STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235730	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northville Manor	520 W Main St Northville, MI 48167

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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 - Minimal harm or potential for 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** 46865 This citation pertains to intake MI00143600. Based on interview and record review the facility failed to supervise residents to prevent a physical altercation for two residents (R16 and R26) of three residents reviewed for abuse, resulting in one resident receiving physical injuries. Findings include: According to the facility's Facility Reported Incident (FRI) summary report, on 3/16/24 at 7:40 PM Licensed Practical Nurse (LPN) A heard commotion coming from the dining room. Once entering the dining room, LPN A observed R26 grab R16 by the shirt. R26 scratched R16 on the chest and hit R16 in the face leaving multiple abrasions on R16's chest and the left side of the face. LPN A approached R16 and R26 and stopped the altercation. On 5/31/24 at 10:29 AM LPN A was interviewed regarding the incident that occurred on 3/16/24. LPN A said that the incident occurred at the middle of shift change. LPN A said that R16 is a frequent wanderer. LPN A said at approximately 7:40 PM she went into the dining room because she heard R16 say, No. LPN A said she saw R26 sitting by the kitchen door when R26 grabbed R16 and scratched her. LPN A was queried about whether there was staff in the dining room when the incident occurred. LPN A said she did not see any staff in the dining room when she entered the area. LPN A was asked if either resident had behavioral issues. LPN A said that R26 has had behavioral issues in the past and that R26 is usually kept separate from the other residents to minimize conflict. On 5/31/24 at 10:50 AM the DON was interviewed regarding the incident that occurred on 3/16/24. The DON said LPN A was the staff member that witnessed the incident. The DON said that R16 was a wanderer that is non-aggressive but touchy when in other residents' personal space. The DON said during the incident, R26 did not appreciate R16 being in her space, so R26 grabbed R16 scratched her on the chest and hit her in the face. The DON was asked about behavioral issues with each resident. The DON said R26 had past episodes of verbal yelling. The DON said that the facility was aware that R16 had problems with getting into the personal space of others. The DON acknowledged that the dining room should have been supervised. The DON said it is expected that the nursing staff identify and understand the circumstances that could take place when the residents are left alone. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R16's Electronic Medical Record (EMR) revealed R16 was admitted to the facility on [DATE]. R16 had the following pertinent diagnoses: Alzheimer's Disease and Major Depressive Disorder. A review of R16's Quarterly Minimum Data Set (MDS) dated [DATE] revealed R16's Brief Interview of Mental Status (BIMS) could not be conducted. The MDS documented that R16 had no behavioral symptoms. According to the MDS R16 required supervision with ambulation. A review of R16's behavioral care plan dated 7/7/23 revealed that the R16 had no physical or verbal aggression with other residents. A review of R26's EMR revealed R26 was readmitted to the facility on [DATE] (initial admitted unknown) and discharged from the facility on 4/10/24. R26 had the following pertinent medical diagnoses: Schizoaffective Disorder, Altered Mental Status, Dementia, and Anxiety. A review of R26's Quarterly MDS dated [DATE] revealed R26 had a BIMS score of 11/15 (moderate cognitive impairment). R26 required moderate assistance with transfers and could not ambulate. The MDS documented that R26 used on a wheelchair. A review of R26's behavior care plan dated 9/12/23 revealed the following: Problem: I have physical behavioral symptoms toward others (e.g., hitting, kicking). I hit another resident . Approach: Allow distance in seating other residents around resident .assess whether the behavior endangers the resident and/or others. intervene if necessary . When resident becomes physically aggressive, move to a quiet, calm environment. A review of the facility policy titled, Abuse, Neglect, and Exploitation, with an implementation date of 11/1/22, revealed, The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur .and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.

