STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235132	A. Building B. Wing	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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 - Many	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** 38471 Based on observation, interview, and record review the facility failed to timely return over 50 residents' personal belongings/property after they moved from the COVID unit into non-isolation rooms, resulting in, multiple complaints from facility residents, regarding access to their personal belongings, substandard communication to residents regarding their personal property and poor development of processes and procedures in moving, storing, and returning residents' possessions. Findings include: During initial tour on 2/14/22 many residents expressed their concern with not having their personal belongings with them. There was a plethora of observations of resident rooms that were bare of personal affects that would provide the room with a homelike versus institutional sense. The following are interviews from residents that expressed their disdain and frustration with not having access to their personal belongings: Resident # 43 explained when they had COVID they packed up all their belongings and stored them in the Sunnyside Cafe. But they have been out of quarantine for a few weeks and have not been dispersed their items. Resident #43 stated the facility has not communicated with them their process of returning all their items. The resident reported her roommate does not have here belongings either and her daughters have been bringing her in new items. Resident #89 reported none of his personal items are with him in his current room. The resident's room did not have any personal effects and the resident stated he does not know where any of belongings are. Resident #2 explained they packed up all her items and placed them in the cafeteria when she had COVID. She reported and is not sure when they plan on returning all her items. Resident #90 explained when he tested positive for COVID they packed up all his belongings and placed them in the Sunnyside Cafe. He was moved to his current room from quarantine and his belongings were never given back to him. He reported he spoke to the Nurse Manager regarding his items and was informed in the next few days (about a week prior) their items should be released but there was not a definite date. Resident #90 stated he has none of his items to keep him occupied throughout the day and stated he is discharging in a week and wanted to organize his items before he left. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Residents #72 and #73 were both resting in bed when this writer walked in. They were asked about their time at the facility they reported they would like all their clothing back and explained it is being store in the cafeteria. They stated they have received no communication from the facility regarding a return date for their possessions. On 2/14/2022 at 11:40 AM, this writer observed the Sunnyside Cafe where all the residents' possessions were housed. The Cafe is the main dining area for facility residents and is approximately 700 square feet. The room had multiple boxes stacked on one another, that lined the perimeter of the cafe. There were boxes and large plastic bags on top of the steam table and other tables in the room. There were wheelchairs, clothing on hangers, suitcases, hampers and three compartment storage bins riddled throughout the room as well. Many of the items did not have resident names on them nor did there appear to be any type of organization to the room. There was a narrow walkway to access all the items as there was over 70+ boxes and bags in the cafe. It appeared when they resident items were placed in the cafe, they put them down wherever there was space. On 2/14/22 at 2:20 PM, an interview was conducted with Social Services Director C regarding the resident items in the Sunnyside Cafe. Director C explained when they moved residents to the COVID unit they packed up all their belongings and the residents kept a few items to last them through their quarantine period. Director C reported they moved the residents in January and at least half of the facility residents, personal belongings, are housed in that room. Director C was queried as to when the residents will receive their items back. It was explained when they are moved back to their original rooms (rooms they were in prior to contracting COVID) they will be provided with their belongings. Director C continued some of the residents' items are labeled and others are not. Director C was uncertain if an inventory list of each resident's item was completed prior to the move and who was responsible for organization of such a widespread resident move. She reported their medical records individual has a list of when the residents are going back to their original room. She was not able to answer why residents could not have their belongings back while in their current rooms. On 2/14/22 at 2:30 PM, an interview was conducted with Medical Records Clerk W, regarding the resident's belongings in the Cafe. She reported she is currently organizing the move for residents back to their original rooms and was not involved when the residents were initially moved into quarantine. She reported there are 70 residents that must be moved over the course of 10 days and they are starting those moves in the next week or so. This writer was directed to Housekeeping/Laundry Supervisor D. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/22 at 3 PM, an interview was conducted with Housekeeping/Laundry Supervisor D regarding his/his staff's involvement with moving the residents to quarantine and their personal belongings. Supervisor D explained he informed his staff to pack up the resident's room, label all the items and place them in the Sunnyside Cafe. He explained they initially placed resident items on the perimeter of the room and once that was filled, they utilized the space in the middle. Supervisor D was asked if he verified his staff followed his directive and placed resident names on all the items in the cafe. Supervisor D stated he did not verify they were putting names on the items, nor has he gone into the cafe to verify names are on all the items in there. Supervisor D was queried if there was an inventory list of each residents' belongings or list of all the residents who have items in the Cafe. Supervisor D reported he was not sure if there was a list was completed of residents whose belongings were in room and stated an inventory of their items prior to being moved was not completed. He further explained when they move back to their original rooms toward the end of the month, they will be able to get their belongings back. Supervisor D expressed he was not in charge or the residents moving, nor did he take the lead on ensuring it was a smooth process. At this time Supervisor D was asked to go to the cafe and see if there were names on the resident belongings. When he returned, he reported some of the items were labeled but not all of them. He stated there are about 40-50 residents' belongings in the Sunnyside Cafe. He was not able to answer why residents could not have their belongings back while in their current rooms and reiterated he was not the lead on this task. On 2/16/22 at approximately 3:00 PM, an interview was conducted with the Administrator regarding the residents' personal belongings and property in the Sunnyside Cafe. The Administrator explained when facility residents began to contract COVID, they started moving residents to the COVID unit. When moving to that unit, the residents took minimal personal property, and the majority of their item were packed and placed in the cafe. The Administrator stated there were about 55 residents that were moved to the COVID unit and items stored in the Cafe. the Administrator explained the resident names are on all their belongings and any resident that requested their items staff were able to retrieve them from the Cafe. The Administrator added Maintenance Director A and Housekeeping Supervisor D were the point persons on this endeavor. A conversation was held with the Administrator that in speaking to her staff they all placed responsibility on other facility staff, could not verbalize a process or explain why residents had to wait until they were moved back to their initial rooms to regain access to their belongings. It was further explained that while it's understandable why all their personal belongings were not moved with them while on the COVID unit, they have been off that unit for some time and still have not been given their items back. The Administrator was further informed the residents' name were not listed on all their belongings. The Administrator was not able to provide reasoning why the residents did not have their belongings when they had been off the COVID unit or why the process was not managed and organized more efficiently. It can be noted there was no organizational processes in place when moving the residents' belongings from their rooms to the Sunnyside Cafe. The facility did not label, inventory or provide dates to the resident as to when their items would be returned. Furthermore, there was not a solidified date as to when the residents would be moved back to their original rooms. The residents began to be moved to the COVID unit mid-January 2022. Upon the survey team exiting, facility residents were still not in possession of their belongings. facility staff were questioned about a date, they were all time frames as to when they would begin the room moves. The Sunnyside Cafe is in disarray with the resident items and it unknown if the moves for the residents back to their rooms will be a smooth transition and if all their items will be returned. Lastly, there was no reasoning provided as to why residents personal belongings/property was not returned once they were moved from the COVID unit. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/2/22 at 1:00 PM, a review was completed of the facility document entitled, Your Rights and Protections as a Nursing Home Resident. The Rights packet stated the following, .Get Proper Privacy, Property and Living Arrangements: You have the following rights: To keep and use your personal belongings and property . 37668 Resident #22: On 2/15/22 at 8:12 AM, Resident #22 was observed in their room in bed. The Resident was unshaven with an unkept appearance. There were no personal items present in the room. An interview was conducted at this time. When queried regarding the care they receive in the facility, Resident #22 stated, I can't get out of bed (independently), and they (staff) don't help me. Resident #22 was asked about personal items in the facility, including clothing, and Resident #22 directed this surveyor to open the closet door in their room. The closet was noted to be empty. Resident #22 stated, Nothing in there. All my stuff is missing. When queried regarding the location of their personal items, Resident #22 revealed they did not know. At this time, Certified Nursing Assistant (CNA) J entered the Resident room without knocking. After CNA J exited the room, Resident #22 was queried if staff normally knock when they enter the room and replied, No. When asked how that made them feel, Resident #22 revealed they were lonely and did not feel that anyone cared about them. At 3:57 on 2/15/22, Resident #22 was observed in their room in the facility. The Resident was in bed and remained dressed in a hospital gown. Review of Resident #22's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, gout, dysphagia (difficulty swallowing), and urinary incontinence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required two-person, extensive assistance with dressing and was totally dependent upon staff for bed mobility, toileting, and personal hygiene. Resident #27: On 2/15/22 at 9:27 AM, Resident #27 was observed in their room in bed. The Resident was wearing a hospital style gown and positioned on their back with their heels positioned directly on the mattress. An interview was conducted at this time. When queried regarding their room, Resident #27 revealed they had moved rooms. Resident #27 then stated, They took all my clothes. When asked about specific dates and information regarding their clothing, Resident #27 revealed they were unable to remember dates, but reiterated staff had taken all their clothes and they did not have any now. When asked, Resident #27 indicated they liked to get dressed and wanted their clothes. Record review revealed Resident #27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia, diabetes mellitus, kidney disease, and heart failure. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive two-person assistance for bed mobility, transferring, dressing, toileting, and personal hygiene. Review of census documentation revealed since 1/14/22 revealed Resident #27 had been sent to the hospital twice and in three different facility rooms. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #29: Record review revealed Resident #29 was admitted to the facility on [DATE] with diagnoses which included hypothyroidism, depression, and weakness. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to limited assistance to perform all Activities of Daily Living (ADLs). On 2/15/22 at 12:41 PM, an observation and interview with Resident #29 was completed in their room. Upon entering the room, an overpowering and exceeding foul, odor permeated the air. A garbage bag was on the floor, directly next to the door of the room. The bag was tied and contained garbage. The floor in the room was sticky with an unknown substance. The Resident was sitting in a wheelchair, directly next to their bed. The Resident did not have on pants and their brief and lower extremities were exposed. When asked, Resident #29 revealed they wanted to talk. An interview was conducted at this time. When asked about care received in the facility, Resident #29 stated, They don't give a shit about us here. During the interview with Resident #29, Unit Manager Licensed Practical Nurse (LPN) E opened the door to the Resident's room without knocking. Unit Manager (LPN) E left the room door open without speaking to the Resident and leaving the Resident exposed and visible from the hallway of the facility. Resident #77: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/22 at 3:34 PM, an observation occurred of Resident #77 in their room. The Resident was in bed, a fitted sheet was not observed on the bed under them and there were no blankets covering them. There was a notable lack of personal items present in the room. When queried regarding their bedding, Resident #77 revealed the fitted sheet was bunched up under them and stated, It pulled off the corners. When asked, Resident #77 stated, I don't like it but they ain't gonna do nothing about it. Resident #77 continued, They (staff) put the wrong size sheet on it. When queried regarding their room, Resident #77 revealed they had been moved rooms. Resident #77 stated, Apparently I had Covid. I woke up one morning with some chest congestion. I asked for some cold medicine and the Doctor wanted me to have a Covid test. It was negative. Resident #77 revealed they had a second Covid test the following day which was also negative. With further inquiry, Resident #77 stated, They (staff) didn't even tell me I had Covid. They just pulled open the curtain and said are you ready. Resident #77 disclosed they had questioned the staff members and were told, To go to the Covid wing. The Resident stated, I didn't even know I had Covid. Resident #77 continued, I haven't had my cell phone since they moved me over here. When asked about contacting family and making phone calls, Resident #77 revealed they had not been able to make or speak to their family on the phone. When asked about other personal belongings, Resident #77 revealed their belongings were not moved with them and they were unsure of location of their belonging and/or when they would get them back. Resident #23 stated, They (staff) lie. We were supposed to only be here (current room) for 10 days. It's been a month. When asked, Resident #77 revealed they heard new residents had moved into their room. The Resident revealed they had asked staff when they would be able to move back and stated, All they say is another week. Resident #77 then stated, I did not get a shower for 23 days. The Resident revealed they did not have any of there clothes and had to ask a staff member to get them clothes so they could have clean clothes after 23 days. Resident #77 continued, These underwear I have on are too small and indicated they were digging into their skin. When asked how long they had been wearing the underwear which were too small, Resident #77 replied, Probably five to seven days. Resident #77 then stated, I am at my wits end. I thought the old company ran this place like garbage, but this place is like a garbage fire. When asked how they felt about what had occurred and the care they received, Resident #77 stated, The thing I hate the most is that they don't see us as people, they see us as a bed. Resident #77 continued, You just cant take care of people like that. Record review revealed Resident #77 was admitted to the facility on [DATE] with diagnoses which included left sided hemiplegia and hemiparalysis (one sided paralysis) following cerebral infarction (stroke), depression, seizures, and tremors. