the stains won't come out. I have no floor technician. It needs to be replaced, I have talked to the owner about it. 44750 On 7/14/2024, during a tour of the facility the carpet was observed to be in poor condition. The carpet in front of rooms [ROOM NUMBERS] had a large black stain. The carpet was observed to be buckled and not flat by rooms [ROOM NUMBERS]. Multiple bleach stains were observed in the 100 halls, as well as the carpet buckled by room [ROOM NUMBER]. On 7/14/2024 at 2:30 PM, an interview was conducted with Maintenance Director (MD) D. MD D stated they do have a carpet cleaner/extractor, but they do not have the staff to operate the machine at this time. MD D stated quotes have been obtained to replace the carpet throughout the facility, but it would be costly. On 7/15/2024 at 2:48 PM, an interview was conducted with the resident that resided in room [ROOM NUMBER] regarding the facility. The resident stated they hate the carpet and it is dirty and they get embarrassed when people come and visit because they talk about how nasty and unsafe the carpet throughout the facility is. On 7/16/2024 at 3:16 PM, an interview was conducted with the Director of Nursing (DON) via phone. The DON stated they have taken a little trip on the carpet themselves and they know the carpet needs to be addressed. 49102 (continued on next page)

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	235719	A. Building B. Wing	07/16/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/15/24 at 2:00 PM , a confidential group of residents revealed the following concerns: The carpet is dangerous and dirty. Several residents stated the carpet is buckling and unraveling in several places and they are fearful someone is going to fall. One resident revealed they almost tripped on the carpet when walking with their walker on the carpet. A review of the facility's policy titled Safe and Homelike Environment implemented 11/1/22 revealed the following, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can recieve care and and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49102 This citation pertains to Intake MI00145446. Based on interview and record review, the facility failed to protect one (R4) of three residents reviewed for abuse, from sexual abuse (grabbing their breast) by another resident (R45) . Findings include: A review of Intake MI00145446 revealed the following, Incident Summary: (R45) was observed reaching out trying to touch (R4) inappropriately. (R45) was observed by staff trying to touch (R4's) chest. Further review of the Intake revealed the following interventions: 1. R45 room was changed from 202A to 213A. 2. Checks are conducted on R45 hourly. 3. R45 is being followed by psych services. 4. Legal guardians was notified. 5. R45 was petitioned out for an psychological evaluation. Review of a facility investigation revealed an Incident where R45 inappropriately grabbing R4 breast on 6/11/24. A review of the following progress notes revealed the following: -On 6/6/24 a progress note written by LPN N revealed (R45) attempted to grab on residents' breast area several times today. Writer (LPN N) explained to resident that he can not touch residents. Staff had to redirect (R45) several times today. -Late entry: On 6/5/24, Director of Nursing (DON) observed R45 on 6/5/24 attempting to touch two female residents on two separate occasions. R45 was redirected by writer on both occasions and informed that behavior was not appropriate. The DON observed R45 attempting to touch the unit manager inappropriatly. -On 6/11/24, LPN N observed R45 grabbing R4's breast. R45 was immediated redirected. -On 6/11/24, The DON noted R45 had to be redirected more than five times from following specific female patients who R45 appears to seek out and approach. On 7/16/24 at 09:45 AM, in an interview with Licensed Practical Nurse (LPN) N, who witnessed the alleged incident, was asked what happened. LPN N said on 6/11/24, R45 was observed grabbing R4's breast. R45 was redirected by the nurse and taken to their room and Director of Nursing (DON) was notified. On 7/16/24 at 10:00 AM, in an interview with LPN O, was asked about the incident, LPN O revealed they did not see the incident, however was told by other staff what occurred. LPN O confirmed on that day, I had to redirect R45 several times from going into R4's room. Staff had to monitor R45's whereabouts for the rest of that day. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A copy of the monitoring sheets for R45 was requested and one day of monitoring (6/11/24) was received. The DON was not able to provide any additional evidence of protective interventions for R4 from R45 who's room was directly across the hall. A progress note dated 6/14/24 from psychological services provider documented, R45 seen as priority for ongoing sexual behaviors . A nurses noted dated 6/20/24 documented, R45 going into R4's room and staff observed R45 trying to get into the bed with R4 and redirected R45 out of the room. The DON was not able to provide any additional evidence of protective interventions for R4 from R45 who's room was directly across the hall. A progress noted dated 6/26/24 documented, (R45) was petitioned out to the hospital due to resident's inappropriate behavior in regard to requesting sexual favors from staff and residents, grabbing staff and residents. It was decided by the facility to administrator to have resident petitioned out to the hospital for a psychiatric evaluation. R45 returned on 6/27/24 from the hospital. On 6/28/24 R45's room was changed from right across the hall from R4, to further down the hallway in room (17 days after sexual assault incident). A review of R4's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included, Hypertensive Heart Disease, and Dementia. A review of R4's Minimum Data Set (MDS) assessment revealed the resident had moderately impaired congnition and required extensive assistance for Activities of Daily Living. A review of R45's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included, Vascular Dementia, Hemiplegia and Hemiparesis. A review of R45's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Infterview for Mental Status (BIMS) assessment of 8 which indicated moderate cognitive impairment. On 07/16/24 at 10:00 AM, a phone interview occurred with Director of Nursing (DON). The DON was asked her expectations for protecting their residents regarding abuse and stated, Every resident has a right to be protected from harm and abuse. A review of the facility's Abuse, Neglect and Exploitation revealed the following: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Prevention of Abuse, Neglect and Exploitation The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49102 This citation pertains to Intake MI00145446. Based on interview and record review, the facility failed to ensure abuse allegations were reported timely to the State Agency (SA) for one resident (R4) of three residents reviewed for abuse. Findings include: A review of an Intake MI00145446 revealed the following, Incident Summary: R45 was observed reaching out trying to touch R4 inappropriately. R45 was observed by staff trying to touch R4's chest. The incident occured on 6/11/24. The facility incident report was received via online submission on: 6/25/24 at 10:47 AM (14 days after incident occured). On 07/16/24 at 10:00 AM, a phone interview occurred with the Director of Nursing (DON). DON was asked their expectation for reporting abuse and stated, All abuse investigations shoud be reported to the Abuse Coordinator and State Agency in a timely manner. In this case when the incident occurred the administator was on vacation and I did not know how to report, so the incident was reported when the administator returned. A review of the facility's Abuse, Neglect and Exploitation Policy revealed the following: Reporting/Response - A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. The incident was not reported to the State Agency until 6/24/24. Reporting requirements for alleged abuse and neglect is within 2 hours of incident.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40330 Based on interview and record review, the facility failed to provide written transfer notification to the resident and Ombudsman notification for one Resident (R29) of two residents reviewed for required acute care hospital transfer notifications. Findings include: During an interview on 7/14/24 at 1:58 p.m., R29 confirmed they were recently hospitalized when they had a bruise which worsened and caused a wound. Review of R29's census revealed R29 was hospitalized on [DATE] and returned to the facility in the same room and bed on 3/21/24. Review of R29's Electronic Medical Record (EMR) revealed no written notification of transfer to the acute hospital. The survey team requested documentation of R29's written transfer notification, and the Ombudsman monthly notification list from corporate administrative staff on 7/16/24, per regulatory guidance. The administrative staff confirmed neither were found by survey exit.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Manor Nursing and Rehabilitation Center	13990 Lakeside Circle Sterling Heights, MI 48313