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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. 46865 This citation pertains to intake MI00143600. Based on interview and record review the facility failed to report an incident of abuse to the State Agency in a timely manner for two residents (R16 and R26) of three residents reviewed for abuse. Findings include: According to the facility's Facility Reported Incident (FRI) summary report, on 3/16/24 at 7:40 PM Licensed Practical Nurse (LPN) A heard commotion coming from the dining room. Once entering the dining room, LPN A observed R26 grab R16 by the shirt. R26 scratched and hit R16 in the face leaving multiple abrasions on R16's chest and the left side of the face. LPN A approached R16 and R26 and stopped the altercation. The Director of Nursing (DON), emergency contacts, and physician were notified of the incident. R16 and R26 were separated, R16 and R26 were assessed for injuries, and the local police were contacted at 8:00 PM. A review of the FRI revealed the incident occurred on 3/16/24 at 7:40 PM and was discovered on 3/16/24 at 7:40 PM. As documented in the FRI, the Nursing Home Administrator (NHA) did not submit the incident to the state agency until 3/26/24 at 5:13 PM. On 5/31/24 at 12:22 PM the NHA was interviewed regarding the submission of the abuse incident. The NHA acknowledged that the incident was discovered on 3/16/24 but was not reported until 3/26/24. The NHA said it is the expectation that reporting abuse that involves physical injury should be reported within two hours of discovery. A review of the facility policy titled, Abuse, Neglect, and Exploitation, with an implementation date of 11/1/22, revealed, The facility will have written procedures that include: 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 timeframe: immediately, but no later than 2 hours after the allegation is made, if the events that the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were signed and submitted to CMS (Centers for Medicare and Medicaid Services) in a timely manner for six residents (R2, R12, R15, R20, R21, and R22), resulting in a delay in monitoring of the quality of care provided to the facility's residents and potential for delay in the identification of resident's health concerns. Findings include: On 5/30/24 at 9:06 AM, Licensed Practical Nurse (LPN)/MDS Coordinator L, was queried about MDS submissions to CMS. LPN L said her hire date was 3/25/24 and that the facility was without a MDS coordinator for about three months. LPN L stated, We are pretty far behind. A review of MDS submissions was conducted with LPN L to determine compliance with CMS guidelines. According to LPN L, the following MDS assessments have not been submitted and are considered late: 1. Resident #2's quarterly MDS assessment dated [DATE] was due for submission on 5/6/24 but had not been submitted. 2. Resident #12's quarterly MDS assessment dated [DATE] was due for submission on 4/1/24 but had not been submitted. 3. Resident #15's quarterly MDS assessment dated [DATE] was due for submission on 3/30/24 but had not been submitted. 4. Resident #20's quarterly MDS assessment dated [DATE] was due for submission on 4/3/24 but had not been submitted. 5. Resident #21's quarterly MDS assessment dated [DATE] was due for submission on 3/31/24 but had not been submitted. 6. Resident #22's quarterly MDS assessment dated [DATE] was due for submission on 4/3/24 but had not been submitted. On 5/31/24 at 3:29 PM, the Nursing Home Administrator (NHA) stated her expectations for timely submissions of MDS assessments were, so we are in line with state regulations and policies and procedures. A review of the facility policy titled, MDS 3.0 Completion, dated 2/23/24 documented in part the following: - Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Transmission Requirements: All assessments shall be transmitted to the designated CMS system within 14 days of completion. On 5/31/24 during the exit conference, the NHA and Director of Nursing were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on observation, interview, and record review, the facility failed to ensure proper weight monitoring occurred for one resident (R128) deemed to be at nutrition risk out of three residents reviewed for nutrition status, resulting in the potential delay in identification of undesirable change in weight status and compromise in nutrition status. Findings include: During an observation on 5/29/24 at 9:38 AM, Resident #128 (R128) was observed asleep with the head of the bed raised at approximately 45 degrees. A tube feeding formula was infusing at 55 ml/hr (milliliter/hour). R128 was thin in appearance. A review of the Face Sheet for R128 documented an admitted [DATE]. R128's diagnoses included Cerebral Palsy, Dysphagia, and Moderate Protein-Calorie Malnutrition. Record review of R128's care plans documented in part the following: Communication care plan of 5/9/24: I have difficulty making myself understood. I am non-verbal. Nutritional Status care plan of 5/8/24: Resident requires feeding tube related to history of protein calorie malnutrition, history of inadequate oral intake, and dysphagia diagnosis. Resident is at risk for alteration in nutritional status related to past medical history. A review of R128's clinical record documented the following weight measurement: 87.2 lbs. obtained on 5/16/24. During an interview on 5/31/24 at 12:19 PM, Registered Dietitian (RD) F said R128 was considered a resident at high nutrition risk because she was on a tube feeding. A review of the weight measurement obtained on R128 revealed there was no admission weight obtained, no weight obtained during her third week of residency in the facility and no weight obtained so far on the Friday of the fourth week of her residency. RD F said staff should have obtained weekly weights for four weeks, which would include an admission weight, and monthly weights thereafter unless there was a significant change. The initial weight should have been obtained 24-48 hours after admission. RD F said regular weight measurements are important to