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to limited assistance to perform all ADLs with the exception of eating. Review of evaluation documentation revealed a Room Change Notification form in Resident #77's medical record dated 1/19/22. Resident #82: At 7:51 AM on 2/15/22, an observation of Resident #82 occurred in their room in the facility. CNA J was in the Resident's room obtaining a blood pressure measurement. Resident #82 did not respond, verbally or non-verbally, when spoke to. When asked the Resident's name, CNA J revealed they did not know the Resident's name. CNA J stated, I am actually from agency (staffing company) and revealed they did not know the facility residents. Resident #82 had an unkept appearance with long, visible hair on their chin and thick, goopy-appearing substance surrounding both of their eyes, and visibly soiled bedding and hospital gown. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review revealed Resident #82 was originally admitted to the facility on [DATE] with diagnoses which included dementia, dysphagia (difficulty swallowing) gastrostomy (surgically created through the abdomen into the stomach for nutritional support), and pain. Review of MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required two-person extensive to total assistance to perform ADLs. 39059 Resident #24: On 2/14/22, at 2:22 PM, Resident #24 was sitting in their room and complained that when they were moved all their belongings were not moved. Resident #24 further stated that all their belongings are in the Sunnyside cafe in a pile. Resident #24 firmly stated they I want my stuff back. On 2/14/22, at 3:00 PM, Social Worker C was interviewed regarding Resident #24's belongings being stored in the Sunnyside cafe. Social Worker C was alerted Resident #24 wanted their belongings back today and Social Worker C stated that they would go get them from the Sunnyside cafe and give them to the resident. On 2/14/22, at 3:23 PM, Social Worker C stated that they gave Resident #24 clothes, [NAME] knacks and puzzles back and that the resident was ok with waiting for their bookshelf until they move back to their original room. On 2/14/22, at 4:00 PM, Resident #24 was sitting in their room and was thankful they got their stuff back. Resident #24 offered that they were fine with waiting for their bookshelf and books until they move back to their original room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to implement and operationalize policies and procedures for advanced directives for one resident (Resident #22) of six residents reviewed, resulting in the lack of two physicians' evaluations of incompetency, lack of communication regarding resident incompetency determination to the predesignated Durable Power of Attorney (DPOA), and the likelihood for inappropriate incompetency determinations, ongoing lack of communication, and resident/resident representative dissatisfaction. Findings include: Resident #22: Review of Resident #22's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, gout, dysphagia (difficulty swallowing), and urinary incontinence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required two-person, extensive assistance with dressing and was totally dependent upon staff for bed mobility, toileting, and personal hygiene. The Electronic Medical Record (EMR) included the following documentation related to Resident #22's advance directives: - Order, dated 9/20/21, indicating Resident #22 was a Full Code - Designation of Patient Advocate for Health Care document, dated 6/27/21, designating (Family Member K) as their patient advocate in the event they are deemed incompetent by their attending physician and another physician or licensed psychologist. - Report of Physician or Mental Health Professional, dated 12/18/21 and signed by one Health Care Provider, Physician L. The document indicated Physician L determined Resident #22 was unable to make informed decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Social Worker C on 2/22/22 at 11:45 AM. Social Worker C was asked how Resident advance directives and code status is addressed per facility policy/procedure. Social Worker C replied, Ask during the first care conference. When queried regarding facility policy/procedure pertaining to incompetency determination, Social Worker C replied, I ask the Doc to do it based on the BIMS (Brief Interview for Mental Status score). Social Worker C was then asked when DPOA's took effect and replied, Immediately when facility gets the (DPOA) paperwork. When asked the difference between DPOA and guardianship in regard to incompetency, Social Worker C stated, Oh yeah, have to be deemed incompetent for a DPOA. Social Worker C was then queried regarding only one physician certification of incompetency in Resident #22's medical record but did not provide an explanation. When queried regarding facility policy/procedure pertaining to communication with and/or notification of DPOA of Resident incompetency determination and/or enactment of the DPOA, Social Worker C revealed they do not notify and/or discuss the incompetency determinations and/or DPOA enactment with the DPOA. When asked how they know the DPOA is in effect if the information is not communicated to them, Social Worker C replied, I see what you are saying. We do not tell them. When queried if they provide an Advance Directive document to each admission and receive acknowledgement of receipt as detailed in the provided facility policy/procedure, Social Worker C stated, I don't. I don't give them anything. I just ask. An interview was completed with the facility Administrator on 2/23/22 at 8:46 AM. When queried if a Resident's designated DPOA should be made aware and involved when a Resident is deemed incompetent, the Administrator replied, Yes. When queried if two physicians were required to deem a Resident incompetent, the Administrator indicated two physician evaluations were required. When queried regarding facility policy/procedure including communication, the Administrator indicated the facility social worker coordinated the process and stated, It's on the face sheet. There should be a progress note. When asked why there was no note and why Social Worker C stated they did not contact the DPOA, an explanation was not provided. Review of facility provided policy/procedure entitled, Advance Directives (Original Date: October 2019) revealed, It is the policy of [NAME] Care to provide information to resident/responsible party regarding his/her rights to formulate advanced directives including the right to refuse or accept medical care . Procedure: 1. The facility will provide a copy of the Indiana State Department of Health: Advanced Directives, Your Right to Decide to each admission to the facility. The receipt of this information will be gathered in writing via the Advanced Directive Acknowledgement Form. 2. Executed Advanced Directives will be documented in the medical record. Code status directives (both full and no code will be documented via a physician's order, on the face sheet and care plan. 3. Advanced Directives will be reviewed quarterly in the care plan conference with the IDT and resident/responsible party as applicable .

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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** 37668 Based on interview and record review, the facility failed to implement policies and procedures to ensure ombudsman notification of resident transfers for three residents (Resident# 22, Resident #27, and Resident #29) of three residents reviewed, resulting in a lack of notification of transfers, the potential for inappropriate transfers, and the likelihood of depriving all 97 facility residents from access to an advocate to inform them of their rights related to facility transfers and discharges practices. Findings include: Resident #22: Review of Resident #22's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, gout, dysphagia (difficulty swallowing), and urinary incontinence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required two-person, extensive assistance with dressing and was totally dependent upon staff for bed mobility, toileting, and personal hygiene. Further review of Resident #22's medical record revealed the Resident was transferred to the hospital due to a change in condition on 11/24/21 and readmitted to the facility on [DATE]. No documentation of ombudsman notification of transfer was noted in Resident #22's medical record. Resident #27: Record review revealed Resident #27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia, diabetes mellitus, kidney disease, and heart failure. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive two-person assistance for bed mobility, transferring, dressing, toileting, and personal hygiene. Addition record review revealed the following transfers to the hospital due to changes in medical condition since 1/1/22 for Resident #22: - Transferred to the hospital on 1/4/22 and returned to the facility on [DATE] - Transferred to the hospital on 1/15/22 and returned 1/28/22 - Transferred to the hospital on 2/9/22 and returned on 2/10/22 No documentation of Ombudsman notification of transfer was noted in Resident #27's medical record. Resident #29: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #29 was admitted to the facility on [DATE] with diagnoses which included hypothyroidism, depression, and weakness. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to limited assistance to perform all Activities of Daily Living (ADLs). Additional record review revealed Resident #29 was discharged from the facility to the hospital on 11/24/21 and returned on 11/27/21. No documentation of Ombudsman notification of transfer was noted in Resident #27's medical record. An interview was conducted with the facility Administrator on 2/23/22 at 9:43 AM. When queried regarding Ombudsman notification of resident transfers, the Administrator indicated they would look into the process. A follow up interview was conducted with the facility Administrator on 2/23/22 at 10:22 AM. When queried regarding Ombudsman notification of resident transfer, the Administrator stated, I just spoke with the Social Worker and (Social Worker) hasn't done this. So, I can assume it hasn't been done. With further inquiry, the Administrator revealed the facility did not have a procedure in place to notify the Ombudsman of resident transfers from the facility. On 2/23/22 at 10:25 AM, a policy/procedure related to resident transfers and ombudsman notification was requested from the Administrator via email but not received by the conclusion of the survey.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview, and record review the facility failed to timely complete Level 1 Preadmission Screening/Annual Resident Review (PASARR) screening for three residents (Resident #41, Resident #46 and Resident #71), resulting in Resident #46's PASARR not being completed, after they surpassed their 30 -day exemption period and Resident's #41's and Resident #71's PASSAR's not being completed on an annual basis by the facility and the likelihood for residents to forgo specialized behavior health services local Community Mental Health Organization. Findings Include: Resident #46: On 2/14/22 at 4:21 PM, Resident #46 was observed in her room eating Cheez-It's. She reported she has been at the facility for a few months and is working toward going home. On 2/14/22 at approximately 4:30 PM, a review was completed of Resident #46's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included Diabetes, Major Depression Disorder, Bipolar Disorder and Schizophrenia. Further review was completed of Resident #46's chart and a PASSAR was not able to be located. Resident #46 would have required a new PASSAR once she remained in the facility past 30 days after admission from the hospital. The hospital exempted PASARR and the required new PASARR were not located in the chart. Resident #41: On 2/14/22, during initial tour Resident #41 was observed resting in bed, he did not appear to be in any distress and was in good spirits. On 2/16/22 at 8:46 AM, a review was completed of Resident #41's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included Anxiety Disorder, Major Depressive Disorder and Kidney Disease. Further review was completed of his chart and the most recent Level I PASARR Screening was completed on 8/27/20. Resident #46 also qualified for an Omnibus Budget Reconciliation Act (OBRA) Level II Assessment that was not triggered because the Level I screening was not completed in 2021. Resident #71: On 2/14/22, during initial tour Resident #71 was observed in bed watching old western shows. She spoke about how she just enjoyed some cookies and was waiting on lunch to arrive. On 2/16/22 at 8:50 AM, a review was completed of Resident #71's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses of Anxiety Disorder, Paranoid Schizophrenia and Parkinson's Disease. Further review was completed and the last. Further review was completed of her chart and the most recent Level I PASARR Screening was completed on 12/2/2020. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/16/22 at 9:45 AM, an interview was conducted with Social Worker C regarding Resident #41, #46 and #71's overdue PASARR's. The Social Worker reported she never received access to the new PASSAR system and therefore cannot complete or submit any PASARR's for facility residents. She reported the other social worker had access to the system and would submit the PASARR's for the building but since she left, she has no way of completing them. Social Worker C stated she has not had access to the system since October 2021. On 2/22/22 at 10:20 AM, an interview was conducted with Social Worker C regarding the requested PASARR's for Residents' #41, #46 and #71. Social Worker C reported they do not have them and it was explained the outdated one's the facility provided is what they have on file currently. According to MDHHS (Michigan Department of Health and Human Services), .Under the PASARR program, all persons seeking admission to a nursing facility who are seriously mentally ill or have an intellectual disability are required to be evaluated to determine whether the nursing facility is the most appropriate place for them to receive services and whether they require specialized behavioral health services .IN addition, persons residing in a nursing facility .are required to undergo a similar review annually .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 39059 Based on interview and record review, the facility failed to develop person-centered comprehensive care plans for two residents (Resident #48, Resident #70) of five residents reviewed for comprehensive care plans, resulting in unmet nutritional care needs with the likelihood of unmet dialysis care needs. Findings include. Resident #48: On 2/10/22, at 1:54 PM, Resident #48 was lying in their bed and complained about the tough food the facility provided and had been having vomiting. Resident #48 offered that they couldn't eat the food because they had a lap band procedure in the past and are used to eating soft foods and soups. Resident #48 stated that they asked to see the dietician more than five times and the dietician had not been in. Resident #48 ended up having their lap band removed the day before because of the tough food offered. Resident #48 was asked if they had different foods to eat would they have had to remove the lap band and Resident #48 stated No, that they could eat soups and soft foods without difficulty. Resident #48 also complained that they felt they had lost weight but had not been weighed at the facility. On 2/22/22, at 11:57 AM, a record review of Resident #48's electronic medical record revealed an admission on 1/5/22 with diagnoses that included Sarcopenia, Lumbago and muscle weakness. Resident #48 required assistance with all Activities of Daily Living and had intact cognition. A record review of the care plans revealed Focus Resident is at risk for nutrition or hydration problems Date Initiated: 01/06/2022 Goal Resident will receive adequate nutrition and hydration Target Date: 04/06/2022 Interventions Diet as ordered Date Initiated: 01/06/2022 The problem or history of lap band and the need for soft foods/soups was not listed on the care plan. A review of the Dietician_Review Date: 1/10/2022 admission assessment revealed Dietician Review 1. Current Diet Order & supplements was left blank. 