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 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** 49102 Based on observation, interview and record review, the facility failed to implement a plan of care for one resident (R15) out of three residents reviewed for respiratory care. Findings include: On 07/14/24 at 10:00 AM, R15 was observed lying in bed with oxygen concentrator running and the nasal cannula lying on floor next to the bed. At 02:26 PM, R15 was observed lying bed. R15 was asked if they were having trouble breathing and the reply was yes. The nasal cannula remained laying on the floor next to the bed. On 07/15/24 at 08:59 AM, R15 was observed sitting up in the bed eating breakfast. The nasal cannula was observed on the floor with oxygen concentrator running. At 010:15 AM, Nurse U was asked to assess R15's oxygen reading and it revealed 92%. The nurse was asked to show the physician's order for R15 oxygen. There was no active order. A review of R15's medical record revealed they were admitted into the facility on [DATE] with diagnoses of Acute Respiratory Failure, Pneumonia, Adjustment disorder with anxiety, and Chronic Obstructive Pulmonary Disease. A review of R15's Minimum Data Set (MDS) assessment dated [DATE] revealed, R15's Brief Interview for Mental Status assessment score was a 10 indicating moderately impaired cognition. Further review of R15's medical record revealed there was no care plan for oxygen or respiratory care. On 07/16/24 at 01:05 PM, an interview was held with MDS/Registered Nurse (RN) T regarding the care plan. When asked about the oxygen care plan, RN T replied My expectation is all the orders are to be transcribed, and care plans written for the care of each resident. A review of the facility's policy titled Baseline Care Plan implemented 10/26/22 revealed the following, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

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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** 38207 Based on interview and record review, the facility failed to update the fall care plan interventions following resident falls for one resident (R39) of two reviewed for care planning. Findings include: On 7/14/24 at 9:22 AM, during a tour of the facility R39 was observed to have bruising on their upper forehead. When interviewed, R39 indicated they had a recent fall at the facility. A review of R39's incidents and accidents (I/As) from April 2024 to the present revealed that R39 had falls at the facility on 4/28/24, 5/1/24, 5/5/24, 5/12/24, 5/15/24, 5/29/24, 6/11/24, and 7/8/24. A review of R39's fall care plan revealed no new interventions were placed on the care plan following any of the above listed falls. The most recent fall intervention listed on R39's care plan was dated with a start date of 4/23/24. A review of R39's electronic medical record (EMR) revealed that R39 was admitted to the facility on [DATE] with diagnoses that included Encephalopathy (Damage or disease that affects the brain) and Type 2 diabetes. R39's most recent minimum data set assessment (MDS) dated [DATE] revealed R39 had a moderately impaired cognition and required supervision for all activities of daily living (ADLs). On 7/16/24 at 1:34 PM, MDS/Registered Nurse (RN) T was interviewed and R39's falls and fall care plan interventions were reviewed. RN T confirmed the most recent intervention on R39's fall care plan was dated 4/23/24. RN T indicated a new intervention should be placed on the care plan following each fall. On 7/16/24 at 3:20 PM, the Director of Nursing (DON) was interviewed by phone regarding their expectations for interventions being placed on care plans following a resident fall. The DON stated, It depends on the occurrence. If there is a new intervention we can try then it should be on the care plan. A facility policy titled Care Plan Revisions Upon Status Change Date Implemented: 10/26/2022 was reviewed and revealed the following, Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation And Compliance Guidelines: 1. The Comprehensive Care Plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure For Reviewing And Revising The Care Plan .b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. d. The care plan will be updated with the new or modified interventions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation pertains to Intake MI00145293. Based on interview and record review, the facility failed to provide consistent, scheduled showers for one resident (R29) of three residents reviewed for Activities of Daily Living (ADL) bathing care needs. Findings include: During an interview on 7/14/24 at 1:55 p.m., R29 reported they wanted to receive showers regularly. R29 stated, I want a shower and I am not getting them, as they are at night, and they [nursing staff] will not do them. I talked to a nursing manager about it [unnamed], and they are supposed to be twice a week. R29 reported this made them feel upset and frustrated, as being clean was important to them, and they wanted full showers. Review of the Electronic Medical Record (EMR) revealed no shower logs. Review of R29's, ADL bath logs showed R29 had received four baths in a one-month period, with six entries showing, activity did not occur, without explanation. There was no documentation of any showers for R29 during the 30-day look back, only baths. Three entries showed, partial bed bath, and one entry showed, bath - other. Four of the four baths were provided during the day shift; none occurred in the evening or night, per resident preference during interview to bathe/shower before bed. Given R29 was scheduled for showers twice a week and missed showers on at least eight opportunities. Review of R29's Minimum Data Set (MDS) assessment, dated 6/17/24, revealed R29 was admitted to the facility on [DATE], with diagnoses including limb amputation (leg), peripheral vascular disease (progressive disorder of the blood vessels), stroke, anxiety, and depression. R29 required maximal assistance with toileting and bathing/showers, and moderate assistance with bed mobility and transfers. R29 was incontinent of bladder and bowel. R29 had a range of motion limitation in one upper extremity and both lower extremities and was independent with wheelchair mobility (using a power wheelchair). During a phone interview on 7/16/24 at approximately 4:30 p.m., the Director of Nursing (DON) was asked about R29's missed showers. The DON reported they spoke to R29 on two occasions [about their showers] and it was difficult to accommodate the time R29 preferred their showers, as they liked their showers before going to bed. The DON acknowledged they were aware of R29's concerns and believed they had been addressed. Review of the policy, Activities of Daily Living, implemented 11/01/22, revealed, Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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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 - Some	Provide activities to meet all resident's needs. 44750 Based on observation, interview, and record review, the facility failed to provide activities to meet the resident needs for four residents (R9, R19, R20, and R32) out of five reviewed for activitites. Findings include: R9 On 7/15/2024 at 12:29 PM, R9 was interviewed regarding the activities provided in the facility. R9 stated they do not offer activities for everyone. R9 stated when they get up in their wheelchair, there is nothing to do except ride in circles in my chair. On 7/15/2024 at 2:03 PM, activity notes were requested for R9. None were received by end of survey. R19 On 7/15/2024 at 11:00 AM, R19 was observed walking around the facility. R19 stated they were bored and wondered where the best place in the facility was to bird watch. R19 was observed walking around the facility, sitting in the lobby, and then going back to their room. On 7/15/2024 at 2:03 PM, activity notes were requested for R19. None were received by end of survey. R20 On 7/15/2024 at 2:43 PM, an interview was conducted with R20 regarding activities in the facility. R20 stated they don't get out their room much, so they do activities in their room. R20 stated when they first arrived in the facility they used to come in the room and do activities or invite them out to do things but the last couple of months, they have seen no one and they are no longer being offered activities. R20 stated their family has to bring them leisure materials. On 7/15/2024 at 2:03 PM, activity notes were requested for R20. None were received by end of survey. R32 On 7/15/2024 at 2:00 PM, R32 was interviewed regarding activities in the facility. R32 stated no one comes by the room and makes visits, however they have been without an activity's director. R32 stated they would like to take off site trips and they don't have any activities on the weekend. On 7/15/2024 at 2:03 PM, activity notes were requested for R32. None were received by end of survey. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/2024 at 11:29 AM, an interview was conducted with Activities Aide (AA) I. AA I stated they are currently working by themselves Monday-Friday. AA I stated they do not work weekends and they do not have coverage. AA I stated they make up the calendars and do the best they can until they receive some help. A review of a policy titled, Activities noted the following, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 44750 Based on interview and record review the facility failed to employ a full-time activities director this deficient practice has the potiential to affect all 58 residents that resident in the facility. Findings Include: On 7/15/2024 at 2:00 PM, an interview was conducted with a resident regarding activities in the facility. The resident stated the facility does not have an Activities Director and has not had one in months. The resident confirmed they do not have many activities, including none on the weekend. On 7/16/2024 at 10:00 AM, an interview was conducted with the Regional Nursing Home Administrator (RNHA). The RNHA stated they do not believe the facility has an Activities Director right now, but they have hired one and they should be starting soon. On 7/16/2024 at 11:29 AM, an interview was conducted with Activities Aide (AA) I. AA I stated the facility has been without an activities director for months and they have been by themselves. AA I stated they have been in the role as an activity's aide for the last year, both part time and full time. AA I stated prior to role they were the receptionist, as well as a certified nursing aide. AA I confirmed they have hired a Activity's Director and are currently waiting for them to start. A review of a facility policy titled, Activities did not mention Activities Director and their role.