establish a baseline and monitor for any changes. During an interview on 5/31/24 at 2:37 PM, the Director of Nursing said R128 should have had documented weights upon admission and weekly after that for four weeks. We should be monitoring her weight loss or gain. A review of the facility policy titled, Weight Monitoring, dated 3/27/24, documented in part the following: - Weight can be a useful indicator of nutrition status. Significant unintended change in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A weight monitoring schedule will be developed upon admission for all residents: a.) Weights should be recorded at the time obtained. b.) Newly admitted residents - monitor weight weekly for four weeks. On 5/31/24 during the exit conference, the facility Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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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. 47964 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was on duty for eight consecutive hours a day, seven days a week; resulting in the potential for inadequate coordination of emergency or routine care and unmet care needs, affecting all 27 residents who resided in the facility. Findings include: On 5/30/2024 at 2:22 PM review of the staffing timecards with Scheduler B for the following dates revealed there was no consecutive 8 hour scheduled RN coverage: April 1st, 2nd, and 15th. (2024) May 12th, 14th and 26th. (2024) On 5/30/2024 at 2:25 P.M. the Director of Nursing (DON) was interviewed and said that he recently accepted the position as the DON and that there was another RN that worked midnights and weekends but went on an extended vacation. When asked how the facility ensured there was daily 8-hour RN coverage the DON replied, We just hired another RN to help cover when I am not working. The DON agreed there needs to be daily 8 consecutive hours of RN coverage and acknowledged there was a problem with staffing. Review of the Facility Policy titled Nursing Services-Registered Nurse, RN revealed in part .The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day 7 days per week.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47964 Based on interview and record review, the facility failed to ensure certified nurse aides (CNAs) fulfilled the requirement to complete 12 hours of in-service education annually for four of five certified nurse aides (B, H, I, J) resulting in the potential for unmet resident care needs. Findings include: On 5/30/2024 at 2:30 PM, the following five certified nurse aide annual 12-hour nurse aide training/ in-services were reviewed: -CNA B was hired on 6/26/21. There were no 12-hour training/ in-services provided by the facility. -CNA H was hired on 10/25/22. There were no 12-hour training/ in-services provided by the facility. -CNA I was hired on 12/1/23. There were no 12-hour training/ in-services provided by the facility. -CNA J was hired on 9/7/23. There were no 12-hour training/ in-services provided by the facility. There was no evidence provided by the facility that annual 12-hour trainings/ in-services were completed for the certified nurse aides reviewed. On 5/30/24 at 3:45 PM the Director of Nursing (DON)/Staff Development Coordinator was interviewed and stated I do not have a record of 12 hours of in-services for any staff. I took over as DON recently and there are no records from the previous DON and to date, I have not held any formal in-service trainings. The DON further stated There needs to be 12 hours of in-service training annually for CNAs. Review of the Facility Assessment Tool, updated 5/4/2024, documented: Required in-service training for nurse aides must be sufficient to ensure the continuing competence of aides, but must be no less than 12 hours per year

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46865 Based observation, interview, and record review, the facility failed to store biologicals and medications at the recommended temperature parameters for 12 residents (R2, R8, R9, R10, R11, R12, R13, R14, R16, R19, R23, and R24) and to consistently document the refrigerator temperatures for 27 residents reviewed for storage of drugs and biologicals. Findings include: On 5/31/24 at 8:56 AM, an observation was made of the medication refrigerator temperature. The temperature read 32 degrees Fahrenheit. On 5/31/24 at 8:59 AM, an observation was made of the refrigerator temperature monitoring logs from January 2024 thru May 2024. Documentation of refrigerator temperatures were omitted on the temperature monitoring logs on the following dates: January 2024: 1/1 thru 1/11, 1/13, 1/14, 1/17, and 1/22. February 2024: 2/1, 2/20, 2/22, 2/23, and 2/27. May 2024: 5/14, and 5/23 thru 5/31. The following dates revealed when the refrigerator temperatures were less than 36 degrees Fahrenheit: January 2024: 1/12, 1/15, 1/16, 1/18, 1/19, 1/20, 1/21, 1/23, 1/24, 1/25, 1/26, 1/27,1/29, 1/30, and 1/31. February 2024: 2/4, 2/5, 2/6, 2/7, 2/8, 2/9, and 2/2. March 2024: 3/5, 3/20, 3/21, and 3/25. May 2024: 5/9, 5/18, 5/20, 5/21, and 5/22. The following medications observed in the medication refrigerator have documented temperature parameters where the medications are to be stored between 36 degrees Fahrenheit and 46 degrees Fahrenheit: -Latanoprost Ophthalmic Solution 0.005% -Influenza Vaccine Flulaval Quadrivalent (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Tuberculin Purified protein Derivative, Diluted Aplisol -Pneumococcal 20-valent Conjugate Vaccine (Prevnar 20) -Levemir Flexpen 100 unit/ML -Novolog Flexpen 100 unit/ML -Lantus Solostar 100 unit/ ML -Insulin Aspart Flexpen 100 unit/ML -Novolin 70-30 Flexpen 100 unit/ML The following medications observed in the medication refrigerator have documented temperature parameters where the medications are to be stored between 58 degrees Fahrenheit and 86 degrees Fahrenheit: -Refresh Tears -Artificial Tears -Brimonidine Tartrate Ophthalmic Solution Hydrochloride - Olopatadine Ophthalmic Solution 0.1% R2 A review of R2's Electronic Medical Record (EMR) revealed R2 was admitted to the facility on [DATE]. R2 had the following pertinent medical diagnosis: age-related nuclear cataract, bilateral. A review of R2's physicians orders revealed the following: Refresh Tears drops 0.5% one drop in both eyes twice daily. R8 A review of R8's EMR revealed R8 admitted to the facility on [DATE]. R8 had the following pertinent medical diagnosis: Glaucoma. A review of R8's physicians orders revealed the following: Latanoprost drops 0.05% one drop in both eyes once daily. R9 A review of R9's EMR revealed R9 was admitted to the facility on [DATE]. R9 had the following pertinent medical diagnosis: Type 2 diabetes mellitus with hyperglycemia. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R9's physicians orders revealed the following: Lantus Solostar 100 unit/ML 14 units subcutaneous in the morning. R10 A review of 's EMR revealed R10 was admitted to the facility on [DATE]. R10 had the following pertinent medical diagnoses: Type 2 diabetes mellitus without complications and obesity. A review of R9's physicians orders revealed the following: Lantus 100 unit/ML. 27 units subcutaneous at bedtime and Novolog 100 unit/ML sliding scale. Subcutaneous before meals. R11 A review of 's EMR revealed R11 was admitted to the facility on [DATE]. A review of R11's physicians orders revealed the following: Brimonidine 0.2% 1 drop in each eye twice daily, Latanoprost 0.005% one drop in both eyes once daily, and Natural Tears 0.1-0.3% 1 drop in both eyes once daily. R12 A review of 's EMR revealed R12 was admitted to the facility on [DATE]. R12 had the following pertinent medical diagnosis: Type 2 diabetes mellitus without complications. A review of R12's physicians orders revealed the following: Novolog 100 unit/ML sliding scale subcutaneous before meals. R13 A review of 's EMR revealed R13 was admitted to the facility on [DATE]. R13 had the following pertinent medical diagnosis: Type 2 diabetes mellitus without complications. A review of R13's physicians orders revealed the following: Novolog 100 unit/ML sliding scale subcutaneous before meals. R14 A review of 's EMR revealed R14 was admitted to the facility on [DATE]. A review of R14's physicians orders revealed the following: Latanoprost 0.005% one drop in both eyes at bedtime. R16 A review of 's EMR revealed R16 was admitted to the facility on [DATE]. A review of R16's physicians orders revealed the following: Olopatadine 0.1% one drop in both eyes twice daily. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R19 A review of 's EMR revealed R19 was admitted to the facility on [DATE]. R19 had the following pertinent medical diagnosis: Type 2 Diabetes Mellitus with hyperglycemia. A review of R19's physicians orders revealed the following: Novolin 70-30 100unit/ML. 15 units subcutaneous twice daily. R23 A review of 's EMR revealed R23 was admitted to the facility on [DATE]. A review of R23's physicians orders revealed the following: Latanoprost 0.005% one drop in both eyes at bedtime. R24 A review of 's EMR revealed R24 was admitted to the facility on [DATE]. A review of R24's physicians orders revealed the following: Latanoprost 0.005% one drop in both eyes at bedtime. On 5/31/24 at 9:05 AM, the Director of Nursing (DON) was interviewed regarding the documentation on the Refrigerator Monitoring Log. The DON acknowledged that the logs for January 2024 thru May 2024 were missing documentation. The DON said it was the expectation of the nurses to fill out the temperature log daily. The DON said if the temperature falls out of the parameters, the nurses should contact maintenance to fix the refrigerator temperature. A review of the facility policy titled, Storage of Medication Requiring Refrigeration, with an implementation date of 11/1/22, revealed, Staff should observe proper storage and labeling requirements for all medications and vaccines during the performance of their daily tasks and should demonstrate safety in regard to the medication's integrity, such duties should include but not be limited to: a. Report improper refrigerator storage temperatures - i. Below 36 degrees Fahrenheit, or ii. Above 46 degrees Fahrenheit. b. Do not administer medication exposed to the above temperature extremes. c. Remove any expired medications from active stock and discard medication according to facility policy. d. Only use medication(s) maintained at proper temperatures for administration.

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Northville Manor	520 W Main St Northville, MI 48167

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on observation, interview, and record review, the facility failed to ensure resident food preferences were honored for one resident (R129) out of three residents reviewed for food preferences, resulting in resident meal dissatisfaction. Findings include: The posted menu for lunch on 5/29/24 in the facility included sausage & peppers on bun, roasted red potatoes, sauteed onions, wheat roll, cinnamon applesauce, coffee or tea, and milk. The posted menu for dinner on 5/29/24 included stuffed green peppers, buttered corn, sauteed summer squash, wheat bread, strawberries with whipped topping, coffee or tea, and milk. On 5/29/24 at 12:49 PM, Resident #129 (R129) was observed in her room with her lunch meal tray in front of her. R129 was alert, able to speak and express herself clearly. R129 said she likes vegetables and ate the peppers and onions off the sausage. R129 said she asked staff for carrots and green beans to eat. R129 said no meal alternative was offered to her. On 5/29/24 at 1:49 PM, R129 said she did not receive her requested green beans or carrots. On 5/30/24 at 8:35 AM, R129 said for dinner last night she ate corn and cabbage or green pepper, but not what they were stuffed with. R129 said no one informed her of the available food items that could be requested at mealtimes as an alternative. On 5/31/24 at 11:47 AM, Dietary Manager (DM) E said residents can always order off the alternate menu. DM E said R129 said she likes everything. A review of R129's meal ticket documented resident likes veggies. No dislikes were listed. DM E stated, We usually make two vegetables (even though) there is only