1.a. Does the resident have any food allergies/intolerance's The boxes for yes or no were not check marked. 4. Most recent Weight was left blank. There was a typed note that revealed Additional comments/recommendations . poor app (appetite) . lap band . The residents usual body weight was not listed. On 2/22/22, at 3:07 PM, Dietician B was asked why the care plan did not mention the lap band and the need for soft foods and Dietician B complained that the care plan system had a glitch and was unaware it was not complete. Resident #70: On 2/22/22, at 11:05 AM, record review of Resident #70's electronic medical record revealed an admission on 1/15/22 with a readmission on 1/26/22 with diagnoses that included end stage renal disease requiring dialysis, metabolic encephalopathy and Diabetes Type 2 with complications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Focus Resident is at risk for nutrition or hydration problems Date Initiated: 01/16/2022 revealed Goal was left blank and Interventions Date Initiated: 01/16/2022 was left blank of interventions. There was a second care plan listed for Resident #70 that revealed Focus (the resident) presents with potential for nutritional risk related to therapeutic diet, Diabetes, Kidney disease, obesity Date Initiated: 01/26/2022 . Goal (the resident) will not exhibit significant weight change . Interventions document food/fluid intakes Date Initiated: 01/26/2022 honor food/fluid preferences as possible Date Initiated: 01/26/2022 Provide and serve diet as ordered. Consistent CHO Renal diet Date Initiated: 01/26/2022 . RD to evaluate and make diet change recommendations PRN. Date Initiated: 01/26/2022 Weights as ordered/indicated, notify MD of significant weight changes Date Initiated: 01/26/2022 There was no mention of Resident #70 need for dialysis. There was no dialysis care plan for Resident #70. On 2/22/22, at 2:00 PM, a record review of the facility provided Care Planning Reviewed 9/28/17 policy revealed A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident Minimum Data set (MDS) . Resident assessments are begun on the first day of admission and completed no later than the fourteenth (14th) day after admission . A baseline care plan for each resident, within 48 hours of their admission, which includes the instructions needed to provide effective and person-centered care that meets professional standards of quality care . On 2/22/22, at 2:40 PM, the Administrator was asked to provide dialysis communication documents for Resident #70. On 2/23/22, at 9:20 AM, the Administrator was asked to provide dialysis communication documents for Resident #70 with the response by the Administrator that the facility does not have communication forms.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize discharge planning policies and procedures for one resident (Resident #29) of one resident reviewed resulting in lack of coordination, communication, and follow-up for a resident's requested transfer to a different facility and the likelihood for psychosocial distress, unnecessary separation from family, and overall dissatisfaction with care. Findings include: Resident #29: An interview was conducted with Resident #29 in their room of the facility on 2/15/22 at 12:40 PM. The Resident had an unkept and unclean appearance and a distinctly strong, foul and permeating urine odor was present in the room. When queried regarding the care they receive in the facility, Resident #29 stated, They don't give a shit about us here. When asked why they felt that way, Resident #29 revealed they just did not feel like anyone cared about what was important to them. When asked for an example, Resident #29 revealed the staff do not bring their medications on time. Resident #29 stated, They bring them (meds) at midnight. I am already sleeping. Resident #29 then stated, I want to go somewhere else. When asked if they had brought their concerns to the facility staff, Resident #29 indicated they had. With further inquiry, Resident #29 revealed they wanted to be transferred to a facility closer to their family. The Resident revealed their family was in agreement with the plan and they had spoke to the facility social worker about it as well. When queried regarding the facility social worker response, Resident #29 revealed they had been told they would look into finding a different facility and getting them transferred but nothing had ever happened. Record review revealed Resident #29 was admitted to the facility on [DATE] with diagnoses which included hypothyroidism, depression, and weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to limited assistance to perform all Activities of Daily Living (ADLs). Review of progress note documentation in resident #29's medical record revealed the most documentation of care coordination by facility social services occurred on 10/7/21 in which the facility social worker reached out to a senior apartment complex per resident request. An interview was conducted with Social Worker C on 2/22/22 at 11:45 AM. When queried if they were aware Resident #29 wanted to relocate to a facility closer to their family, Social Worker C revealed they were. With further inquiry, Social Worker C indicated they other facility social worker who had left employment at the facility had been working with Resident #29. When asked why there was no documentation in Resident #29's progress notes of any attempted care coordination, Social Worker C was unable to provide an explanation but indicated there should be documentation. When informed of Resident #29's statement of feeling that no one cared about then and lack of follow up regarding requested transfer to a different facility, Social Worker C stated, I can see why they would feel like that. Social Worker C revealed they would follow up with the Resident. When queried why discharge planning had not been implemented and followed up on prior to this notification, Social Worker C revealed they were only one person. No further explanation was provided. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the facility Administrator on 2/23/22 at 8:46 AM. When queried regarding the lack of discharge planning and follow-up of Resident #29's discharge request, an explanation was not provided. A policy/procedure related to discharge planning was requested at this time but not received by the conclusion of the survey. Review of facility provided policy entitled, Resident Rights (October 2019) did not include any information pertaining to discharge planning and/or rights.

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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** 37668 Based on observation, interview and record review, the facility failed to ensure the provision of Activities of Daily Living (ADL) care for one resident (Resident #22) of one resident reviewed, resulting in a lack of assistance with eating, showering, bathing, oral care, dressing, general unkept and unclean appearance, and resident verbalization of feelings of frustration and discontentment. Findings include: Resident #22: On 2/15/22 at 8:12 AM, Resident #22 was observed in their room in bed. The Resident was unshaven and had an unkept appearance. An interview was conducted at this time. While speaking, the Resident was observed to have missing teeth with visible build up on the teeth they have. When queried regarding the level of assistance they require for transferring and ambulation and the care received in the facility, Resident #22 stated, I can't get out of bed (independently), and they (staff) don't help me. Resident #22 was asked when they last received a shower and revealed they had not gotten a shower in the facility. When queried regarding brushing their teeth, Resident #22 indicated they had not brushed their teeth. There were no oral care products observed in the room. Resident #22 revealed they did not feel that anyone in the facility cared about them. At 3:57 on 2/15/22, Resident #22 was observed in their room in the facility. The Resident was in bed and remained dressed in the same hospital gown. When queried if they had received or been assisted with ADL care including bathing and/or oral care, the Resident indicated they had not. Review of Resident #22's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, gout, dysphagia (difficulty swallowing), and urinary incontinence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required two-person, extensive assistance with dressing and was totally dependent upon staff for bed mobility, toileting, and personal hygiene. Review of Resident #22's care plans revealed a care plan entitled, Resident needs assistance with all activities of daily living (Initiated: 11/2/21). The care plan included the interventions: - Personal hygiene: staff assistance X 2 staff (Initiated: 11/2/21; Revised: 2/9/22) - Eating: Staff assistance of 1 . (Initiated: 11/2/21) - Bed mobility: Totally dependent on 2 staff (Initiated: 11/2/21) On 2/16/22 at 1:22 PM, an interview was completed with Certified Nursing Assistant (CNA) X. When queried regarding facility policy/procedure related to showering residents, CNA X stated, No showers. They (facility staff) don't do that here. It's sad. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/16/22 at 1:25 PM, Resident #22 was observed in their room. The Resident was in bed with their eyes closed and a food tray in front of them on the overbed table. The food was untouched. No silverware/eating utensils were present on the tray. The Resident remained unshaven and was visibly dirty with unknown substances on their face and hospital gown. The Resident's feet were uncovered and large chunks of dried, flaking skin were present on the fitted mattress sheet by their feet. An interview was completed with CNA EE on 2/16/22 at 1:29 PM. When queried, CNA EE revealed they were assigned to care for Resident #22. An observation of the Resident occurred with CNA EE at this time. When queried regarding the Resident not eating any of their lunch, CNA EE revealed they had brought the tray in but Resident #22 is tired. CNA EE was asked how the Resident could eat the food without silverware but did not provide a response. CNA EE was then queried if they had provided ADL care to the Resident including washing them and oral care and replied, No. When asked why they had not, CNA EE stated, I'm agency (staffing company). No one told me. CNA EE was asked if they were able to see the Resident was dirty and stated, Yes. When queried why they would not clean and provide hygiene care to a Resident who is visibly dirty, CNA EE stated, No one told me. When queried regarding showering Resident #22 and other Residents, CNA EE stated, I don't do that. No one told me. Review of Resident #22's shower task documentation in the Electronic Medical Record for the past 30 days revealed no documentation of the Resident receiving a shower. An interview was completed with the facility Administrator on 2/22/22 at 5:27 PM. When queried regarding Resident observations and staff statements pertaining to ADL care and showering, the Administrator was unable to provide an explanation. Review of facility provided policy/procedure entitled, Activities of Daily Living (ADLs), Supporting (Revised March 2018) revealed, Residents will provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to ensure the provision of care coordination for dependent resident activity participation for one resident (Resident #82) of one resident reviewed for activities, resulting in lack of activities and basic stimulation for residents who are dependent on staff for transferring and mobility and the likelihood for depression and feelings of melancholy using the reasonable person concept. Findings include: Resident #82: On 2/15/22 at 7:51 AM, Resident #82 was observed in their room. The Resident's touch call light was on the floor behind the head of the bed. The Resident was positioned on their back in bed, wearing a hospital style gown. The room was dark with the window shades closed and no lights on. There was no activity calendar observed in the room. At 2/15/22 at 2:28 PM, Resident #82 was observed in their room in bed. The Resident's room remained darkened with the shades down and no lights on in the room. There were no personal items in the room and no source of stimulation or entertainment. On 2/16/22 at 8:30 AM, Resident #82 was observed in their room, in bed. The room was dark with the lights off and shades drawn. There was no source of stimulation or entertainment in the room. Record review revealed Resident #82 was originally admitted to the facility on [DATE] with diagnoses which included dementia, dysphagia (difficulty swallowing) gastrostomy (surgically created through the abdomen into the stomach for nutritional support), and pain. Review of MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required two-person extensive to total assistance to perform ADLs. Review pf Resident #82's care plans revealed a care plan entitled, (Resident #82) enjoys activities such as listening to a variety of music (Oldies), watching oldies television shows, getting nails done occasionally, and social visits with staff (Initiated and Revised: 7/29/21). The care plan included the interventions: - Allow patient time to respond (Initiated: 7/29/21) - Assist in planning and/or encourage to plan own leisure time activities (Initiated: 7/29/21) - Assist to transport to & from activities of choice such as Ladies Nail Boutique, Movie days/nights, social events, and Musical entertainment (Initiated and Revised: 7/29/21) - Encourage participation in group activities of interest such as Movie days/nights, Musical Entertainment, social events/gatherings, Ladies nail boutique (Initiated and Revised: 7/29/21) (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Provide sensory stimulation and 1:1 activities room visits 2X weekly for increased socializing and activity participation (Initiated and Revised: 7/29/21) Review of Resident #82's Activity task documentation revealed the only activities documented for the Resident included Conversation and Religious Services/Bible Study. An interview was completed with Activity Director FF on 2/16/22 at 12:05 PM. When queried regarding activities for dependent residents in the facility, Director FF revealed Activity staff stop by and visit with Residents as often as possible. Director FF was then asked about the number of Residents who require staff assistance observed not dressed and in bed throughout the day and revealed they had noticed the same trend. When queried how that impacted activities, Director FF stated, We (activity staff) fight with nursing staff to get them (residents) out of bed and sometimes by the time they do, the activity is over. Director FF continued, It's a struggle and it makes me feel horrible. Director FF was then asked if they were familiar with Resident #82 and indicated they were. Director FF was asked about observations of Resident #82's room always being dark with no stimulation. Director FF revealed that was unacceptable and indicated the Resident really enjoyed music. An interview was completed with the Administrator on 2/23/22 at 8:39 AM. When queried regarding observations of dependent residents undressed and in bed throughout the day, the Administrator was unable to provide an explanation. When queried regarding the lack of activities for dependent residents and activity staff statements revealing residents are unable to participate in activities due to nursing staff not getting residents out of bed, an explanation was not provided. When queried regarding Resident #82's room being without stimulation, dark, and [NAME], the Administrator did not provide a response. Review of facility provided policy/procedure entitled, Activity Programs (Revised 7/2018) revealed, 1. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs .