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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 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** 44750 This citation has two Deficient Practice Statements (DPS). DPS #1 Based on observation, interview, and record review, the facility failed to set up follow up appointments for one resident (R55) out of two residents reviewed for follow up appointments, resulting in delay of care. Findings include: On 7/15/2024 at 9:55 AM, R55 was observed laying in bed. R55 stated they were waiting for a pain pill. R55 stated they had a fracture in their left knee, upon observation the left knee was visibly swollen. R55 stated they had a left hip replacement due to a fall at home. A surgical dressing was observed on the left hip. R55 stated the dressing had been there since 6/12/2024 and they had not had a follow up with Orthopedics (bone specialist) yet. R55 also stated they had cancer and should be receiving chemotherapy. R55 stated they should be going every Friday, and they have missed four treatments since being admitted into the facility. A review of the medical record revealed that R55 admitted into the facility on [DATE] with the following diagnoses, Fracture of left femur and Fall. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) 15/15 indicating an intact cognition. R55 also required assistance with bed mobility and transfers. Further review of the medical record revealed R55 was recommended to follow up with their orthopedic physician on 7/3/2024 and their oncology physician within 1-2 weeks of admission into the facility. A follow-up note from these appointments was requested and not received by end of survey. On 7/16/2024 at 12:13 PM, an interview was completed with Receptionist H. Receptionist H stated they had been in the position since July 2nd, 2024, and they were in charge of scheduling follow up appointments. Receptionist H stated they just received a follow up appointment for R55 to follow up with oncology and they were going to call after lunch to schedule it. Receptionist H stated it was the first they had heard of the appointment. Receptionist H was queried regarding R55's Orthopedic follow up appointment. Receptionist H stated there was one scheduled for July 22nd, and they can not speak to why a follow up was not scheduled prior to that. On 7/16/2024 at 3:16 PM, an interview was conducted with the Director of Nursing (DON) via phone. The DON stated they recently received an email regarding R55 not having their follow up appointments. The DON stated they were not familiar with R55 and could not comment on the specifics. A facility policy for outside appointments was requested, but not received prior to the end of survey. 49102 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DPS #2 Based on observation, interview and record review, the facility failed to ensure appropriate physicians orders were in place for oxygen one resident (R15) out of three residents reviewed for respiratory care. Findings include: On 07/14/24 at 10:00 AM, R15 was observed lying in bed with oxygen concentrator running and the nasal cannula lying on floor next to the bed. At 02:26 PM, R15 was observed lying bed. R15 was asked if they were having trouble breathing and the reply was yes. The nasal cannula remained laying on the floor next to the bed. On 07/15/24 at 08:59 AM, R15 was observed sitting up in the bed eating breakfast. The nasal cannula was observed on the floor with oxygen concentrator running. At 010:15 AM, Nurse U was asked to assess R15's oxygen reading and it revealed 92%. The nurse was asked to show the physician's order for R15 oxygen. There was no active order. Further review of the R15's medical record revealed there were no active physician orders for oxygen A review of R15's medical record revealed they were admitted into the facility on [DATE] with diagnoses of Acute Respiratory Failure, Pneumonia, Adjustment disorder with anxiety, and Chronic Obstructive Pulmonary Disease. A review of R15's Minimum Data Set (MDS) assessment dated [DATE] revealed, R15's Brief Interview for Mental Status assessment score was a 10 indicating moderately impaired cognition. On 07/16/24 at 01:05 PM, an interview was held with MDS/Registered Nurse (RN) T regarding the care plan. When asked about the oxygen care plan, RN T replied My expectation is all the orders are to be transcribed, and care plans written for the care of each resident. A review of the facility's policy titled Oxygen Administration implemented 11/01/22 revealed the following, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.

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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 services to one resident (R29) of one resident reviewed for limited range of motion and restorative services. Findings include: During an observation on 7/14/24 at 1:00 p.m., R29 was observed in their room, seated in a power wheelchair. R29's right arm was bent up at the elbow, and their right hand was closed tightly, with increased muscle tone, and they had an amputated right leg, below the knee. R29 reported they had a right-hand splint, which they wore during the day on and off, and showed surveyor a right hand and forearm padded handroll splint on their dresser. R29's power wheelchair had a joystick on the left side, and R29 reported they used thier left hand to maneuver their joystick and operate the power wheelchair. During an interview on 7/14/24 at 1:53 p.m., R29 reported they wanted exercise and range of motion to their right arm and remaining leg to maintain and improve their mobility, and stated, No one is coming to exercise me. R29 was asked if they were receiving restorative therapy or was enrolled in therapy, and R29 reported they were not receiving either, but wanted more therapy so they could maintain or even possibly improve their function and comfort. Review of R29's physician orders revealed, Restorative Therapy. Special instructions: Restorative therapy to maintain upper extremity strength and range of motion. Once a Day on Tues, Wed, Thu [days of week] . The order was dated 4/05/24 and was open ended, showing an active order, to be completed by a CNA [Certified Nurse Aide]. A second order showed R29 was to wear their right upper extremity splint up to 6 hours daily. Review of R29's Care Plan, accessed 7/16/24, revealed, Problem start date: 5/14/24. Category: ADLs, Functional Status/Rehabilitation Potential. RESIDENT IS ON A RESTORATIVE PROGRAM. Short term goal targe date: 9/14/2024. Maintain B [bilateral] ue [upper extremity] strength and ROM. Approach start date: 5/14/24. RUE [right upper extremity] all planes [of body] 3 sets x 10-15 reps. LUE [left upper extremity] all planes. 3 sets x 15 reps. Discipline: Nursing . Review of the Electronic Medical Record (EMR) revealed no restorative logs including participation in a range of motion program for R29. An email was requested for any documentation related to R29's participation in a restorative exercise program, per physician orders. A return email was received on 7/16/24 from corporate administration, which confirmed no restorative logs or documentation of participation in a restorative program was found for R29. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R29's Minimum Data Set (MDS) assessment, dated 6/17/24, revealed R29 was admitted to the facility on [DATE], with diagnoses including limb amputation (leg), peripheral vascular disease (progressive disorder of the blood vessels), stroke, anxiety, and depression. R29 required maximal assistance with toileting and bathing/showers, and moderate assistance with bed mobility and transfers. R29 was incontinent of bladder and bowel. R29 had a range of motion limitation in one upper extremity and both lower extremities and was independent with wheelchair mobility (using a power wheelchair). The assessment showed R29 had occasional pain, at 6/10, with a score of 10 the worst pain. The BIMS assessment revealed a score of 15/15, which indicated R29 was cognitively intact. During a phone interview on 7/16/24 at approximately 4:20 p.m., the Director of Nursing (DON) was asked about R29 not receiving restorative services for range of motion. The DON stated, .This is the first I have heard of it. We will address this . Review of the policy, Activities of Daily Living [ADL's], implemented 11/01/22, revealed, .Policy Explanation and Compliance Guidelines .2. The facility will provide a maintenance and restorative program to assist the resident in achieving and maintain the highest practicable outcome based on the comprehensive assessment. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44750 This citation pertains to Intake MI00145043 Based on interview and record review, the facility failed to use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, resulting in the potential for inadequate coordination of care and negative clinical outcomes, potentially affecting all residents residing in the facility. Findings include: On 7/15/2024 at 9:56 AM, a request was made for daily staff postings. Upon review of the postings RN coverage was not noted on the following dates: January -2 March-7,11,12,13,15,21,27 and 29 June-3,4,5,7,12,18,19,20,21,22,23,24, and 25 July-3 On 7/16/2024 at 1:00 PM, an interview was conducted with the scheduler, Staff J. Staff J stated sometimes they do have a hard time getting RN coverage. Staff J stated they have the weekend supervisor and a night RN and can sometimes use the Director of Nursing (DON) for coverage. On 7/16/2024 at 3:16 PM, an interview was conducted with the DON via phone. The DON stated initially when they joined in March, they did not have consistent RN coverage. However, they are working on it now and the last two months they have had RN coverage. A review of a facility policy titled, Nurse Staffing Posting Information did not mention RN coverage.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 40330 Based on interview and record review, the facility failed to record and post necessary staffing information to ensure the facility had adequate staff per regulatory guidance to meet the care needs of the residents. This deficient practice had the potential to affect all 58 facility residents. Findings include: Review of the Centers for Medicare and Medicaid PBJ staffing data report showed the facility triggered for three areas of staffing concerns. During the quarter 1/01/24 to 3/31/24, the concerns were: low weekend staffing, one-star staffing rating, and no RN (Registered Nurse) consistent hours, per regulatory guidance. During an observation on 7/14/24 at approximately 9:35 a.m., a binder with nursing staff schedules was found at the central nurse's station on South Hall, which showed the names of the staff scheduled, and which hall and rooms they covered. There was no staff posting data, showing the number and hours of the staff working, for RN's or CNAs (Certified Nurse Aides). An interview was conducted 7/14/24 at approximately 9:40 a.m. with the Unit Manager, RN B who was asked for this data, or a separate staff posting page. RN B reported this was all they had, and there was no other data available showing the number of nursing staff and hours they were working. RN B confirmed there was no staff posting on 7/14/24, and there was only a staff schedule. A second nurse on the South Hall was asked about staff postings, and confirmed the staff schedule was all that was available, and there was no staff posting. Staff postings were requested by the survey team during the survey beginning on 7/14/24, and 7/15/24, and were not received until 7/16/24 by corporate administrative staff. The staff postings (as well as schedules) were requested for the following random two-week time periods: 7/01/24 to 7/16/24. 1/01/24 to 1/15/24. 3/15/24 to 3/31/24. Review of the staff postings from 7/01/24 to 7/16/24 showed the staff postings were missing and/or not completed for the following (seven) dates: 7/01/24, 7/02/24, 7/04/24, 7/05/24, 7/06/24, 7/07/24, and 7/13/24. The survey team re-requested timecards for July, 2024, by date (day), from the corporate administrative staff on 7/16/24, both in person and via email, to ascertain the number of nursing staff and the hours worked on the missing dates of the staff postings. This documentation was not received by survey exit. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/16/24 at 1:16 p.m., the Regional Nursing Home Administrator reported to the survey team they had no staff postings for January 2024, and acknowledged the missing staff postings for July 2024. NHA G stated, We [management staff] are missing the dates in July; whatever I gave you is what we have. During an interview on 7/16/24 at 1:27 p.m., the Regional Nursing Home Administrator returned and provided a few staffing postings from January 2024, but reported they were unable to find the remainder of staff postings for January 2024. NHA G provided staff postings for 1/01/24, 1/02/24, 1/04/24, 1/10/24, 1/19/24, and 1/22/24, which showed there were 25 staff postings for January 2024, which remained missing and/or were not completed. Review of the July 2024 and January 2024 staff postings showed the facility was not consistently tracking and/or keeping records of the number of nursing staff present in the facility and their hours via staff posting sheets, per regulatory requirements. During a phone interview on 7/16/24 at 4:13 p.m., the Director of Nursing (DON) was apprised of the missing nurse postings for January 2024 and July 2024. The DON reported they started their position at the facility in March 2024, and had not been made aware of the missing staff posting logs for those dates, and understood the expectation was they would be available and completed. Review of the policy, Nurse Staffing Posting Information, implemented 11/01/22, revealed, It is the policy of the facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. Policy explanation and Compliance Guidelines: 1.The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name. b. The current date. c. Facility's current resident census. d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses. ii. Licensed Practical Nurses/Licensed Vocational Nurses. iii. Certified Nurse Aides. 2.The facility will post the Nurse Staff Posting Sheet at the beginning of each shift . 3. The information posted will be: a. Presented in a clear and readable format. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. In a prominent placed readily accessible to residents and visitors. 4. A copy will be available to all supervisors to ensure the information posted is up-to-date and current . 5. Nursing schedules and posting information will be maintained by the Human Resources department for review for a minimum of 18 months or as required by State law, whichever is greater. 6. The facility will, upon oral or written request, make the nurse staffing data available to the public for review .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 44750 Based on interview and record review, the facility failed to ensure that a physician responded to Pharmacist Medication Regimen Reviews (MRR) recommendations timely for one resident (R29) out of two reviewed for MRR's. Findings include: A review of the medical record revealed pharmacy progress notes that stated, See report for any irregularities on the following days: 1/3/2024, 3/6/2024, and 6/5/2024. On 7/16/2024 at 2:35 PM, an email was sent requesting the complete MRR and pharmacy recommendations for R29. On 7/16/2024 at 3:43 PM, an email was received stating they did not have the full MRR and/or the pharmacy recommendations with the physician follow up. On 7/16/2024 at 4:47 PM, an interview was conducted with the Director of Nursing (DON) via phone. The DON stated the staff in the facility probably could not find the MRR's because they are in a binder in the office. The DON stated they were not sure why they were not provided. No additional information was provided prior to the end of survey. A policy for MRR's was requested, but not received prior to the end of survey.