one vegetable listed on the menu. We've had residents to say, 'I want carrots', so we make a serving of veggies. DM E indicated that the always available menu was only posted in the dining room. Upon admission, DM E informed R129 that there was an always available menu, however, R129 was not told what food was on the always available menu nor was she given a copy. A review of the facility document titled, Alternate Menu, included Chef Salad/Dressing as an item that was available during kitchen hours of operation 7 AM to 7 PM, pending availability. A review of the Face Sheet for R129 documented an admitted [DATE] with diagnoses that included fracture of lower right femur. R129 was prescribed a Regular diet with thin liquids. On 5/31/24 at 3:22 PM, the Nursing Home Administrator (NHA) said residents need to be aware of the always available menu whether it was posted in the dining room or in their room. Regarding R129's requests for green beans and carrots, the NHA stated, There should have been follow through for the vegetables. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 during the exit conference, the facility Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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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. 22050 Based on observations, interviews, and record reviews, the facility failed to: (1) effectively clean and maintain food service equipment, and (2) effectively date mark all potentially hazardous ready-to-eat food products effecting 27 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, resident foodborne illness. Findings include: On 05/29/24 at 09:10 A.M., An initial tour of the food service was conducted with Dietary Manager E. The following items were noted: One-half gallon of Prairie Farms whole milk was observed with a manufacturer's use-by-date that read May 26. The half-gallon of whole milk was also observed within the Traulsen 2-door reach-in cooler without an open or out date. Dietary Manager E stated: We date mark the product when opened for a total of 7 days, if the manufacturer's use-by-date allows. The 2017 FDA Model Food Code section 3-501.17 states: (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY 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 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. The Traulsen 2-door reach-in cooler door gaskets were observed heavily soiled with accumulated and encrusted dust and dirt deposits. The Traulsen 2-door reach-in-freezer door gaskets were observed heavily soiled with accumulated and encrusted dust and dirt deposits. The can opener assembly mounting plate was observed heavily soiled with (dust, dirt, grime) deposits between the mounting plate perimeter and table surface. Dietary Manager E indicated she would have maintenance remove the mounting plate for appropriate cleaning as soon as possible. The Ice-O-Matic ice machine interior plastic resin retention plate was observed soiled with accumulated and encrusted dirt deposits. The garbage disposal overhead spray valve assembly was observed heavily soiled with accumulated and encrusted dust, dirt, and food debris deposits. Dietary Manager E indicated she would have staff thoroughly clean and sanitize the valve assembly as soon as possible. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2017 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 11 of 24 overhead light assembly end caps were observed missing. Dietary Manager E indicated she would contact maintenance for end cap installation as soon as possible. The 2017 FDA Model Food Code section 6-202.11 states: (A) Except as specified in (B) of this section, light bulbs shall be shielded, coated, or otherwise shatter-resistant in areas where there is exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; or unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. 180 181 (B) Shielded, coated, or otherwise shatter-resistant bulbs need not be used in areas used only for storing FOOD in unopened packages, if: (1) The integrity of the packages cannot be affected by broken glass falling onto them; and (2) The packages are capable of being cleaned of debris from broken bulbs before the packages are opened. (C) An infrared or other heat lamp shall be protected against breakage by a shield surrounding and extending beyond the bulb so that only the face of the bulb is exposed. Basement: The Kelvinator refrigerator interior flooring surface was observed severely corroded and particulate. Dietary Manager E stated: We have a new refrigerator currently on order. The 2017 FDA Model Food Code section 4-501.11 states: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened. On 05/31/24 at 01:00 P.M., Record review of the Policy/Procedure entitled: Sanitation Inspection dated 01/2024 revealed under Policy: It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary, and in compliance with applicable state and federal regulations. Record review of the Policy/Procedure entitled: Sanitation Inspection dated 01/2024 further revealed under Policy Explanation and Compliance Guidelines: (1) All food service areas shall be kept clean, sanitary, free from litter, rubbish, and protected from rodents, roaches, flies, and other insects. On 05/31/24 at 01:15 P.M., Record review of the Policy/Procedure entitled: Ice Machines and Portable Ice Carts dated 03/08/2024 revealed under Policy: It is the policy of this facility to ensure that ice machines/carts are working in proper order, cleaned, and maintained as per Federal, State, local, or facility guidance, according to manufacturer's instructions and current standards of practice. Record review of the Policy/Procedure entitled: Ice Machines and Portable Ice Carts dated 03/08/2024 further revealed under Policy Explanation: Ice machines/carts can be prone to microbial contamination due to improper handling or storage of ice, poor cleaning, or maintenance of equipment, or through ice handling equipment. Proper cleaning, maintenance, and infection control in relation to ice machines is important to decrease the risk of illness to residents, staff, and visitors.