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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. 28834 Based on interview and record review, the facility failed to ensure the Activity Department was directed by a qualified professional, resulting in the potential for a lack of individualized recreational activities to meet the needs and abilities of all 81 residents. Findings include: On 6/6/2022 at 4:35 PM, Activity Aide JJ provided two activity calendars for the surveyor. Activity Aide JJ stated that she had been in the activity department since November of 2021 and she had been in housekeeping before changing to the activity department. She stated that the activity department has been without a director since December 2021. She further stated that she did not do assessments or care plans, she did not work with computers and that the corporate people did the paper work and she ran activities. On 6/7/2022 at 11:00 AM, Activity Aide JJ could not identify any of the activities on the June 2022 calendar that had a focus for residents with dementia diagnosis. Activity Aide JJ stated that the residents with dementia were provided one to one activities, such as being read to or short conversations during room visits which were not listed on the calendar. The activity cart included word search, cross words, pages to color, and channel 4 is controlled by the facility through a lap top computer and we have Bingo on it or, find you-tube videos for yoga or dance for residents. On 6/8/2022 at 11:00 AM, during an interview with Nurse Consultant Z she stated that the activity department did not have a director right now. In 6/13/2022 at 9:55 AM, during an interview with the Director of Nursing, Corporate staff GG, and the administrator, they reported that the contracted firm handles social work and activities department. They reported that the previous activity director went on a maternity leave on 12-24-2021 and decided not to come back to work in March 2022. They also reported that Activity Aide JJ did a hard copy of the resident assessments and we input into the computer. The Activity Director job description, updated 3/25/2021, the summary was that the director develops a program of activity therapy from a holistic approach to meet the needs of a diverse resident population. The essential performance responsibilities included performing a comprehensive assessment for each resident to determine the level of abilities combined with past and current interests. To develop an individualized program of activity pursuits that were meaningful to each resident, complete the Minimum Data Set assessment and resident assessment protocols in a timely manner, to document the residents' response to care plans, to develop and use a budget sufficient to maintain equipment and purchase supplies, to utilize cutting edge models of approach, such as music therapy, pet therapy, aroma therapy, therapeutic touch, etc. , to reduce symptoms of anxiety, depression, aggression, and pain, to provide a venue for resident activism through the resident council process, to communicate expressed desires and concerns of those residents to appropriate department heads of the facility, to develop and maintain community volunteer efforts, and to supervise the Activity Assistants.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to operationalize policies and procedures to ensure timely communication and care coordination of Hospice for one resident (Resident #44) of one resident reviewed for Hospice resulting in a lack of staff knowledge of Hospice provider, lack of timely assessment and care planning, lack of communication with Hospice provider, and the likelihood for uncoordinated and unmet needs. Findings include: Resident #44: Record review revealed the Resident #44 was admitted to the facility on [DATE] with diagnoses which included heart disease and Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, required extensive assistance for bed mobility, dressing, and personal hygiene. A significant change MDS dated [DATE] was also noted in Resident #44's medical record. On 2/16/22 at 12:39 PM, an interview was completed with Licensed Practical Nurse (LPN) V. When queried regarding facility policy/procedure related to communication with Hospice providers when Residents are receiving Hospice services, LPN V indicated the Hospice staff come to the facility to see Residents. With further inquiry regarding documentation and how they know what services were provided and/or care plan updates, LPN V stated, We don't get a paper from the aide or nurse with what they did with the patient. LPN V was then asked the policy/procedure regarding order changes for Hospice residents and stated, If they (Hospice) give me a new order, then I put the order in (the Electronic Medical Record [EMR]) and then write a note. With further inquiry, LPN V revealed they do not receive any written orders from Hospice. When queried regarding the types of orders they receive and enter from Hospice staff, LPN V indicated all orders. LPN V was asked if they were referring to treatment and medication orders and replied, All that. When asked how long they had worked at the facility, LPN V revealed they were an agency staff member and stated, I don't think there is anybody (working) who actually works here. When queried what Hospice company the Resident received services from and how facility staff knew know the contact the Hospice provider and when to expect them at the facility, LPN V indicated there may be information in the Resident's chart. Resident #44's paper chart was not present on the unit and LPN V was unaware of its location. LPN V also revealed there was No Hospice book (resident specific binder containing hospice information) at the nurses' station. LPN V then stated, If (Resident #44) did (have a hospice book), it might be on Central. With further inquiry, LPN V revealed the chart and Hospice book may not have been moved with the Resident when they were moved rooms due to Covid-19 in January 2022. When asked why no one would have noticed the chart and Hospice book were not at the nurses' station, LPN V was unable to provide an explanation. At 1:05 PM on 2/16/22, an interview was completed with LPN Z and Certified Nursing Assistant (CNA) X. When queried regarding Hospice care coordination for Resident #44's, CNA X stated, I didn't even know (Resident #44) was on hospice. LPN Z then stated, I don't know where the Hospice book is. When queried who Resident #44's Hospice provider is, LPN Z stated, It should be on the profile (in the EMR). LPN Z proceeded to review Resident #44's EMR and stated, Not there. I don't know. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's medical record documentation, including electronic progress notes and scanned documentation revealed no documentation from the Resident's Hospice provider. Review of progress note documentation revealed the following note: - 9/20/21 at 3:48 PM: Social Services Note . SW (Social Worker) . notified Hospice for clarification if resident agreed to sign for hospice care. [NAME] through (Company) Hospice stated to this writer that (Resident #44) agreed for Hospice and signed papers on August 30th, 2021. Review of Resident #44's care plans revealed a care plan entitled, (Resident #44) is receiving hospice services due to (blank) from (Hospice provider name and phone number [Company name and phone number not detailed]) (Initiated and Revised: 9/27/21). The care plan included the interventions: - Hospice care per Hospice plan of care. Nursing facility to provide required care in the absence of Hospice personnel (Initiated: 9/27/21) - Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met (Initiated: 9/27/21) Review of Resident #44's Kardex did not indicate the Resident was receiving Hospice services. An interview was completed with the facility Administrator on 2/16/22 at 2:49 PM. When queried regarding facility policy/procedure pertaining to communication for residents receiving Hospice services, the Administrator indicated there is a Hospice book for each Resident at the nurses' station. When queried why Resident #44 did not have a Hospice book and why staff were not aware the Resident was receiving Hospice services, the Administrator was unable to provide an explanation. When queried why there was no Hospice documentation in Resident #44's medical record, the Administrator indicated there should be documentation. When queried regarding the date of Hospice admission per the SW note, the date of the Significant change MDS, and incomplete areas on the care plan, the Administrator did not provide an explanation. When asked if they were able to see the concern, the Administrator revealed they were. Review of facility provided policy/procedure entitled, Hospice Services (July 2020) revealed, Policy: It is the policy of this facility that when a resident elects the hospice benefit that the contracted hospice company and facility will coordinate to establish both a person-centered plan of care reflecting the physical, spiritual, mental and psychosocial needs of the resident as well as a pattern of communication between the hospice company, healthcare professionals, facility staff and resident/representative . Procedure . when a resident elects the hospice benefit, the hospice, members of the IDT and the resident/representative will coordinate the resident's plan of care .Contact information will be present on the chart for the hospice company . Significant change MDS completed upon admission to hospice . Hospice documentation available at the facility . Facility staff will contact the hospice company with any significant change in the resident's condition . The Social Services Director or designee will act as the Hospice Coordinator .

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures to ensure accurate assessment, documentation, implementation and monitoring of interventions to prevent the development and/or worsening of pressure ulcers (wounds caused by pressure) for seven sampled residents (Resident #7, Resident #27, Resident #46, Resident #77, Resident #82, Resident #88, and Resident #82) and four unsampled residents (Resident #1, Resident #2, Resident #3, Resident #4) of eleven residents reviewed. This deficient practice resulted in lack of facility staff/administration knowledge of pressure ulcer status, lack of assessment, monitoring, and documentation of pressure ulcers, lack of implementation and monitoring of interventions for pressure ulcer prevention, lack of treatment completion, lack of appropriate infection control procedures during wound care, development and worsening of Stage IV (full thickness tissue loss with exposed bone and tendon), unstageable/Deep Tissue Injury (DTI- pressure ulcer with unknown depth), and Stage II (open ulcer with partial thickness dermis loss) pressure ulcers for Resident #27 and Resident #82, and the likelihood for infection, unnecessary pain, and decline in overall health. Findings include: Review of the facility provided CMS-672 Form Resident Census and Conditions form detailed there were six residents with pressure ulcers, excluding stage one (intact skin, non-blanchable redness usually over a bony prominence) pressure ulcers. The CMS-672 form further detailed three of the six residents had pressure ulcers upon admission indicating three residents had developed pressure ulcers in the facility. Review of the facility provided CMS-802 Resident Matrix form only indicated two residents had pressure ulcers. Resident #27: On 2/15/22 at 9:27 AM, Resident #27 was observed in their room in bed. The Resident was wearing a hospital style gown and positioned on their back with their heels positioned directly on the mattress. Wound care dressing supplies were observed on the Resident's bedside table. An interview was conducted at this time. When queried regarding the wound dressing supplies in their room, Resident #27 revealed they had sores on their heels but were unable to provide any further information. Record review revealed Resident #27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia, diabetes mellitus, kidney disease, and heart failure. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive two-person assistance for bed mobility, transferring, dressing, toileting, and personal hygiene. The MDS further indicated the Resident was at risk for pressure ulcer development but did not currently have pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	An interview was conducted with Licensed Practical Nurse (LPN) R on 2/15/22 at 9:44 AM. When queried if Resident #27 had any wounds and/or pressure ulcers, LPN R indicated they were not aware of the Resident having a wound. When asked why the Resident had wound care dressing supplies in their room if they did not have a wound, LPN R indicated the supplies may have been for a different resident. An observation of the Resident's skin and/or daily care was requested to be completed at this time. LPN R indicated there was no staff available at this time but would contact this surveyor by phone when ready. LPN R did not contact this surveyor to complete observation. A list of residents with wounds was requested from the facility Director of Nursing (DON) on 2/15/22 at 11:30 AM. The DON was asked to delineate which wounds were pressure ulcers and which pressure ulcers were facility acquired versus community acquired on the list. On 2/15/22 at 1:35 PM, the requested list of residents with wounds was received from the DON. The list was titled, Wound Rounds and included 12 residents. The type of wound was not defined on the list. Resident #27 was not included on the provided list. An interview was conducted at this time. When queried regarding the wound etiology of the resident wounds provided on the list, the DON revealed they did not know. The DON indicated they would have to look into it and follow-up. When asked about the discrepancies identified between the CMS-672 and CMS-802 forms, the DON was unable to provide an explanation. Review of Resident #27's care plans revealed the following care plans and interventions: Care plan: Alteration in skin integrity related to immobility and weakness with hx (history) of abscess to left groin secondary to uti (urinary tract infection), right lateral foot, right 2nd toe, left plantar foot, left great toe, left lateral calluses present upon admission (Initiated: 2/8/16; Revised: 6/4/21). The care plan included the interventions: - Encourage and assist as needed to turn and reposition; use assistive devices as needed (Initiated: 2/8/16; Revised: 12/26/20) - Prafo boots (boots which prevent/treat pressure and foot drop contractures) on while in bed (Initiated: 1/13/21; Revised: 8/28/21) - Use pillows and/or positioning devices as needed (Initiated: 12/26/20; Revised: 7/12/21) Care plan: At risk for alteration in skin integrity/pressure ulcers related to decreased mobility, increased skin moisture, decreased sensory perception of pressure, potential for nutritional deficits secondary to chronic disease and incontinence (Initiated: 6/1/18; Revised: 6/4/21). The care plan included the included the interventions: - Barrier cream to Buttocks and peri area (Initiated: 6/9/16; Revised: 8/28/21) - Float heels as tolerated (Initiated and Revised: 8/30/17) - Pressure relieving mattress and pad on bed/chair (initiated and Revised: 10/30/19) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Care plan: Resident has impaired skin integrity to left buttocks . (Initiated: 9/8/21; Revised: 9/13/21). The care plan included the interventions: - Assess and document skin condition, notify MD of signs of infection . (Initiated: 9/8/21) - Assist with bed mobility to turn and reposition routinely (Initiated: 9/8/21) - Wound treatment as ordered (Initiated: 9/8/21) - Notify MD of worsening or not improvement in wound (Initiated: 9/8/21) - Check for incontinence and provide incontinence care as needed. Notify nurse . (Initiated: 9/8/21) Care plan: ADL Self Care deficient related to decreased functional mobility, reduced balance, chronic pain in knees, morbid obesity, osteoarthritis . (Initiated: 7/28/15; Revised: 6/4/21). The care plan included the intervention, Trapeze to bed to increase mobility (Initiated: 7/15/20; Revised: 8/28/21). Note: Resident #27 did not have a trapeze on their bed. Review of Resident #27's progress note documentation in the Electronic Medical Record (EMR) revealed the following related to altered skin integrity and wounds: - 9/7/21 at 9:26 PM: General Progress Note . returned via EMS from (hospital) approx @ 1930 (7:30 PM) post (cardiac procedure) . Post procedure res c/o (complain of) pain to buttocks . drainage noticed from L (left) buttocks. Orders given to keep area clean + dry with frequent brief changes and f/u (follow up) with wound care, per nursing staff. Area assessed upon returned clean and dry, no drainage noted during shift . - 11/26/21 at 1:48 PM: General Progress . Draining cyst observed to resident's right buttocks . - 11/27/21 at 12:25 AM: Skilled Nursing Late Entry . patient resting but awakens easily complaining of discomfort from boil on right buttocks. skin area raised and filled with fluid tender to touch . - 11/27/21 at 9:36 AM: General Progress Note . Alert and oriented to baseline . Remains on oral antibiotics r/t (related to) fluid filled cysts on right buttocks . Small amount of red odorous drainage is observed . - 11/29/21 at 12:30 AM: Skilled Nursing Late Entry . patient awakens easily and is oriented to situation. Boil on right buttocks draining mod (moderate) amount serosanguinous drainage . - 11/30/21 at 11:50 AM: Skilled Nursing . (Resident) took shower this morning on Bactrim (antibiotic) for boils on buttocks moderate drainage from boils . -1/4/22 at 3:07 PM: General Progress Note . Phoned (Physician O) explained resident has been having emesis for two weeks and is requesting to be sent to the hospital. (Physician O) stated wasn't aware of the emesis and agreed that resident should be sent to the hospital to be checked over . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- 1/6/22 at 12:23 AM: General Progress Note Late Entry . Resident returned from (Hospital) no new order . - 1/28/22 at 10:58 PM: General Progress Note . Resident returned from hospital via ambulance, Resident is Covid recovery. Resident present with PICC (Peripherally Inserted Central Catheter- catheter inserted in the body through the arm that extends to the heart and utilized for long term administration of intravenous medications) in (right) upper arm . - 1/31/22 at 12:00 AM: Progress Notes . Visit Type: Acute . Chief Complaint . Follow-up ER visit . seen today in follow-up on ER visit. Unfortunately, records are not available, and I am unsure why (Resident #27) was in the emergency room . Patient does have multiple wounds. (Resident #27) is also noted to have a left buttocks wound . (Authored by Nurse Practitioner (NP) Q) - 2/1/22 at 1:47 PM: Skilled Nursing . Pt (Patient) wound care order was reinstated until wound consult can be done. (Physician O) was called multiple times to obtain orders. Wound cleaned and dressed. (No) acute issues to note at this time will cont. to monitor. - 2/8/22 at 2:00 AM: eINTERACT SBAR Summary . Change in Condition . Skin wound or ulcer . Skin Status Evaluation: Pressure ulcer/injury . Pain Status Evaluation: Does the resident/patient have pain? Yes . Nursing observations, evaluation, and recommendations are changed 4*4 needs a wound consult notified on call . Date and time of clinician notification: 2/7/22 at 2:00 AM . Recommendations: wound consult . Review of Assessment/Evaluation documentation in Resident #27's medical record revealed the following: - 1/28/22 at 11:10 PM: Nursing Admission/Readmission Assessment . Skin Conditions . Site . R (right) heel has opening on it . covered with a dry clean dressing . Coccyx: open red areas coved with a dry clean dressing . Other: R buttocks has open area with tunneling . Review of Historical data within the Nursing Skin Assessment documentation detailed the following: - 10/13/21: Other . Site: (Blank) . - 10/20/21: Other . Site: (Blank) . - 10/22/21: Admission . Site: (Blank) . - 12/21/22 Other . In Progress . Site . Right Buttocks . Description: Fluid filled and draining cysts . - 2/6/22: Other . Site . Left buttocks . Description (Blank) . - 2/8/22: Admission . Site . Left Heel . Description (Blank) . Right Trochanter (hip) . Description (Blank) . - 2/9/22: Admission . Site: (Blank) . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- 2/14/22: Admission . Site: (Blank) . - 2/8/22 at 2:00 AM: eINTERACT Change in Condition Evaluation . Skin Status Evaluation: Pressure ulcer/injury . Describe the pressure ulcer/injury . New onset Grade 2 or higher pressure ulcer/injury, OR progression of pressure ulcer/injury . Document location and details . left heel has an ulcer . Documentation of wound measurements were not present in Resident #27's medical record. Review of Resident #27's Census records revealed the following discharge and readmitted s during the previous year: - discharged : 9/3/21; readmitted : 9/7/21 - discharged [DATE]; readmitted : 1/5/22 - discharged : 1/15/22; readmitted : 1/28/22 - discharged : 2/9/22; readmitted : 2/10/22 Review of Resident #27's Healthcare Provider orders as well as Medication Administration Record (MAR) and Treatment Administration Record (TAR) detailed the following wound care orders/treatments: - Apply Medi honey to coccyx and R heel, apply bordered foam Q (every) evening shift and as needed every evening shift for wound care (Ordered: 2/20/22; Start: 2/21/22) - Resident is in need of wound consult. One time only for wound until 02/10/22 . left heel (Ordered: 2/8/22) - Clean and dry right buttock, pack with iodoform packing strip, cover with gauze and border gauze. Change daily and as needed every day shift for tunneling wound (Start: 12/16/21; Discontinue: 1/5/22; Start: 1/6/22; Discontinue: 2/2/22; Start: 2/3/22). Review of the MAR/TAR for December 2021, January 2022, and February 2022 revealed the following blank documentation on the MAR/TAR (indicating treatment was not completed) on 1/12/22, 1/14/22, 1/15/22, 1/28/22, 2/1/22, 2/12/22, and 2/15/22. The following discontinued orders were also noted: - Cleanse right lateral foot, right 2nd toe, left plantar foot, left great toe, left lateral foot with NS (Normal Saline), pat dry, apply skin prep every night shift . (Start: 1/14/21; Discontinue: 1/28/22) Treatment documentation was blank on 1/4/22 and 1/28/22. - Apply Chamosyn (skin barrier product which nourishes skin, relieves discomfort, and calms discomfort) with honey to coccyx leave OTA (Open to Air) Q (every) shift and as needed (Ordered: 2/18/22; Discontinued: 2/20/22) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	There was no documentation of completion on the MAR/TAR. - Right Buttocks: Cleanse draining cysts with NS, apply TAO (Treatment as Ordered) and cover with dry dressing until resolved every day shift for skin care (Start: 11/28/21; Discontinued: 12/15/21) Treatment documentation was blank on 12/9/21. Review of facility provided list of Residents with pressure ulcers detailed the following for Resident #27, 1/28/22 Right buttock on admission has reported wound. Order in place but not classified as wound type 'Tunneling'. Note: Resident #27 was readmitted to the facility on [DATE] and the treatment was in place prior to their discharge to the hospital. Upon request for healthcare provided documentation of Resident #27's pressure ulcers, the facility provided the following: - Note authored by NP Q on 1/31/22 identified and reviewed previously. - Note dated 1/14/21 and authored by NP S. The note dated 1/14/21 detailed, Wound care consulted for the evaluation and treatment of multiple wounds . Physical Exam . Right lateral foot had an intact corn/callus which was easily removed . no drainage and area is completely closed . Right second toe callus is completely closed and without drainage . Left plantar callus is complete closed and without drainage . Left lateral foot callus is completed closed and without drainage . Left hallux resembles and old DTI (Deep Tissue Injury - pressure ulcer with unknown depth). This wound measures 1.3 (centimeters-cm) X 1.7 (cm) X 0 cm . completely closed and without drainage . appears to have purple center under thick callused skin . Diagnosis . Pressure ulcer of left foot, unstageable . Plan: Issues will not be followed by wound care team but recommend consultation to podiatry . Resident #77: An observation of Resident #77 occurred on 2/14/22 at 3:34 PM in their room. The Resident laying in bed, uncovered and a fitted sheet was not observed on the bed under them. An alternating air mattress was present on the bed. The settings on the alternating air mattress were firm. An interview was completed at this time. When queried regarding their bedding, Resident #77 revealed the fitted sheet was bunched up under them and stated, It pulled off the corners. Resident #77 continued, They (staff) put the wrong size sheet on it. When asked, Resident #77, I don't like it but they ain't gonna do nothing about it. When asked if they had any wounds, Resident #77 indicated their buttocks was sore, but they did not think it was an open wound. When queried regarding the mattress settings, Resident #77 revealed staff did not check the mattress. Record review revealed Resident #77 was admitted to the facility on [DATE] with diagnoses which included left sided hemiplegia and hemiparalysis (one sided paralysis) following cerebral infarction (stroke), depression, seizures, and tremors. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to limited assistance to perform all ADLs with the exception of eating. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #77's care plans revealed a care plan entitled, At risk for alteration in skin integrity related to CVA (Cerebral Vascular Accident - stroke) with left sided weakness, impaired mobility . (Initiated: 5/14/21; Revised: 7/7/21). The care plan included the intervention, Pressure relieving mattress and pad on bed/chair (Initiated: 7/11/19; Revised, 5/18/21). Review of Resident #77's MAR and TAR for February 2022 included the task, Body audit on Wednesday & Saturday Evening Shift every evening shift every Wed (Start Date: 7/14/21). The task was documented as administered on 2/2/22 and 2/9/22. There was no corresponding documentation in the assessment/evaluation and/or progress note sections of the Resident's medical record related to skin assessment. Task documentation within Resident #77's EMR included the task, Bed - Pressure Relieving mattress to bed with the question, Was the pressure reducing device placed on the bed while the resident was in it? For February 2022, No was documented on 2/2/22, 2/4/22, 2/5/22, 2/6/22, 2/13/22, 2/14/22, 2/15/22, 2/16/22, and 2/18/22. Resident #82: On 2/15/22 at 7:51 AM, Resident #82 was observed in their room. The Resident's touch call light was on the floor behind the head of the bed. The Resident was positioned on their back in bed, wearing a hospital style gown and CNA J standing on the left side of the Resident's bed obtaining vital sign measurements. Resident #82 did not respond, verbally or non-verbally, when spoke to. Resident #82's eyes were coated with a white colored, viscous appearing substance. A dark rusty brown colored dried substance with the appearance of dried blood was present on the Resident's lips. The Resident's mouth was open, and their tongue and mucous membranes were visibly dry. The Residents bedding and hospital gown were visibly soiled with unknown substances. When asked the Resident's name for confirmation, due to the name plate outside of the door being blank, CNA J stated, I am actually from agency (staffing company) and revealed they did not know the Resident's name. When queried, CNA J revealed they had worked at the facility previously as an agency CNA and had cared for Resident #82 before. CNA J was asked if Resident #82 had any pressure ulcers and stated, On their left hip and butt. With further inquiry, CNA J revealed they changed it last week when were assigned to care for Resident #82. When queried how they knew what care the Resident required when they did not even know their name, CNA J did not provide an explanation. At this time, NP Q entered the Resident's room. When queried regarding Resident #82's non-responsiveness and wounds, NP Q revealed the Resident was more lethargic than when they had previously seen them. NP Q reviewed Resident #82's medical record and confirmed the Resident had multiple pressure ulcers. When asked if they were assessing the pressure ulcers today, NP Q revealed they were not. An alternating air mattress was present on Resident #82's bed. The mattress controller was set at Static (non-alternating air) and Firm 350 lbs. (pounds). The Alarm Reset light was also on. A container of Medihoney (wound care treatment) was present on the dresser next to the Resident's bed. Record review revealed Resident #82 was originally admitted to the facility on [DATE] with diagnoses which included dementia, dysphagia (difficulty swallowing) gastrostomy (surgically created through the abdomen into the stomach for nutritional support), and pain. Review of MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required two-person extensive to total assistance to perform ADLs. The MDS further revealed the Resident was at risk for pressure ulcer development and had one stage 4 pressure ulcer that was present upon admission/reentry. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #82's care plans revealed a care plan entitled, Resident has impaired skin integrity Sacrum Pressure Ulcer (Initiated: 6/23/21; Revised: 9/23/21). The care plan included the interventions: - Assess and document skin condition, notify MD of signs of infection (redness, drainage, pain, fever) (Initiated: 9/23/21) - Assess for pain and treat as indicated (Initiated: 9/23/21) - Assist with bed mobility to turn and reposition routinely (Initiated: 9/23/21) - Check for incontinence and provide incontinent care as needed. Notify nurse of any redness or irritation (Initiated: 9/23/21) - Notify MD of worsening or not improvement in wound (Initiated: 9/23/21) - Pressure reducing/redistributing mattress on bed (Initiated and Revised: 9/23/21) - Wound Location: Sacrum (Initiated and Revised: 9/23/21) - Wound treatment as ordered (Initiated and Revised: 9/23/21) Resident #82 had another care plan titled, At risk for alteration in skin integrity related to generalized weakness, impaired mobility, physical limitations .dementia . (Initiated: 5/14/21; Revised: 8/2/21). The care plan included the interventions: - Barrier cream to peri area/buttocks q (every) shift (Initiated: 4/29/21; Revised: 6/24/21) - Diet and supplements per physician order (Initiated: 4/29/21; Revised: 6/24/21) - Elevate heels as able (Initiated: 4/29/21; Revised: 6/24/21) - Encourage fluids (Initiated: 4/29/21; Revised: 6/24/21) - Encourage to reposition as needed; use assistive devices as needed (Initiated: 4/29/21; Revised: 6/24/21) - Heels up while in bed (Initiated: 7/7/21; Revised: 8/28/21) - Observe skin condition with ADL care daily; report abnormalities (Initiated: 4/29/21; Revised: 6/24/21) - Obtain Labs as ordered and report results to physician (Initiated: 4/29/21) - Pressure redistributing device on bed: APM (Alternating Pressure Mattress) (Initiated: 4/29/21; Revised: 5/14/21) - Use pillows/positioning devices as needed (Initiated: 4/29/21; Revised: 6/24/21) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A third care plan entitled, Resident has Stage IV pressure ulcer to sacrum, present upon admission (Initiated and Revised: 4/30/21). The care plan included the following interventions: - Administer analgesics as needed (Initiated: 4/30/21) - Daily body audit (Initiated: 4/30/21) - Dietary consult (Initiated: 4/30/21) - Friction reducing transfer surface (Initiated: 4/30/21) - Incontinence management (Initiated: 4/30/21) - Pain evaluation prior to treatment (Initiated: 4/30/21) - Pressure redistributing support surface (Initiated: 4/30/21) - Repositioning during ADLs (Initiated: 4/30/21) On 2/16/22 at 9:03 AM, observation of ADL care for Resident #82 was completed with CNA X and CNA Y. Prior to beginning care, the Resident was noted to be in bed, positioned on their back. The alternating air mattress remained set at Static (non-alternating air) and Firm 350 lbs. (pounds) with the Alarm Reset light on. When CNA X and CNA Y uncovered the Resident and unfastened their brief, an uncovered, open wound was observed on the Resident's right hip. The area was directly over the bony prominence and approximately 2 inches by 2 inches in size. On Resident #82's back, along the bottom of prominently notable scapula (shoulder blade) near the spine, two dark purple/maroon colored, non-blanchable pressure areas were noted. The proximal wound was approximately the size of a nickel and the distal was slightly larger than a half dollar. During repositioning, Resident #82 began moaning and displaying non-verbal signs and symptoms of pain including wincing and facial grimacing. The staff proceeded to position the Resident on their right side to remove their brief and restore hygiene as Resident #82 had a bowel movement. When the Resident was turned on their side, a large, gaping pressure ulcer was observed on the Resident's sacrum. A second, large open pressure ulcer was present on the left buttocks/hip area. There were no dressings in place over either wound. A foul sour putrid odor immediately permeated the air when the pressure ulcers were exposed. The brief was saturated with thick yellow and red colored wound drainage. When queried regarding the drainage, CNA X stated, It's like pus. When asked, the staff indicated the wounds were supposed to be covered with a dressing and CNA Y notified the nurse. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	While waiting for the nurse, CNA X and CNA Y restored Resident #82's hygiene and observation of the pressure ulcers occurred. The left buttocks/hip pressure ulcer was open with tissue loss and active drainage. The wound bed was approximately 3 inches by 1 inch in size. The sacrum pressure ulcer had significant depth and was approximately the size of a softball in diameter. The wound edges were black with necrotic tissue present and the base was pink and white in color with an area of black, necrotic tissue noted at the 5 o'clock position. Observation of Resident #82's skin revealed a raised, fluid filled blister was observed on the medial aspect of the right foot. The area was irregularly shaped with a distinct, dark colored border and appeared to be approximately the size of a quarter. A second fluid filled blister was present along the medial aspect of the right great toe. At this time LPN Z entered the room with supplies to complete wound care and obtain wound measurements. LPN Z did not perform hand hygiene prior to beginning wound care. LPN Z rinsed Resident #82's sacral pressure ulcer with normal saline and wiped with gauze. LPN Z obtained wound measurement at this time at stated, It's 11 (centimeters- cm) by 5.5 (cm) x 2.4 (cm) deep. LPN Z did not perform hand hygiene and/or doff their gloves. LPN Z then proceeded to pack the wound bed with 4 X 4 gauze saturated in normal saline, cover the wound bed with a Maxord Ag dressing (wound dressing), and cover with an ABD pad. During the dressing application, Resident #82 was moaning and wincing. No treatment/dressing was completed on the open right buttocks/hip wound. LPN Z proceeded to place bordered gauze over the pressure injuries on the Resident's back. When asked about the areas, LPN Z indicated the areas were DTI pressure ulcers. Observation of Resident #82's skin on their lower extremities was completed at this time. A large wound approximately 5 inches long by 3 inches wide was present on Resident #82's right lateral malleolus (ankle). The wound did not have a dressing in place. The wound encompassed the entire lateral malleolus and extended above the ankle bone. The pressure ulcer contained two distinct open areas with visible, significant depth. The proximal end of the wound bed was black in color with white/yellow colored tissue at the distal end of the black tissue which progressed to the proximal open area. The base of the proximal open wound, directly over the ankle bone, was white and black in color with distinct necrotic tissue in the center and along the nine to eleven o'clock position. The tissue surrounding the wound was dark in color with irregular borders. When queried regarding the areas, CNA X and CNA Y indicated the pressure ulcer looked better than it did. With further inquiry, CNA X stated, I came in two weeks ago and the cath (indwelling urinary catheter to drain urine from the bladder) tubing was imbedded into (Resident #82's) ankle. CNA X stated, It was sore with pus. CNA Y revealed there had been an odor when the urinary catheter tubing was pulled out of the wound bed on Resident #82's ankle. LPN Z did not wash their hands but did don new gloves to apply a dressing to Resident #82's right lateral ankle. LPN Z did not cleanse the pressure ulcers prior to treatment. LPN Z applied Santyl (debriding wound treatment) to both open areas using the same Q-tip. LPN Z then applied an ABD pad and wrapped the Resident's ankle with Kerlix gauze dressing. Resident #82's toenails were noted to be untrimmed and thickened with jagged edges. The toenail on the fifth phalange (small toe) was digging into the Resident's skin. Upon request, LPN Z separated Resident #82's toenails. A foul odor was immediately noted which increased in intensity closer to the Resident's toes. An unknown black colored substance was present in-between each of the Resident's toes. When asked what the black was, LPN Z used a Q-tip between the toes and removed a large amount of an unknown malodorous black colored substance from between the Resident's toes. When asked what the substance was, LPN Z stated, Filth. A dark maroon/purple colored area was present on fifth phalange between the fourth and fifth phalanges. When asked, LPN Z revealed the area was an unstageable pressure ulcer. A dime sized open wound was observed on Resident #82's left lateral malleolus. The wound was open and approximately the size of a dime. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	When queried regarding Resident #82's signs and symptoms of pain during treatment and pain management, LPN Z revealed they were not aware CNA staff were going to be completing care to premedicate for pain and directed the CNA staff to notify them prior to completing care. With further inquiry, LPN Z revealed the Resident had not had anything available for pain until recently when they got it ordered. When asked why there were no dressings in place over the wounds, LPN Z was unable to provide an explanation. When asked how long the wounds had not had a dressing in place, the staff were unable to provide a response. CNA X and CNA Y did reveal this was the first time they had been in to provide care to the Resident during their shift. Resident #82 was repositioned on their back following treatment. When queried why the Resident was positioned on their back again, CNA X and CNA Y revealed the Resident did not have any positioning devices in their room. LPN Z confirmed and revealed they had attempted to obtained wedge positioning devices for the Resident previously but were informed none were available. No additional pillows for positioning were present in the Resident's room. When queried who checks and monitors the settings on alternating air mattresses in the facility, both CNAs revealed they don't check. LPN Z indicated they only make sure the bed is inflated. The settings on Resident #82's bed were reviewed with the staff at this time. When queried if Resident #82 weighed 350 lbs., all three staff revealed the Resident did not. When asked if the bed was supposed to be set at static, LPN Z stated, It (air mattress) ain't right. CNA X and CNA Y were unaware of the air mattress being able to be set to static for surface stability during care. CNA X then stated, It (mattress) was the same two weeks ago and indicated the air within the mattress did not move (alternating) when they had provided care to the Resident and CNA Y corroborated. When queried the air mattress was providing appropriate pressure reduction and redistribution to prevent and reduce pressure for Resident #82 at the current settings, LPN Z stated, No. LPN Z adjusted the air mattress settings at this time by clearing the alarm, deactivating the static setting, and decreasing the weight setting to 175 lbs. When queried why there was a container of medihoney in the Resident's room if they are not receiving it as a treatment, LPN Z stated, I don't know. When queried regarding hand hygiene during wound care and separation of treatment of open wound beds during wound care as it relates to infection control and cross contamination of wounds, LPN Z revealed that had not considered that. Review of Resident #82's EMR revealed the Resident weighed 147 lbs. on 1/6/22. Review of task documentation in Resident #82's EMR revealed the task, Bed - Pressure Relieving mattress to [TRUNCATED]

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 This Citation pertains to Intake Number MI00126206. Based on observation, interview, and record review the facility failed to assess and monitor four resident's (Resident #5, Resident #41, Resident #46 and Resident #87) foot health resulting in the four residents having long, thick and/or jagged toenails, dry skin, shedding in large pieces on their bedding and complaints/frustrations regarding the facility not addressing their toenail and consulting podiatry timely. Findings include: Resident #41: On 2/14/22, during initial tour Resident #41 was observed resting in bed, he did not appear to be in any distress and was in good spirits. Resident #41's feet were observed to dry, cracked and skin particles were shedding onto his sheets. The resident's toenails were long and thick. He reported he did not know the last time his toes had been trimmed. On 2/16/22 at 8:46 AM, a review was completed of Resident #41's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included Anxiety Disorder, Diabetes Major Depressive Disorder and Kidney Disease. Further review was completed of Resident #41's medical records and there was nothing located in his care plan, tasks list or progress notes regarding a Podiatry consult or trimming of his toenails. Resident #46: On 2/14/22 at 4:21 PM, Resident #46 was observed in her room eating Cheez-It's. She reported she has been at the facility for a few months and is working toward going home. Resident #46 stated since she was admitted at the facility her toes have not assessed or trimmed. On 2/14/22 at approximately 4:30 PM, a review was completed of Resident #46's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included Diabetes, Major Depression Disorder, Bipolar Disorder and Schizophrenia. Further review was completed of Resident #46's record and there was nothing located in her care plan, tasks list or progress notes regarding a Podiatry consult or trimming of his toenails. On 02/16/22 at 12:34 PM. Resident #46 was observed in her room resting and permission was granted from the resident to observe her toes. Nurse G pulled the covers from atop her feet. Resident #46's toenails on both feet were long and she reported since her admission to the facility her toenails have not been trimmed to an appropriate length. Nurse G agreed her toes were long and stated she would add her to the list for podiatry. Resident #5: (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/22 at 1:52 PM, Resident #5 was observed lying in bed. This writer observed Resident #5's bilateral feet to edematous and her toes were long and jagged. The resident reported she cannot remember the last time her toes were clipped. On 2/14/22 at 2:00 PM, a review was completed of Resident #5's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Peripheral Vascular Disease, Chronic Pain, Polyneuropathy and Gastro-Esophageal Reflux Disease. Resident #5 is cognitively intact and able to make her needs known. Further review was completed of Resident #5's record and there was no documentation there was nothing located in her care plan, tasks list or progress notes regarding a Podiatry consult or trimming of his toenails. Resident # 87: On 2/14/22 at 12:25 PM, Resident #87 was observed in her room and when asked general questions she reported her toes have not been cut in 7 months. The resident stated she is not diabetic and is confused as to why facility staff have not addressed this. Resident #87's feet were observed to be dry with large pieces of dangling skin on her feet and her toenails were extremely long. On 2/14/22 at 12:35 PM, a review was completed of Resident #87's medical records and the resident was admitted to the facility on [DATE] with diagnoses that included: Atrial Fibrillation, Dysphagia, Polyneuropathy and Congestive Health Failure. Resident #87 is cognitively intact and able to make her needs known. There was nothing located in her care plan, tasks list or progress notes regarding a Podiatry consult or trimming of his toenails. On 2/17/22 at 10:30 AM, an interview was conducted with Social Worker C regarding the process for podiatry consults. Social Worker C explained Podiatry comes in every three months and they were recently at the facility. Social Worker C stated they were scheduled to come out two weeks ago but to due to their COVID outbreak they had to cancel. The Social Worker added that nursing staff will let her know when a resident needs to be placed on the list. She added she does ensure all long-term care residents are on the list to be assessed by podiatry. On 2/17/22 at 1:52 PM, this writer received an email from the Administrator that stated, (Resident #46) is not on the list (podiatry) but will be as of today (Resident #41) is on the list (Resident #5) is on the list . (Resident #87) will be added on the list as of today . Review was completed of a Podiatry list provided by the facility. The list indicated residents that were eligible to be seen upon Podiatry's next visit on 11/2/21 at 9:00 AM. Residents #41 and #5 were listed but it did not indicate when the last time they were seen by Podiatry. On 2/22/22 at 12:10 PM, an interview was conducted with Social Worker C regarding Podiatry consults. Social Worker C reported the last time Podiatry was in the building was on 10/2/21 and they did not come on 11/2/2021. On 3/1/22 at 9:00 AM, a review was completed of the facility policy entitled, Foot Care. The policy stated, Resident will receive appropriate care and treatment in order to maintain mobility and foot health. Resident will be provided with foot care and treatment in accordance with professional standards of practice .Trained staff may provide routine foot care .Resident with food disorders or medical conditions associated with foot complications will be referred to qualified professionals.