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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** 44750 Based on interview and record review, the facility failed to provide a 14 day stop date to an antianxiety or provide adequate documentation to justify use beyond 14 days for PRN (as needed) medication for two residents (R21 and R44) out of four reviewed for unnecessary medications. Findings Include: R21 A review of the medical record revealed that R21 admitted into the facility on [DATE] with the following diagnoses, Anxiety and Rheumatoid Arthritis. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R21 also required assistance with bed mobility and transfers. Further review of the physician orders revealed the following orders, Alprazolam-Schedule IV tablet;0.25 mg: amt: 1 tablet; oral. Special Instructions: take 1 tablet 2 times a day as needed. Alprazolam-Schedule IV tablet;0.5 mg: amt: 1 tablet; oral. Special Instructions: take 1 tablet 2 twice a day as needed. No stop date was noted for either order. On 7/15/2024 at 11:28 AM, an interview was conducted with the Social Service Director (SSD). The SSD stated they have educated everyone abut stop dates and the Director of Nursing (DON) and Unit Manager should be looking over those orders to ensure they have a stop date. The SSD stated all anti-anxiety medications that are PRN should have a 14 day stop date, unless noted otherwise. On 7/16/2024 at 3:16 PM, an interview was conducted with the DON via phone. The DON stated they need a stop date on those orders and that they have to go in and manually put in the stop dates for PRN orders. 49102 R44 On 07/14/24 at 09:03 AM, R44 was observed laying in bed. R44, nonverbal and unable to verbalize needs. A review of R44's medical record revealed they were admitted into the facility on [DATE] with diagnoses of Encephalopathy, Depression, Vascular Dementia and Hypertension. A review of R44's Minimum Data Set (MDS) assessment dated [DATE] revealed, R44's Brief Interview for Mental Status assessment score was a 0 indicating severely impaired cognition. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R44's medical record revealed a physicians order for Xanax .5mg daily PRN without a stop date. On 7/16/24 an interview was with SW discussing the expectations of having psychotropic PRN medication without a 14 day stop or documentation justifying further use. SSD stated the following, I am not sure why there is no stop date. I have spoken with nurse management about the PRN medications and the need for stop dates. SSD revealed the expectation is for all residents on PRN meds should have a stop date or documentation from physician justifying use. A review of the facility's policy titled Ue of Psychotropic Medication implemented 11/1/22 revealed the following Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) . PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident ' s medical record and indicate the duration for the PRN order. Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 22960 This citation pertains to intakes MI 143412 Based on observation, interview, and record review, the facility failed to ensure meal portion sizes met the nutritional needs of the residents, resulting in the potential for inadequate protein intake, weight loss, and decreased meal enjoyment. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 7/15/24 at 12:30 PM, Dietary Supervisor L was observed preparing meal trays for the lunch service. Dietary Supervisor L was observed placing a small 2 1/2 inch x 2 1/2 inch piece of baked chicken on each plate, along with a vegetable side, a pasta side and a dinner roll. A test tray of this lunch meal was requested. On 7/15/24 at 12:45 PM, the test tray was observed with Registered Dietitian (RD) M. RD M was queried about the size of the baked chicken that was being served for lunch to the residents. RD M stated that the piece of chicken served was probably around 2 ounces, and that it was not big enough. RD M stated that 2 pieces of the chicken would have been a more appropriate size. On 7/15/24 at 1:00 PM, RD M provided a diet spreadsheet for the lunch meal. The spreadsheet noted that for a regular diet, the portion size of the herb baked chicken should be 4 ounces. On 7/15/24 at 2:00 PM, a confidential group of residents stated that they don't get enough food due to the small portions.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38207 This citation pertains to Intake MI00145270. Based on observation, interview, and record review, the facility failed to serve food in a palatable manner and at the preferred temperature for one resident (R2) and seven confidential group residents, resulting in dissatisfaction during meals. Findings include: R2 On 7/14/24 at 2:38 PM, R2 was interviewed about food palatability at the facility and stated, The food is cold. I don't eat most of it. On 7/15/24 at 10:10 AM, a follow-up interview was conducted with R2 and they were asked about the palatability of their breakfast. R2 indicated they did not eat their breakfast and stated, It didn't look good. On 7/15/24 at 12:40 PM, an observation was made of staff serving lunch trays to residents' rooms with the food cart doors left open. On 7/15/24 at 12:43 PM, a random food tray off of the food cart was temperature checked by Registered Dietician (RD) M and the temperatures of the food was the following: Baked Chicken: 112 degrees Fahrenheit; Cooked Mixed Vegetables: 111 degrees Fahrenheit; Orzo (Pasta): 120 degrees Fahrenheit. RD M was interviewed regarding the preferred temperature for the items on the food tray. RD M indicated they liked to see the hot food items at 165 degrees Fahrenheit or above. RD M tasted the chicken on the meal tray and stated, It tastes pretty good. On 7/15/24 at 12:46 PM, the meal tray was taste tested by the surveyor and revealed the food tasted luke warm which negatively impacted the food palatability. On 7/16/24 at 1:45 PM, a facility policy titled, Food Preparation Guidelines Date Implemented: 11/1/2022 was reviewed and revealed the following, Policy: It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition .Policy Explanation And Compliance Guidelines: 3. Foods .shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include: c. Serving hot foods .hot .

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 22960 This citation pertains to intake MI 143412 Based on observation, interview, and record review, the facility failed to ensure meals were served in a timely manner and in accordance with the scheduled mealtimes for the resident, resulting in late meals and resident dissatisfaction. Findings include: A review of an undated facility document titled, Meal Times, revealed the following: Breakfast 7:30 am-8:30 am, Lunch 11:30 am-12:30 pm. On 7/14/24 at 9:15 am, kitchen staff was observed getting ready to start the breakfast meal trayline service. When queried as to why the breakfast meal was late, Dietary Aide K stated that they do not have enough staff in the kitchen, and that if's difficult to get meals out on time when they are trying to do everything with just 1 or 2 staff members. On 7/14/24 at 10:30 am, breakfast trays were still being delivered to residents throughout the building. On 7/14/24 at 3:07 pm, lunch trays were observed being passed to residents on the South Hall. Resident #6 and Resident #34 complained about the late lunch meal and stated they were hungry. On 7/15/24 at 2:00 PM, a confidential group of residents stated that the meals are always served late, and not within the facility's documented meal times.

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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 store, prepare and serve food under sanitary conditions. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 7/14/24 at 8:40 AM, the trash can located at the handwashing sink near the main entrance of the kitchen, was observed with no liner, and was heavily soiled on the inside and outside with a black mold-like substance. In addition, the handwashing sink located near the ice machine was observed with food debris in the sink basin, and there were no paper towels in the towel dispenser. According to the 2017 FDA Food Code section 5-501.116 Cleaning Receptacles, .(B) Soiled receptacles and waste handling units for REFUSE, recyclables, and returnables shall be cleaned at a frequency necessary to prevent them from developing a buildup of soil or becoming attractants for insects and rodents. According to the 2017 FDA Food Code section 5-205.11 Using a Handwashing Sink, .2. (B) A HANDWASHING SINK may not be used for purposes other than handwashing. Pf According to the 2017 FDA Food Code section 6-301.12 Hand Drying Provision, Each handwashing sink or group of adjacent handwashing sinks shall be provided with: (A) Individual, disposable towels;. On 7/14/24 at 8:45 AM, the sink located in front of the walk-in cooler in the kitchen was observed to be 1/4 full of water, with raw, boneless pork chops soaking in the water. The internal temperature of the pork chops ranged from 71-74 degrees Fahrenheit. When queried at that time, Dietary Supervisor L stated that the pork chops were frozen, and she had placed them in the water to thaw them out for lunch. Dietary Supervisor L stated that she didn't mean to leave the pork chops in the sink, but that she had been so busy, she wasn't able to get back to them. On 7/14/24 at 10:15 AM, the pork chops were still in the sink, but the water had been drained, so they were sitting in a dry sink basin. According to the 2017 FDA Food Code section 3-501.13 Thawing, Except as specified in (D) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be thawed: 1. (A) Under refrigeration that maintains the FOOD temperature at 5 C (41 F) or less; or 2. (B) Completely submerged under running water: 1. (1) At a water temperature of 21 C (70 F) or below. 2. (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and 3. (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5 C (41 F), or 4. (4) For a period of time that does not allow thawed portions of a raw animal FOOD requiring cooking as specified under 3-401.11(A) or (B) to be above 5 C (41 F), for more than 4 hours including: 1. (a) The time the FOOD is exposed to the running water and the time needed for preparation for cooking, or 2. b) The time it takes under refrigeration to lower the FOOD temperature to 5 C (41 F);. On 7/14/24 at 8:50 AM in the kitchen walk-in cooler, there was an opened, undated 1 gallon container of mayonnaise and an undated 1/4 ham roast. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/14/24 at 8:55 AM in the kitchen True reach-in refrigerator, there was an undated foam container of potatoes, an opened undated package of pink salmon, an opened undated package of sliced turkey, and an opened undated deli sandwich. 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. On 7/14/24 at 9:00 AM, the flooring throughout the kitchen was observed with a heavy buildup of grime and food debris. In the dry storage room, there was a buildup of food debris on the floors under the racks. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean. On 7/14/24 at 9:05 AM, the ventilation cover located above the clean dishware rack was observed to be soiled with dust. According to the 2017 FDA Food Code section 6-501.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition, (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. On 7/14/24 at 11:00 AM, dietary staff were observed getting ready to wash the breakfast dishes in the dish machine. The dish machine log was observed, and the last documented temperature reading had been recorded on 7/2/24. Dietary aide K was queried as to how the dish machine was monitored to ensure adequate sanitation, but was unsure. Registered Dietitian was queried as to how the dish machine was checked to ensure that it was properly sanitizing the dishware, and stated that they would check the temperature on dials. When queried about the temperature log, RD confirmed that staff were to be filling out the dish machine temperature log daily. According to the 2017 FDA Food Code section 4-703.11 Hot Water and Chemical, After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: .