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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. 49103 Based on observation, interview, and record review the facility failed to effectively maintain continuity of internal programs throughout leadership changes, such as: reporting of abuse, Minimum Data Set (MDS) assessments, Quality Assurance and Improvement (QAPI/QAA) meetings, in-service, competencies/employee training, staffing, infection control, and vaccine policy affecting all 27 residents. Findings include: On 5/30/24 at 9:06 AM during interview with the Minimum Data Set (MDS) Coordinator L review of resident MDS assessments revealed a delay in the processing of the assessments. The MDS Coordinator L explained the facility had been without an MDS Coordinator for about a 3 month period. The current MDS Coordinator L hire date was 3/25/24. We are pretty far behind she said. MDS records over 120 days late were for the following residents: R15, R 2, R22, R21, R 12 and R20. On 5/31/24 at 3:29 PM the NHA was interviewed and acknowledged the lapse and explained the MDS assessments need to be completed and submitted on time in order to be in line with state regulations and policies and procedures. On 5/30/2024 at 2:25 P.M. the DON was interviewed about staffing concerns regarding the lack of consecutive 8-hour Registered Nurse (RN) coverage. The DON said that he recently accepted the position as the DON and that there was another RN that worked midnights and weekends but went on an extended vacation. When asked how the facility ensured there was daily 8-hour RN coverage the DON replied, We just hired another RN to help cover when I am not working. The DON agreed there needs to be daily 8 consecutive hours of RN coverage and acknowledged there was a problem with staffing. On 5/30/24 at 3:45 PM the state required 12-hour Certified Nurse Assistant (CNA) in-service and competencies (including abuse and dementia training) programs were discussed and the records for five sampled CNAs (B, H, I, J, and K) were reviewed. The Director of Nursing (DON) stated, I do not have a record of 12 hours of in-services for any staff. I took over as DON recently and there are no records from the previous DON and to date, I have not held formal in-service training. The DON acknowledged there needs to be 12 hours of training for CNAs which would include the abuse and dementia training. On 5/31/24 at 9:49 AM, the facility's Infection Control Program was reviewed with the DON who was the Infection Preventionist, and the following was noted: 1. The DON received certification as an Infection Preventionist on 5/20/24. The facility's previous Infection Preventionist's employment ended November 2023. 2. The DON indicated that documentation of infection identification, tracking, monitoring, analysis of surveillance data, responding follow-up activity, and antibiotic stewardship ended November 2023. 3. The facility's Influenza Vaccination policy was last updated 11/1/22. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. The staff call-in log was not available for review. The DON stated, I don't know where it is at. I don't know how to pull it up. On 5/31/24 at 3:25 PM, the NHA said there should have been an Infection Preventionist appointed, and the work should have been done. On 5/31/24 at 10:31 AM Quality Assurance and Improvement (QAPI) survey meeting was held with the NHA. The past resident, family and staff concern sheets, titled, (Facility Name) Health Care Management Concern Form, were reviewed. The NHA said there had not been any concern forms submitted since 1/5/24. When asked about the value of reviewing past concerns to ensure the concerns had been addressed, the NHA stated, I could have. I didn't. On 5/31/24 at 12:22 PM, during the Nursing Home Administrator (NHA) interview, review of a resident-to-resident abuse disclosed an eleven-day delay in reporting of the incident to the State Agency. During interview the administrator acknowledged the delay and spoke of the administrative change of personnel during that time period: The abuse incident occurred 3/16/24; the new administrator (NHA) took over the position 3/20/24; the Facility Reported Incident (FRI) was not reported to the state until 3/26/24. On 5/31/24 at 3:17 PM during an interview with the owner of the facility, Facility Owner/CEO N questions were asked about changes in leadership and the ineffective transitions for operations. Facility owner/CEO N said that he was well-aware of the leadership changes and added that he is personally responsible as ultimate decision-maker for leadership personnel hiring. When queried about specific concerns, the Facility Owner/CEO N responded I was unaware of the concerns, because concerns had not been communicated and said that moving forward changes will be made and there will be improvement. Review of the facility policy titled Abuse, Neglect, and Exploitation with a date of implementation of 11/1/2022, states in part, The facility will have written procedures that include: 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: 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 harm. Review of the facility policy titled Abuse, Neglect, and Exploitation with a subheading of Employee Training with a date of implementation of 11/1/2022, states in part, New employees will be educated on abuse, neglect, exploitation, and misappropriation of resident property during initial orientation. Existing staff will receive annual education through planned in-services and as needed. Review of the facility policy titled Infection Prevention and Control Program with a date of revision 3/13/24, states in part, 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 as per accepted national standards and guidelines.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49103 Based on interview and record review the facility did not meet the requirement for an Infection Preventionist member of Quality Assurance and Performance Improvement (QAPI), Quality Assessment and Assurance (QAA) committee for three quarters, resulting in the potential for impaired resolution of infection control and prevention issues or decreased quality of care with the potential to affect all 27 residents residing in the facility. Findings include: On 5/31/24 at 10:45 AM during Quality Assurance and Performance Improvement (QAPI) survey meeting and review, the past Quality Assessment and Assurance (QAA/QAPI) quarterly meeting notes were reviewed with the Nursing Home Administrator (NHA). For three quarters (September 2023, January 2024, and May 2024) the member sign-in sheet did not show a signature for an Infection Preventionist (IP). The NHA explained that the previous NHA O at that time also was serving as Director of Nursing (DON) and was an Infection Preventionist as well. During further interview the NHA said that the current DON currently holds an IP certification. On 5/31/24 at 12:29 PM, during interview: the Business Manager and Human Resource Director M said the IP credentials for the previous Administrator and Director of Nursing O could not be verfied because they could not be located in the records. Upon further review of the QAA sign-in sheet, the last QAA meeting was held 5/15/24. The current DON did not have IP certification at that time. According to an interview held on 5/31/24 at 9:49 AM with the DON, the DON said that IP certification was awarded 5/20/24. Review of the facility policy titled Quality Assurance and Performance Improvement (QAPI) and subtitled Policy Explanation and Compliance Guidelines with an implementation date of 11/1/2022, states in part, The QAA committee shall be interdisciplinary and shall: Consist at a minimum of: The Director of Nursing Services; The Medical Director or his/her designee; at least three other members of the facility's staff, at least one of which must be the Administrator, Owner, a Board Member or other Individual in a leadership role, and the Infection Preventionist.

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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. 34901 Based on interview and record review, the facility failed to consistently implement a comprehensive infection control program that conducted proper facility surveillance to readily identify trends of infections, resulting in missed opportunities for corrective actions and the potential for spread of infectious organisms throughout the facility affecting the entire census of 27 residents. Findings include: On 5/31/24 at 9:49 AM, the facility's Infection Control Program was reviewed with the Director of Nursing (DON) who was the Infection Preventionist, and the following was noted: 1. The DON received certification as an Infection Preventionist on 5/20/24. The facility's previous Infection Preventionist's employment ended November 2023. 2. When asked for documentation regarding infection identification, tracking, monitoring, analysis of surveillance data, responding follow-up activity, and antibiotic stewardship, the DON said this had not been completed since November 2023. 3. The facility's Influenza Vaccination policy was last updated 11/1/22. 4. The staff call-in log that documents the staff's reasons for calling in was not available for review. The DON stated, I don't know where it is at. I don't know how to pull it up. On 5/31/24 at 3:25 PM, the Nursing Home Administrator (NHA) said there should have been an Infection Preventionist appointed, and the work should have been done. A review of the facility policy titled, Infection Prevention and Control Program, dated 3/13/24 documented in part the following: - 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 as per accepted national standards and guidelines. - A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. - An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program. - The facility will conduct an annual review of the infection prevention and control program, including associated programs and policies and procedures based upon the facility assessment which includes any facility and community risk. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/31/24 during the exit conference, the facility Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 34901 Based on interview and record review, the facility failed to ensure consents for immunizations were obtained for three residents (R6, R8, and R10) and failed to ensure influenza and pneumococcal vaccines were offered for one resident (R18) out of five residents reviewed for immunizations, resulting in the potential for diminished ability to make informed decisions regarding plan of care and the spread of influenza and pneumonia among the 27 residents in the facility. Findings include: On 5/31/24 at 9:49 AM, the facility's Infection Control Program and resident clinical records were reviewed with the Director of Nursing (DON) who was the Infection Preventionist, and the following was noted: Resident #6 (R6) has resided in the facility since 5/12/22 and was over the age of 65. R6 received the influenza vaccine on 9/13/23. There was no documentation of a consent to administer the influenza vaccine. Resident #8 (R8) has resided in the facility since 10/6/17 and was over the age of 65. R8 received the influenza vaccine on 9/13/23. There was no documentation of a consent to administer the influenza vaccine. Resident #10 (R10) has resided in the facility since 12/10/22 and was over the age of 65. R10 received the influenza vaccine on 9/19/23 and pneumococcal vaccine on 10/20/23. There was no documentation of consent to administer the influenza or pneumococcal vaccines. Resident #18 (R18) has resided in the facility since 8/11/23 and was over the age of 65. There was no documented indication that R18 had received pneumococcal or influenza vaccines in the past, was ineligible for them, or was offered and refused them. The DON said R18 was in the facility during the prior flu season. On 5/31/24 at 3:25 PM, the Nursing Home Administrator (NHA) said residents should have completed consent forms available for the vaccines so that there would be evidence of consent and education. A review of the following facility policies documented in part the following: 1. Influenza Vaccination Policy dated 11/1/22: - Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine. - Individuals receiving the influenza vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. The completed, signed, and dated record will be filed in the individual's medical record. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Pneumococcal Vaccine Policy dated 3/13/24: Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine. On 5/31/24 during the exit conference, the facility Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 22050 Based on observation and interview the facility failed to provide 80 square feet of space per bed within 6 (2, 7, 10, 11, 12, 14) of 33 resident rooms, resulting in the increased likelihood for resident dissatisfaction with the amount of provided living space. Findings include: On 05/30/24 at approximately 1:45 PM, observation of resident rooms and record review of the facility bed count information revealed the following: Room # Sq./Ft # Beds 2 283 4 7 218 3 10 225 3 11 215 3 12 154 2 14 144 2 Observations and interviews with various residents revealed no specific complaints and no specific health/safety concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235730	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northville Manor	520 W Main St Northville, MI 48167