(B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under SS 4-501.15, 4-501.112, and 4-501.113 and achieving a UTENSIL surface temperature of 71 C (160 F) as measured by an irreversible registering temperature indicator;. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/14/24 at 11:15 AM, the interior lights for the ventilation hood located above the oven were noted to be non-functional. Dietary Aide K stated that the lights don't work and that management is aware, but hasn't done anything to fix the issue. Dietary Aide K further stated that the garbage grinder was also broken. Dietary Aide K stated that management was aware of that as well, but that they refused to purchase the parts needed to fix it. The garbage grinder was observed to be full of old food, with gnats observed flying about the non-functional unit. According to the 2017 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment, (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. On 7/14/24 at 1:45 PM, the ice machine located in the pantry was observed with Facilities Director D. There was a black mold-like substance observed on the interior sides of the ice bin. Facilities Director D confirmed the black substance and stated that the cleaner used for inside the ice machine flows down the back, and doesn't hit the sides. According to the 2017 FDA Food Code section 4-602.11 Equipment Food-Contact Surfaces and Utensils, (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not potentially hazardous (time/temperature control for safety food) shall be cleaned: (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on interview and record review, the facility failed to effectively administer its daily operational processes to provide for the needs of residents for all 58 residents residing in the facility by not correcting unsafe carpet throughout the hallways of the facility, and maintaining or timely replacing resident care equipment. Findings include: On 7/16/24 at 8:35 AM, an interview regarding the condition of the carpet was conducted with Housekeeping/Laundry supervisor (HLS) S. HLS S stated, We have shampooed it and the stains won't come out. I have no floor technician. It needs to be replaced, I have talked to the owner about it. On 7/15/24 at 9:45 AM, Maintenance Supervisor (MS) D was interviewed and asked about the status of the facility's mechanical lift and indicated the lift went out for repairs on/around 7/4/24, and the lift company provided the facility with a temporary mechanical lift which is currently in use at the facility. MS D was further interviewed about the lift being out of the building on/around 6/14/24 and stated, I know nothing about that. MD D was asked to provide documentation regarding lift repairs and indicated they had no documentation regarding repairs done to the lift. On 7/16/24 at 11:00 AM, the Director of Nursing (DON) was interviewed by phone and asked about details regarding the facility's mechanical lift repair. The DON was unable to provide any details and did acknowledge the facility was without a mechanical lift on and around 6/14/24. The DON was unable to provide any verbal or written information regarding the duration of the facility being without a mechanical lift in the building. On 7/16/24 at 11:30 AM, the [NAME] Nursing Home Administrator (RNHA) was interviewed and asked about any details or documentation related to the facility's mechanical lift repairs and carpet plans. The RNHA indicated the facility Administrator (NHA) was on vacation and no documentation and/or information could be located regarding mechanical lift repairs or status of carpeting. On 7/16/24 at 2:30 PM, a Quality Assurance (QA) review meeting was held with the RNHA. The Quality Assurance Binder (QAB) was reviewed with the RNHA present and facility quality assurance (QA) activities were reviewed. No QA activities were observed as documented in the QAB related to the facility worn carpet, and mechanical lift repairs. The RNHA was interviewed regarding QA activities related to the carpet, lift repair, and was unable to provide any information regarding these issues. A facility policy titled Safe and Homelike Environment Date Implemented: 11/1/22 was reviewed and revealed the following, Policy: In accordance with residents' rights, the facility will provide a safe . comfortable, and homelike environment .This includes ensuring that the resident can receive care and services safely .

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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** 22960 This citation has multiple deficient practice statements. Deficient practice #1. Based on interview and record review, the facility failed to implement an active water management plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all of the 58 residents in the facility. Findings include: On 7/14/24 at 1:30 PM, the facility's Water Management binder was reviewed, with a form entitled Steps To Creating a Water Management Program that noted: Establish a Designated Team, Develop Water Flow Diagrams, Identify Areas, Equipment & Systems at Risk, Identify Strategies to Mitigate Risk, Establish Program to Monitor Strategies, Review Program Periodically to Confirm Effectiveness. There was no list of water management team members and no water flow diagram for the building in the Water Management binder. In addition, in the Water Management binder, there was a policy entitled Water Management with an Issue Date of 2/7/2021 that noted: Daily Inspections: 1. The dishwasher will have daily temperature checks and will also run daily. On top of that it will also be de limed twice a month . Weekly Inspections: 6. Empty resident rooms or areas not used will have a weekly inspection. Sinks will run for over a minute, toilets will be flushed, and showers will run for over a minute . Quarterly Inspections: 2. All shower heads and sink aerators will be removed, disinfected, and re-applied. On 7/14/24 at 9:15 AM, the kitchen dish machine was observed with a heavy buildup of lime scale along the bottom edge of the door. In addition, the dish machine log had not been completed with daily temperature checks since 7/2/24. On 7/14/24 at 2:45 PM, Maintenance Supervisor was queried about the Water Management program, and stated that he does not have any involvement in the program. Maintenance Supervisor stated I think the company has someone come out and they take care of it. They do testing I guess. They have a book. When queried about flushing fixtures in empty rooms or areas not used, or removing and disinfecting shower heads and aerators, Maintenance Supervisor again confirmed he had no involvement in the facility's water management program. On 7/15/24 at 2:45 PM, the Director of Nursing/Infection Preventionist was queried via telephone regarding the facility's Water Management program. The DON/IP stated she was not involved in the program, but thought the Administrator was doing testing, but was not sure. On 7/15/24 at 2:50 PM, the Administrator was queried via telephone regarding the facility's Water Management program. The Administrator stated he thought there had been testing done about a year ago, but that it was before his time. The facility was unable to provide any evidence of testing by the end of the survey. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	44750 Deficient Practice #2. Based on observation, interview, and record review, the facility failed to don/doff personal protection equipment (PPE) for three residents (R5, R48, and R50) on enhanced barrier precaution (EBP) out of eight reviewed for infection control. Findings Include: R48 On 7/14/2024 at 2:27 PM, R48's call light was observed activated. A sign stating that R48 was on EBP observed outside of the door. No PPE was noted outside the door. A Certified Nursing Assistant (CNA) was observed going into the room and closing the door. On 7/14/2024 at 2:31 PM, R48 was interviewed regarding staff wearing PPE when providing care. R48 stated if they are supposed to wear PPE, then they do not enforce it because they never wear it. R48 stated they just had their catheter bag emptied and they only thing the staff wore was gloves. A review of the medical record revealed that R48 admitted into the facility on [DATE] with the following medical diagnoses, Cerebral Infarction and Retention of Urine. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R48 also required assistance with bed mobility and transfers. On 7/15/2024 at 2:39 PM, Licensed Practical Nurse (LPN) F was seen exiting R48's room. LPN F was asked if they were in the room performing care. LPN F stated they were helping the CNA perform care on R48. LPN F was queried if they were wearing PPE because R48 was on EBP. LPN F stated they were not wearing PPE and that they did not see any PPE outside the door. R50 On 7/15/2024 at 12:53 PM, A sign was observed on the door stating that R50 was on EBP. No PPE was noted outside the door. CNA E was observed in the room changing R50. CNA E was not observed to be wearing any PPE. On 7/15/2024 at 2:33 PM, R50 was interviewed regarding their care in the facility. R50 stated that they never wear gowns when they change them, just gloves. A review of the medical record revealed that R50 admitted into the facility on [DATE] with the following diagnoses, Pain in left leg and Cerebral Infarction. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 15/15 indicating an intact cognition. R50 also required assistance with bed mobility and transfers. On 7/15/2024 at 2:41 PM, an interview was conducted with Registered Nurse (RN) B. RN B stated they had buckets in front of the door with PPE in it and they don't know what happened into it. RN B stated if care is being provided, they should be wearing PPE, and they were going to replace the buckets. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/16/2024 at 3:16 PM, an interview was conducted with the Director of Nursing (DON) via phone. The DON stated it is the expectation that when they see the BEP sign that they don and doff PPE. 38207 R5 On 7/14/24 at 9:00 AM, an observation was made of signage being present on R5's room door which indicated that R5 was on enhanced barrier precautions (EBP) and stated the following, Providers/staff wear gloves and a gown for the following High-Contact Resident Care Activities .Providing hygiene . On 7/15/24 at 9:35 AM, Certified Nurse Assistant (CNA) V was observed to enter R5's room to wipe R5's mouth without donning a gown and/or gloves. On 7/15/24 at 10:22 AM, CNA Z was interviewed regarding the procedures for providing care to a resident on EBP. CNA Z indicated that you should be wearing gloves and a gown when providing care. On 7/15/24 at 1:30 PM, the Director of nursing (DON) was interviewed by phone regarding their expectations for direct care staff when providing care to residents on EBP. The DON stated, Staff is expected to wear personal protecton equipment (PPE) when providing care to residents on EBP. The DON was further interviewed about what a CNA should be wearing when entering a room to wipe a resident's mouth who was on EBP. The DON stated, They should be wearing gown, gloves, mask, and goggles. A facility policy titled Infection and Control Program Date Reviewed/Revised: 3/13/24 stated the following, Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections per accepted national standards and guidelines. 16. Staff Education: c. Direct care staff shall demonstrate competence in resident care procedures established by our facility.

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 40330 This citation pertains to Intake MI00145142. Based on observation, interview, and record review, the facility failed to ensure patient equipment was in safe operating condition for the prevention of hazards and accidents for four residents (R49, R2, R34 and R6) from a sample of five residents. Findings include: R49 During on observation on 7/14/24 at approximately 9:55 a.m., R49 was observed in the South Hall aisleway. She was seated in a manual wheelchair, with her arms wrapped in gauze, with some bruising noted, and a small amount of blood was seeping from her right arm bandage. Upon further observation, it was noted there was blood on the right armrest of R49's wheelchair. It was further observed the padded wheelchair armrests had cracks in the fabric, and were worn down, so the plastic edge appeared to be a contact point to R49's arms, especially the right armrest. During an interview on 7/14/24 at approximatley 10:00 a.m., R49 was asked about the blood, and their wheelchair. R49 reported they cut their arms on the plastic edge of the wheelchair arms and said they made staff aware, as the armrests were cutting her arms and causing discomfort. Surveyor immediately made R49's nurse aware, Registered Nurse (RN) AA, who reported they were not aware of any equipment concerns and would follow-up. During an interview on 7/16/24 at approximately 1:00 p.m., Corporate Maintenance Director (CMD) W was shown a picture this Surveyor had taken of R49's wheelchair armrests (only), which was timestamped 7/14/24 at 9:58 a.m . Both armrests had cracks in the black encasing cover, however, the right armrest had larger cracks with the plastic casing partially opened revealing the fabric, which showed a light maroon color, appearing like dried blood. Upon review of the picture, CMD W indicated they would have expected the facility maintenance staff to have replaced both armrests on the wheelchair, and routine equipment inspections. R2 During an observation on 7/14/24 at 12:40 p.m., R2 agreed for Surveyor to observe a [total assistance mechanical] lift bed to wheelchair transfer with nursing staff. Two CNA's, CNA Z and an unknown CNA completed the transfer without concern, however the lift creaked during the transfer. It was observed R2 was positioned in a high back power chair with a [Namebrand air] seat cushion after the transfer. It appeared there were two [Namebrand air] cushions on the chair, however Surveyor could not fully visualized them once R2 was seated. It was noted staff placed a gait belt around both his legs, and R2's legs were both placed on the left footrest, crossed, and the right footrest was lifted up. A black pad was observed on the left side of the wheelchair, making contact with R2's right outer thigh, and there was no similar pad on the right side of R2's wheelchair. It was noted the right side of R2's power wheelchair had a joystick for operation, extending from the right armrest. R2 was seated upright in the wheelchair after the transfer. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/14/24 at approximatley 12:45 p.m., the [Total assistance mechanical] lift was observed with the base of the lift was worn, with chipped paint. It was noted the sling was a light blue quilted fabric. When asked, CNA Z and the unnamed CNA did not know the size of the lift sling. Surveyor observed the sling post the transfer, and it was observed as the largest size, an extra-large, on the tag, which appeared to accommodate R2's size, as per nursing staff R2 was nearly 300 pounds. The lift itself was further observed after the transfer. It was noted there was chipped paint where the sling attached to the lift. When inspected further, the lift base appeared unstable, as the anchor post which attached to the lift base had some give, and the lift appeared older and worn. There was an inspection tag, which was dated 12/12/22. Staff were asked if this was the only lift available, and reported there were no other [Total assistance mechanical] lifts in the facility for them to use in the building to transfer residents. Surveyor made the Unit Manager, Registered Nurse (RN) B aware of the mechanical concerns after the transfer, who indicated she was not aware of the slack in the lift base. RN B reported no residents have fallen from the lift. During an interview on 7/14/24 at approximately 12:50 p.m., CNA Z was asked why the gait belt was around R2's thighs, as this could potentially cause pressure. CNA Z reported R2's right leg was weak, and would rotate out, so they had to use a gait belt for positioning. When asked if R2 had any pressure areas in this location, CNA Z stated sometimes R2 had redness on his leg in the location of the gait belt, but it did not last, and they and CNA staff released the gait belt every one to two hours to prevent pressure. The potential skin concerns were also shared with RN B. During an interview on 7/14/24 at approximately 12:55 p.m., R2 denied any falls from the lift, and reported this was the only lift in the building. R2 stated they needed to be in therapy again. R2 explained they had been complaining about their power wheelchair not working properly and the seating being uncomfortable for over a year, and nothing had been done. R2 clarified the staff had not ordered the right sized [Namebrand air cushion], so they had to sit on a pillow for comfort. R2's seat could not be totally viewed with him in the chair and the [Total assistance mechanical] sling under them. R2 reported he kept sliding out of his wheelchair, and his CNA's who were present confirmed R2 did not have any gripper surface between his cushions, and that R2 slid out the wheelchair. The CNA's stated they repositioned R2 back into the chair frequently, and R2 had two cushions in their wheelchair. R2 reported he could not put his right foot down and had to cross his legs as they had footdrop and their right foot would not stay on the footrest, and slipped off, and when this occurred they could not propel their wheelchair. R2 reported he had told staff in the building they needed assistance obtaining a new wheelchair, but nothing had been done, stating, This chair needs to be fixed since last year. The sliding is the biggest problem, and I have to be put back in [their wheelchair] by staff. R2 indicated they had this power wheelchair close to five years and they were due for a new wheelchair. R2 reported the (name of) mechanical lift was rickety, and it sometimes tipped with him in the lift, and stated they were afraid of falling, especially when the regular staff were unavailable to transfer him. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/14/24 at 1:00 p.m., Licensed Practical Nurse (LPN) X was asked about R2's positioning and safety in the lift and the wheelchair. LPN X reported they only worked with R2 from time to time, and agreed the lift was rickety. LPN X stated, They [facility nursing staff] need a new one [total mechanical lift]. I think they made their DON [Director of Nursing] know. They do need a new one [lift] for [R2] as it is scary, as [R2] might fall and we don't want that to happen .They need a shower bench for [R2] that can carry [R2's] weight, as [R2] is about 300 pounds. LPN X was asked if R2 had any skin concerns due to the gait belt. LPN X reported they inspected R2's skin regularly when they worked and had not seen any concerns where the gait belt made contact with R2's legs. LPN X indicated there was nothing else they could do as R2's right leg was flaccid, lacking muscle control, and stated, [R2's] leg goes everywhere. During an interview on 7/14/24 at approximatley 1:10 p.m , both Unit Managers, RN B and LPN BB were asked about the [Total assistance mechanical] Lift and the concerns with equipment safety. Both stated, We need a new one [full mechanical lift], and confirmed this was the only lift in the facility. LPN BB stated, We wanted to send it out and we are getting a new one. Both were asked about R2 sliding out of his wheelchair, and his seating and positioning concerns. RN B reported R2 was sliding off the cushion and staff repositioned them frequently. RN B stated they could not keep R2's feet on the footrests, and stated they adjusted R2 when they slide down in their wheelchair. RN B confirmed at least three other residents on South Hall used the [Total assistance mechanical] lift, and there were other residents who used it in the facility. Surveyor asked both the observe the lift with this Surveyor. RN