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 27 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased air quality. Findings include: On 05/30/24 at 09:30 A.M., A common area environmental tour was conducted with Director of Housekeeping and Maintenance D. The following items were noted: Resident Restroom: The return-air-exhaust ventilation grill was observed heavily soiled with accumulated dust and dirt deposits. The facility corridor carpeting surface was observed soiled with accumulated and encrusted dust, dirt, and stain deposits. Director of Housekeeping and Maintenance D indicated the facility had purchased a floor machine for extracting stubborn stains and accumulated soils. Dining Room: 2 of 2 oscillating wall mounted fans were observed soiled with accumulated and encrusted dust and dirt deposits. The sliding patio door tracks were also observed heavily soiled with accumulated and encrusted dust, dirt, debris (paper products). Director of Housekeeping and Maintenance D indicated he would have staff thoroughly clean and sanitize the door tracks as soon as possible. Day Room: The front double door tracks were observed with accumulated and encrusted dust, dirt, debris (paper products). Front Entrance: The front step handrail support system was observed loose-to-mount. The upper wooden rail was also observed rotted and splintered. The entire handrail support system could be moved from side to side approximately 6-8 inches. Laboratory Specimen Refrigerator: The interior refrigeration unit surfaces were observed soiled with accumulated and encrusted dust and dirt deposits. One container of Chobani greek yogurt was also observed stored within the Laboratory Specimen Refrigerator. The interior dial thermometer was further observed to read 48-50 degrees Fahrenheit. On 05/30/24 at 10:45 A.M., An interview was conducted with Director of Housekeeping and Maintenance D regarding the facility maintenance work order system. Director of Housekeeping and Maintenance D stated: We have a manual maintenance logbook. On 05/30/24 at 12:05 P.M., An environmental tour of sampled resident rooms was conducted with Administrator Support G. The following items were noted: 3: The drywall surface was observed (etched, scored, particulate), adjacent to Bed 1. The damaged drywall surface measured approximately 12-inches-wide by 36-inches-long. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5: An electrical junction box was observed without the protective cover, adjacent to Bed 2. The uncovered electrical junction box was also observed with black taped wires protruding from the receptacle. 6: The restroom hand sink faucet assembly was observed loose-to-mount. The Bed 2 plastic pillow cover was also observed (etched, scored, particulate). Administrator Support G indicated she would discard the faulty pillow as soon as possible. 12: The Bed 1 overbed light assembly was observed loose-to-mount. The Bed 1 and Bed 2 overbed light assemblies were also observed non-functional. The ceiling perimeter electrical conduit was further observed disconnected and dangling loose-to-mount from the wall surface. 14: The entire resident room was observed extremely malodorous. On 05/31/24 at 10:00 A.M., Record review of the Maintenance Log Sheets for the last 90 days revealed no specific entries related to the aforementioned maintenance concerns. On 05/31/24 at 10:15 A.M., Record review of the Policy/Procedure entitled: Cycle Cleaning dated 10/26/2022 revealed under Policy: It is the policy of this facility to identify the functional areas in the facility that require cleaning and to use cycle cleaning schedules to outline the frequencies and maintain regularly scheduled environmental service tasks. On 05/31/24 at 10:30 A.M., Record review of the Policy/Procedure entitled: Environmental Services Inspection dated 10/26/2022 revealed under Policy: It is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis. On 05/31/24 at 10:45 A.M., Record review of the Policy/Procedure entitled: Nursing Environmental Inspection dated 11/01/2022 revealed under Policy: It is the policy of this facility to regularly monitor the nursing services environment to ensure the facility is maintained in a safe and sanitary manner. 34901 On May 29, 2024 at 9:38 AM, the floor underneath Resident #128's (R128) tube feeding pole and at the head of R128's bed was soiled with debris, including torn paper, personal protective equipment (PPE) ties, fingernail clippings, a plethora of small unidentifiable particles, and clumps of hair. On May 30, 2024 at 8:07 AM, the floor underneath R128's tube feeding pole and at the head of R128's bed remained soiled with debris, including torn paper, personal protective equipment (PPE) ties, fingernail clippings, a plethora of small unidentifiable particles, and clumps of hair. On May 30, 2024 at 10:44 AM, Housekeeper C said she was responsible for processing the laundry, cleaning the common areas, and sweeping and mopping all of the residents' rooms but had not been able to do it all. Housekeeper C stated, I try to do it, because the residents should have a clean room. Housekeeper C stated that today she had cleaned the high numbered rooms. This included R128's room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On May 31, 2024 at 8:53 AM, the floor underneath R128's tube feeding pole and at the head of R128's bed remained soiled with debris, including torn paper, personal protective equipment (PPE) ties, fingernail clippings, a plethora of small unidentifiable particles, and clumps of hair. On May 31, 2024 at 11:36 AM, when the floor underneath R128's tube feeding pole and at the head of R128's bed was observed with Maintenance and Housekeeping Supervisor D, he stated, That should have been cleaned. I'll get that swept up.