B soon after observed the [Total Assistance Mechanical] lift with the Maintenance Director, Staff D. Staff D was asked about the lift base and give in the anchoring. Staff D noted a pin was coming loose at the base, and pushed it back in, however reported it did not affect the lift anchoring, as it was otherwise secured and was not going anywhere. Staff D was asked if they were doing anything about the lift today, and responded, No. A second observation was made on 7/15/24 at approximately once R2 was transferred back to bed. R2's wheelchair was observed to have two [Namebrand] air cushions in it, one was flat, with an approximate size of 20 by 24, and a second [Namebrand] air cushion was on top, with a size of 20 x 18, which was verified by the box in R2's room. The cushion underneath was observed to be sliding out of the wheelchair, and the cushion on top was sliding out as well, which was fully observed once R2 was out of the chair. There was no dycem or gripper surface between the cushions, or under the bottom cushion. R2 reported during the observation they kept the flat cushion as otherwise he slipped as the 20 x 18 cushion was too small (which was observed). When R2 was seated in the wheelchair, it was observed they likely needed at least 22 to 24 depth, as they were tall and filled in the chair when positioned back in the chair properly. R2 reported they frequently placed a pillow in this gap, since the top cushion was short (18 depth) and caused them pain. R2 stated they had made staff aware the cushion did not fit, and nothing had been done about it. The survey team discussed the concern with the rehab director, Occupational Therapist (OT) Y, who reported they did not address R2's seating and positioning at that time. Further observation in R2's room yielded a second [Total assistance mechanical lift] sling in R2's closet, per R2's report. R2 and nursing staff confirmed this sling was used when R2's light blue quilted extra large sling became dirty. This sling was inspected, and Surveyor found 3 holes in the sling, with one going through the fabric completely, placing the sling at risk for tearing. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/16/24 at 12:10 p.m. with CMD W, they acknowledged the wheelchair concerns, as R2 showed CMD W and Surveyor during this observation their wheelchair only propelled about 3 feet, and stopped, and they had to restart it. R2 reported the battery worked and it was a chair malfunction, and the chair should tilt back for pressure relief like it did prior but was broken. CMD W observed the chair and confirmed R2's power chair had a tilt in space mechanism which did not function. CDM W reported they would address the wheelchair concerns with the facility. The [total assistance mechanical] lift was also observed by CMD W, and they reported they were following up and understood the concerns. CMD W reported they used an equipment vendor for equipment concerns, and had not been made aware of the R2's wheelchair and lift concerns. During an interview on 7/16/24 at approximately 3:30 p.m., OT Y was asked who was responsible for R2's seating and positioning in the facility. OT Y initially reported nursing staff were responsible, however upon further review of R2's seating and wheelchair concerns acknowledged they were in charge of R2's seating and positioning wheelchair concerns. OT Y returned to the survey team at approximately 4:30 p.m., and reported they had observed R2 in their wheelchair, and they had called the Director of Nursing (DON) about getting R2 a new wheelchair [Namebrand air] cushion, as the current cushion did not fit properly, and R2 reported they were uncomfortable. OT Y also planned to address R2's seating and positioning, although reported this was R2's own wheelchair and said R2 declined them addressing his wheelchair in the past. This was not reported by R2 to this Surveyor and CMD W, as R2 strongly requested facility assistance to obtain a new power chair which fit him properly, and a comfortable, properly fitting [Namebrand] air cushion. OT Y reported they had not known R2 was on two [Namebrand] cushions, and stated, I think it's bad; [R2] is not sliding out but [R2] doesn't look comfortable and [R2] is sliding forward .I recommend no pillow and no deflated [Namebrand air cushion] underneath the current cushion and indicated, Yes, dycem would help. I will follow up with the wound care nurse. OT Y said they knew about the gait belt being used for positioning R2's legs and understood the concern. OT Y clarified the administration would address the wheelchair concerns and they would address the cushion concerns. R34 During an observation on 7/14/24 at 2:00 p.m., it was observed R34's top wooden dresser drawer was missing. Upon further inspection, it was observed the two drawers below were difficult to open, and the third dresser drawer was collapsed onto the fourth dresser drawer. The dresser appeared unsafe and required extensive repair or a new dresser. During an interview on 7/14/24 at 2:24 p.m., R34 showed Surveyor their dresser drawer, and reported it bothered them, and they had asked the facility maintenance staff to repair their dresser at least two months ago. R34 reported it looked bad, and staff could not safely access their dresser. During an observation on 7/16/24 at approximately 12:05 p.m., with CMD W, they observed R34's dresser and confirmed the dresser needed repair. During an interview on 7/16/24 at approximately 12:07 p.m., CMD W was asked if R34's dresser drawer should have been repaired. CMD W reported if they had been made aware, the dresser would have been repaired, and they would immediately follow-up. Soon after, CMD W showed Surveyor R34's dresser had been repaired, with R34 reporting no further concerns. R6 (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/14/24 at 2:39 p.m., R6 reported when they had needed batteries for their room clock (observed on the wall), the Maintenance Supervisor, Staff B told them they could not order batteries, and they would have to purchase their own batteries. R6 shared they bought their own clock batteries from Amazon and were never reimbursed. During further interview, R6 reported their shower in the room did not have enough pressure, and clarified this was where they preferred to bathe (as they had an infection and were on IV antibiotics), so they had to take bed baths and wash their hair in the sink. R6 stated they would like a working shower and had asked the facility maintenance staff to repair the shower head, and who had not addressed it, since their admission last month. During an observation on 7/16/24 at approximately 12:00 p.m., CMD W attempted to turn on the shower head in R6's bathroom, and conveyed it did not run appropriately due to the pressure not being adjusted correctly. During an interview on 7/16/24 at approximately 12:02 p.m., CMD W was asked if the shower head concern should have been addressed. CMD W affirmed they would have expected staff to have fixed the shower head, and the process was the maintenance director or the administrator could have reached out to them if they struggled to correct the concern. CMD W reported they would address the concern immediately, and soon after showed Surveyor R6's shower head was working, and said it had been an easy repair. CMD W was notified about the clock batteries, and indicated this could have been easily addressed by the facility, and R6 should not have had to purchase there own clock batteries. During a phone interview on 7/16/24 at 4:12 p.m., the DON reported they understood the wheelchair and equipment concerns and were glad to hear they were being addressed by CMD W. The DON reported they were not aware R2's [Namebrand air] wheelchair cushion was the wrong size and this would be addressed. Review of the policy, Preventative Maintenance for Wheelchairs, dated 11/01/22, revealed, It is the practice of this facility to develop and implement a preventive maintenance program to ensure wheelchairs are maintained in a safe and operational manner .1. The facility will develop and implement as part of a preventative maintenance program, wheelchair safety and maintenance. 2. All staff have a responsibility to ensure that wheelchairs in need of repairs are not used and are reported for repairs . Review of the policy, Equipment Management, implemented 3/18/22, revealed, It is the policy of the facility to maintain equipment in safe and working order, in accordance with State and Federal regulations .