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 37668 Based on observation, interview, and record review, the facility failed to develop, implement, and operationalize a facility restorative nursing program and failed to maintain accurate and ongoing records and documentation of residents with limitations in Range of Motion (ROM) and contractures (permanent tightening of muscles, tendons, skin, and tissues causing stiff and immobile joints) for three residents (Resident #27, Resident #77, Resident #82) of three residents reviewed and all 97 facility residents resulting in a lack of assessment, a lack of accurate records and accounting of residents with limitations in ROM and contractures, a lack of the provision of ROM activities, and a lack of Restorative Nursing Services to prevent functional decline, diminished mobility, functional decline, and unnecessary pain. Findings include: Review of facility provided CMS-672 form revealed there were 36 residents in the facility with contractures. The form further detailed 14 of the 36 residents had contractures upon admission indicating 22 residents developed contractures at the facility. A list of Residents with contractures was requested from the facility Administrator on 2/16/22 at 8:21 AM. The Administrator was asked to indicate on the list which Residents had facility acquired and/or worsened contractures. An interview was conducted with the facility Administrator and [NAME] President (VP) of Operations CC on 2/16/22 at 11:57 AM. The Administrator was asked the name of the facility Restorative Nurse and stated, We don't have one. With further inquiry, both the Administrator and VP CC revealed they did not have a restorative program. VP CC then stated, No one has one. When asked what they meant, VP CC revealed no skilled nursing facilities have a restorative program and/or nurse at this time. The Administrator requested an interview for clarification be completed with Corporate Consultant Registered Nurse (RN) DD. On 2/16/22 at 12:03 PM an interview was completed with RN DD. When queried regarding restorative nursing services and program in the facility, RN DD stated, When we do daily care, we incorporate restorative with that. RN DD was then asked where tasks including ROM and splint/brace application is documented and replied, The CNAs document. A list of Residents was received from the Administrator on 2/16/22 at 3:27 PM. The list included 35 Residents but did not distinguish which Residents had facility acquired and/or worsened contractures. The list included Resident #27, Resident #77, and Resident #82. Resident #27: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/15/22 at 9:27 AM, Resident #27 was observed in their room in bed. The Resident was wearing a hospital style gown and positioned on their back with their heels positioned directly on the mattress. An interview was conducted at this time. When queried if they had any limitations in ROM, Resident #27 revealed they did but were unable to provide additional information regarding the location and/or severity of the limitation. When asked if they were receiving therapy and/or restorative nursing services, Resident #27 stated, No, not doing anything. Record review revealed Resident #27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia, diabetes mellitus, kidney disease, and heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive two-person assistance for bed mobility, transferring, dressing, toileting, and personal hygiene. The MDS further indicated the Resident had impaired ROM in both lower extremities. Review of Resident #27's Electronic Medical Record (EMR) Task documentation revealed there was no task and no documentation of ROM activities. Review of Resident #27's care plans revealed a care plan entitled, ADL Self care deficit related to decreased functional mobility . (Initiated: 7/28/15; Reviewed: 6/4/21). The care plan included the interventions: - 1-person assist with showers, extensive assist with bed mobility and incontinence care (Initiated: 7/20/17; Revised 8/28/21) - Active range of motion to both arms and legs during ADLs (Initiated: 11/17/15; Revised 8/28/21) - Mechanical lift with transfers (Initiated: 1/16/20; Revised: 2/15/22) - Trapeze to bed to increase mobility (Initiated: 2/18/18; Revised: 8/28/21) Note: Resident #27 did not have a trapeze on their bed. Review of Resident #77's Kardex (Certified Nursing Assistant [CNA] care guide) did not include any information related to the provision of ROM activities. Review of Resident #77's Electronic Medical Record (EMR) Task documentation revealed there was no task and no documentation of ROM. Physical Therapy evaluation documentation was not present in Resident #27's EMR. Resident #77: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/22 at 3:34 PM, an observation occurred of Resident #77 in their room. A lower extremity brace in a left shoe was sitting on the wheelchair seat directly next to the bed. A urinal, half full of dark amber urine, was sitting on the Resident's overbed table, directly next to an uncovered electric toothbrush, a beverage cup, and a container of nuts. An interview was completed at this time. When queried regarding the brace, Resident #77 revealed they had a stroke and had to wear the brace when they got out of bed. When asked, Resident #77 revealed they needed the brace due to having foot drop (ankle contracture in which the front aspect of the foot is unable to be lifted). While speaking to Resident #77, their left hand was spasming and visibly shaking. The fourth digit (finger) on their left hand was observed to be in the shape of a C and remained stationary in the C shape while the hand was shaking. Resident #77 was asked about the shaking in their hand and replied, My left and right shake whenever not resting. Resident #77 indicated they were hypersensitive since the stroke. When asked if they were able to move their fourth finger on their left hand, Resident #77 revealed they were unable to straighten their finger. When queried if they were receiving therapy or Restorative nursing services, Resident #77 disclosed they were not. With further inquiry regarding application of their foot brace and level of assistance required to get out of bed and/or ambulate, Resident #77 indicated they put the brace on by themselves and stated, I get up alone and specified they utilized the wheelchair for mobility. Resident #77 was asked if they had any other braces or devices and revealed they did not. When queried if they had any issues with applying the brace and transferring independently including falls, Resident #77 replied, Yes, I actually fell last week. Resident #77 continued, I really had to go (bowel movement) and revealed they fell after going to the bathroom when they were going back to their bed and had to wait for staff assistance. Resident #77 stated, I've ended up on the floor three times. When asked, Resident #77 revealed one of the falls was related to incorrect application and fastening of their left lower extremity brace. Resident #77 was asked why they did not ask for assistance with the brace and revealed they could not wait to go to the bathroom the amount of time it takes for staff to respond. Resident #77 stated, The amount of people who have quit is just mind blowing. I had two first shift nurses who I really liked who quit. We used to have two nurses per floor, and they cut it down to one. You just can't take care of people like that. Resident #77 stated, The thing I hate the most is that they (staff) don't see us as people, they see us as a bed. Record review revealed Resident #77 was admitted to the facility on [DATE] with diagnoses which included left sided hemiplegia and hemiparalysis (one sided paralysis) following cerebral infarction (stroke), depression, seizures, and tremors. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to limited assistance to perform all ADLs with the exception of eating. The MDS further revealed the Resident had impaired Range of Motion (ROM) in one upper extremity and one lower extremity. Review of Resident #77's care plans revealed a care plan entitled, ADL Self care deficit as evidenced by weakness/CVA (Cerebral Vascular Accident - stroke). Pt (Patient) has tremors to left upper extremity . (Initiated: 7/1/19; Revised: 7/7/21). The care plan included the interventions: - Left AFO (brace) on when out of bed with a shoe (Initiated: 7/25/19; Revised: 8/28/21) - Active range of motion to right arm and passive range of motion to left arm during ADL care . Active assisted range of motion to both legs during ADL care (Initiated: 9/18/19; Revised: 8/28/21) (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Keep left arm on pillow elevated when not using it (Initiated: 9/18/19; Revised: 8/28/21) - Left hand edema glove on during the day (Initiated: 9/10/19; Revised: 8/28/21) - One person assist with transfers and ambulation with left AFO and hemi walker (Initiated: 7/2/19; Revised: 8/28/21) Another care plan titled, At risks for falls due to CVA with left sided weakness, history of fall . (Initiated: 7/1/19; Revised: 7/7/21) was present in Resident #77's medical record. The care plan included the interventions: - Provide assist to transfer via lift (Initiated and Revised: 7/11/19) - Encourage resident to make sure AFO is locked correctly before transfers (Initiated 5/3/21; Revised: 8/28/21) - Reinforce need to call for assistance (Initiated: 7/1/19) - Reinforce w/c (wheelchair) safety as needed such as locking brakes (Initiated: 7/11/19) Review of Resident #77's Kardex (Certified Nursing Assistant [CNA] care guide) did not include any information related to the provision of ROM, AFO brace application/use, edema glove brace/use, and/or level of assistance required for transferring and/or ADL care. Review of Resident #77's Electronic Medical Record (EMR) Task documentation revealed there was no task and no documentation of AFO brace application, edema glove, and/or passive/active ROM. Review of Resident #77's progress note documentation in the EMR did not include any documentation related to completion of ROM activities. The most recent note which addressed the Resident's AFO brace was dated 5/3/21. Physical Therapy evaluation documentation was not noted in Resident #77's EMR. Resident #82: On 2/15/22 at 7:51 AM, Resident #82 was observed in their room. The Resident's touch call light was on the floor behind the head of the bed. The Resident was positioned on their back in bed, wearing a hospital style gown and CNA J standing on the left side of the Resident's bed obtaining vital sign measurements. Resident #82 did not respond, verbally or non-verbally, when spoke to. The Residents bedding and hospital gown were visibly soiled with unknown substances. The Resident's legs were bent at the knees. CNA J was queried regarding Resident #82 not responding and indicated the Resident was completely dependent upon staff for care. When queried if the Resident had any contractures and/or limitations in ROM, CNA J revealed both of the Resident's legs were contracted. When queried if the Resident was receiving any therapy or restorative for their contractures, such as ROM and/or braces, CNA J revealed they were not aware of any. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 9:03 AM on 2/16/22, an observation of ADL care for Resident #82 was completed with CNA X, CNA Y, and Licensed Practical Nurse (LPN) Z. At the beginning of care, Resident #82 was observed in their bed, positioned on their back with their hips bent and knees at approximately a 45-degree angle. The Resident's toes were pointed down, away from their head. When queried regarding the positioning of the Resident's feet and ROM, LPN Z attempted to complete ROM. The Resident's foot was unable to be returned to a neutral position and they were observed wincing in pain. When queried, LPN Z revealed the Resident had foot drop. When asked about Resident #82's ROM in their hips and knees, both CNA X and Y revealed the Resident had contractures in their legs. Resident #82's lower extremities remained in the same position without changes in flexion or extension throughout care. Record review revealed Resident #82 was originally admitted to the facility on [DATE] with diagnoses which included dementia, dysphagia (difficulty swallowing) gastrostomy (surgically created through the abdomen into the stomach for nutritional support), and pain. Review of MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required two-person extensive to total assistance to perform ADLs. The MDS further revealed the Resident had ROM impairment in both lower extremities. Review of Resident #82's care plans revealed a care plan entitled, At risk for complications due to musculoskeletal problems . Bilateral lower extremity contractures (Initiated: 4/29/21; Revised: 2/16/22). The care plan included the interventions - ROM to BLE (Bilateral Lower Extremities) (Initiated: 7/23/21; Revised: 8/28/21) - Assist with bed mobility (Initiated: 4/29/21) Another care plan titled, ADL Self-care deficit related to generalized weakness, impaired mobility, physical limitations . (Initiated and Revised: 4/29/21) was active in Resident #82's medical record. The care plan included the interventions: - Passive/active assisted range of motion to both arms/legs during ADL care (Initiated: 5/14/21; Revised: 8/28/21) - Bilateral knee braces on while in bed as the patient tolerates at night- inspect the skin for redness (Initiated: 8/2/21; Revised: 8/28/21) Resident #82 had a third active care plan entitled, Alteration in musculoskeletal status . (Initiated: 4/29/21; Revised: 6/24/21). The care plan included the goal, The resident's mobility will be improved/restored by use of (specify; prosthesis, use of adaptive equipment such as crutches, cane, walker or wheelchair) with (Specify assistance required) (Revised: 2/1/22; Target: 5/2/22) and one active intervention, Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness (Initiated: 4/29/21; Revised: 6/24/21). Review of Resident #82's Kardex revealed, Special Instructions . Restorative Nursing . Active Range of Motion BID (twice a day) . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Task documentation in Resident #82's EMR revealed a task entitled, Restorative Nursing - Active Range of Motion BID. Review of the previous 30 days revealed no documentation of task completion. On 2/17/22 at 10:38 AM, the Administrator was asked if they knew which Residents on the list had facility acquired and/or worsening pressure ulcers and replied, No, I don't. The Administrator was asked to obtain the information and/or provide a staff member who would be able to provide the information at this time. Physical Therapy evaluation documentation was not present in Resident #82's EMR. At 3:42 PM on 2/17/22, the Administrator provided a list of facility residents with contractures. The list included the following 23 residents and details: - (Resident #56) . CVA right hand contracture - (Resident #46) . Bilateral legs ROM deficit coded Admit 12/18/21 . - (Resident #89) . CVA effecting left side . - (Resident #41) . CVA effecting left side . - (Resident #88) . Contracture hand trigger finger left CVA . - (Unsampled Resident #2) . ROM one sided lower extremity impairment . - (Resident #7) . Admit 3/12/21 ROM impairment lower extremity one side . - (Unsampled Resident #4) . Left hemiplegia - (Resident #52) . CVA left sided - (Resident #27) . ROM bilateral lower extremities coded . - (Resident #68) . CVA right sided hemi (paralysis) . - (Unsampled Resident #5) . Left hemiplegia - (Resident #82) . This resident is on the contracture list . - (Resident #77) . CVA - (Resident #71) . CVA - (Unsampled Resident #3) . CVA - (Resident #2) . CVA Left (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- (Resident #45) . CVA right - (Unsampled Resident #6) . CVA left sided - (Unsampled Resident #7) . CVA left sided - (Unsampled Resident #8) . CVA right sided - (Unsampled Resident #9) CVA right - (Unsampled Resident #10) . CVA An interview was completed with CNA Y on 2/16/22 at 12:13 PM. When queried regarding completion and documentation of ROM activities and splint brace application as it pertains to a restorative nursing program, CNA Y stated, Never told to do ROM. When asked if they provided ROM activities to any of the facility residents, CNA Y revealed they did not. On 2/16/22 at 12:23 PM, an interview was completed with CNA X. When asked if they completed ROM for Resident's they were assigned to care for, CNA X replied, No. With further inquiry, CNA X revealed they were never taught ROM at the facility. An interview was completed with CNA EE on 2/16/22 at 1:29 PM. When queried if they completed ROM and/or restorative activities with facility Residents, CNA EE replied, No, we don't do that. An interview and review of provided information of residents with contractures was conducted with the facility Administrator on 2/22/22 at 11:15 AM. The Administrator was queried regarding the discrepancies in the number of residents with contractures. After review, the Administrator stated, I'm not sure why the contracture doc is different numbers. The Administrator was asked why the facility documentation provided did not include the requested information of which residents had facility acquired and/or worsened contractures. The Administrator did not provide an explanation but stated, I will have the MDS Regional nurse contact you. When asked, the Administrator revealed the facility did not have an MDS nurse at the facility. On 2/22/22 at 12:53 PM, an interview was completed with Regional MDS Nurse AA. MDS Nurse AA was asked how many residents within the facility have contractures and replied, The MDS looks at deformities, disuse or pain causing limitations in ROM. When queried if regarding the discrepancies in the number of residents with contractures on the lists provided and the number on the CMS-672 form, MDS Nurse AA revealed the number provided on the CMS-672 form is pulled from the MDS data but was unable to provide an explanation related to the discrepancies. When asked how resident ROM and/or contractures are assessed, evaluated, and monitored, MDS Nurse AA replied, Definitely need to know if it is a true contracture. When queried how the facility ensured residents maintained their current level of functioning and mobility when they are maintaining and completing accurate records of current function level, MDS Nurse AA stated, We have therapy that does their screening. When queried regarding a Restorative Nursing Program in the facility, MDS Nurse AA stated, I haven't seen any restorative myself. MDS Nurse AA was then queried regarding completion and documentation of ROM activities and splint/brace application and replied, I definitely see where there is room for improvement with that. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted with Therapy Director BB on 2/22/22 at 2:36 PM. When queried regarding residents with contractures in the facility, Director BB stated, The problem is that when the company got sold, we can't access all of our assessments when we were with the other company. When asked what residents, which they were aware of had contractures, Director BB replied, 10 people. Director BB was asked who the Residents were and stated, (Resident #89), (Resident #68), (Resident # 56), (Resident #8), (Resident #88), (Resident #7), and (Resident #52). Therapy Director BB was then asked about Resident #82's ROM in their BLE and stated, I would say they have limited range (ROM). Therapy Director BB continued, They have bilat knee braces. When asked why the braces were not observed in the Resident's room and why staff had stated they were not aware of the Resident having braces, Director BB did not provide an explanation. When asked why Resident #82's care plan detailed that Resident #82 had BLE contractures, staff statements, and observations, Director BB did not respond. Director BB was then queried how CNA staff know how to appropriately apply splints/braces and replied, They are trained in their course. When queried if they were implying that CNA staff were competent to apply medical brace/splint application based upon the unknown training to obtain certification, Director BB did not provide further explanation. Director BB was then asked about Restorative Nursing program/services in the facility and indicated CNA staff are responsible to complete ROM activities. When asked how CNA staff know what joints to complete ROM activities, the degree of stretch/motion, and the number of repetitions to perform in order to prevent decline in ROM, Director BB replied, They are taught in their class. When asked if they were aware of the length of the training course to become a CNA, Director BB indicated they were. When queried how they expected a CNA who received approximately two weeks of training to be competency in ROM and brace/splint application, Director BB did not reply. Director BB then stated, We did training for (Resident #82's) splints in August. When queried if the agency CNAs were trained to apply the splints, Director BB stated, I do not train the agency staff. When asked how the facility determined competency when the staff were not trained, Director BB did not provide an explanation. When queried regarding therapy involvement in implementation of restorative care plans, Director BB stated, We have never done it. Director BB was then asked about Resident #77's ROM including their Left Lower Extremity (LLE) AFO brace and their left fourth digit and replied that Resident #77 was not contracted but limited. When asked if the Resident's limitation had worsened and how they monitored limitations, Director BB indicated Residents are screened by therapy staff. When queried if Therapy measures the degree of flexion and extension in Resident joints, Director BB stated, No, we usually don't. When asked how they determined worsening in ROM if not measuring, Director BB revealed therapy staff only document if ROM is Within Normal Limits (WNL) or impaired. Director BB was then asked how many residents had limitations in ROM and replied, I doubt anyone has full ROM. With further inquiry, Director BB stated, No (Residents) had had to change their device, that is what I would consider when looking for decreases in ROM. When queried any Residents had developed new limitations in ROM, Director BB revealed one resident who is at the hospital and not currently in the facility is the only one. Director BB stated, They are getting tighter, and we had to order braces, but they aren't contracted so we don't count them. Director BB then stated, (Resident #7) also has one finger that is getting tighter. All available therapy evaluation documentation was requested for Resident #27, 77, and 82 at this time but not received by the conclusion of the survey. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was completed with the facility Administrator on 2/23/22 at 8:39 AM. When queried regarding the lack of facility knowledge of Residents with contractures and limitations, the Administrator was unable to provide further explanation. When queried why Therapy Director BB stated Resident #8 had a contracture but the Resident had not been included on any other facility provided lists, the Administrator did not provide clarification. The Administrator was then asked about the lack of documented, measurable assessment for ROM and indicated they were not a therapist. When queried regarding Resident #82's ROM task not having any documentation, the Administrator revealed if there was no documentation, there was no way to show the task had been completed. When queried regarding CNA verbalization that they did not complete ROM and brace/splint application and had not been instructed to do so, an explanation was not provided. Review of facility provided policy/procedure entitled, Restorative Nursing Services (no date) revealed, Residents will receive restorative nursing care as needed to help promote optimal safety and independence . 1. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services . 2. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care. 3. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care . 5. Restorative goals may include, but are not limited to supporting and assisting the resident in: a. Adjusting or adapting to changing abilities; b. Developing, maintaining or strengthening his/her physiological and psychological resources; c. Maintaining his/her dignity, independence and self-esteem; and d. Participating in the development and implementation of his/her plan of care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures to ensure indwelling urinary catheter (tube inserted into the bladder for the drainage of urine) care per professional standards of practice for two resident (Resident #74 and Resident #82) of two residents reviewed resulting in urinary catheter and tubing being maintained in an undignified and unsanitary manner, lack of monitoring of indwelling urinary catheter drainage systems, lack of infection control principles, and the likelihood for infection and feelings of embarrassment and discomfort utilizing the reasonable person concept. Findings include: Resident #74: On 2/15/22 at 8:09 AM, Resident #74 was observed in their room. The Resident was laying in bed on their side with a wheelchair next to the left side of the bed. Resident #74 hair was unbrushed with a greasy/dirty appearance. A urinary catheter drainage bag was hooked on the bottom of the wheelchair and the urinary drainage tubing was stretched across the bed. The tubing contained thick, white colored drainage from the bladder. The urinary drainage bag was exposed and not covered and/or contained in a dignity bag. When spoke to, Resident #74 replied with nonsensical responses. Record review revealed Resident #74 was originally admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, urinary retention, and Benign Prostatic Hyperplasia (BPH- enlarged prostate). Review of Resident #74's Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively intact, required extensive assistance for bed mobility, toileting, eating, dressing, and limited assistance for transferring, locomotion, and personal hygiene. The MDS further revealed the Resident had an indwelling urinary catheter. Review of Resident #74's Electronic Medical Record (EMR) revealed the Resident currently had a Urinary Tract Infection (UTI). Review of Resident #74's electronic Medication Administration Record (MAR) for February 2022 revealed the following antibiotic treatment: - Nitrofurantoin (antibiotic) . 100 milligrams (mg) . 1 capsule by mouth every 6 hours for UTI for 10 Days (Start Date: 2/9/22 at 8:00 AM; Discontinued: 2/11/22 at 4:54 PM). Per the MAR, Resident #74 did not receive their scheduled dose on 2/10/22 at 2:00 AM. The MAR referred included the code, 9=Other/See Progress Notes for the reason not administered. However, no progress notes were noted in the EMR. The Resident received their last done on 2/11/22 at 2:00 PM. - Ciprofloxacin (antibiotic) Tablet 500mg . 1 tablet by mouth every 12 hours for infection UTI for 7 Days Per culture /sensitivity (Start Date: 2/11/22 at 8:00 PM). Per the MAR, the antibiotic was not administered on 2/11/22 at 8:00 PM, with no documented reason, and was refused on 2/15/22 at 8:00 AM. Resident #74's Treatment Administration Record (TAR) for February 2022 did not include any assessment, monitoring, and/or care for the Resident's indwelling urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/15/22 at 9:50 AM, Resident #74 was observed in the hallway of the facility in their wheelchair. The Resident's urinary catheter drainage bag was not covered/contained in a dignity bag. Both the tubing, containing viscous, white colored urine and the drainage bag were dragging on the ground as the Resident propelled themselves in the wheelchair down the hall. Four staff members, including Certified Nursing Assistants (CNAs) and Nurses walked past the Resident but did not address the uncovered and bragging bag/tubing. Review of the Residents progress note documentation in the EMR revealed the following: - 11/13/21 at 2:04 PM: Health Status Note . Resident is a new admit . A/Ox3 (Alert and Orientated to Person, Place, and Time) . has Foley (indwelling urinary catheter) . cleared to walk around with walker per social worker . supervision when toileting or transferring . - 11/14/21 at 6:05 AM: Mood/Behavior . Staff observed resident bedding was wet. Noticed leg Foley bag was not on. Foley bag on bedside table. Resident had trash bag under his leg in bed. When asked what happened, stated they took it off. Writer observed clip on bag was broken. Foley catheter still inserted. Resident appeared upset, yelling at staff, not allowing nurse to fully assess catheter. New leg bag attached. He kept moving nurse hand. Able to assist back to bed . - 12/30/21: Progress Notes Date of Service: 12/30/21 . Visit Type: Acute . Follow up labs . being seen for follow-up to UA (Urinalysis), C&S (Culture and Sensitivity) results . urine culture was positive for Morganella Morgannii (gram negative bacteria normally found in bowels, can cause an unusual opportunistic UTI) . Ertapenem 500mg daily x10 (days); PICC (Peripherally Inserted Central Catheter- catheter inserted in the body through the arm that extends to the heart and utilized for long term administration of intravenous medications) line placement . When I notified (Resident) that requires IV (antibiotic) for a UTI just said ok, you done now? . Nursing has no acute concerns at this time. - 1/1/22 6:47 PM: General Progress Note Late Entry: IV (Intravenous) medication Ertapenem scheduled to start 1-1-22 for 10 days. Called RN access to start IV who states an order is needed for the type of line needed before they could come out. Contacted prescribing physician . will inform upcoming nurse as to why medication admin has been held. - 1/3/22: Progress Notes Date of Service: 1/3/22 Visit Type: Acute . Follow-up PICC line placement issue . Patient is being seen for a follow-up visit for PICC line placement issue. Nursing reports that patient refused PICC line placement; another RN will be coming to reattempt placement. If unable to place PICC at bedside may need to send patient out to hospital for placement . Spoke with (family) . Patient is to have bilateral kidney stent replacement this Friday. - 1/9/22 at 3:04 AM: Health Status Note . Patient returned to facility yesterday approximately 4pm according to admitting nurse via ambulance. According to admission papers patient was diagnosed with a UTI and treated with ATB (antibiotic) injections . - 1/11/22: History and Physical . Bladder infection that is stable and controlled . Patient was sent to the hospital . was refusing to have a PICC line placed to receive antibiotics for UTI . fully worked up at the hospital and has been readmitted to this facility, with a diagnosis of UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/8/22: Progress Notes Date of Service: 2/8/22 Visit Type: Follow Up . Chief Complaint . Follow up nausea . seen today follow-up on nausea as reported by (family) during the visit yesterday (family) states patient had an emesis x10. (Family) also reported to nursing they felt (Resident #74's) urine was slightly red in color. To this end CBC (Complete Blood Count- laboratory blood test), CMP (Complete Metabolic Panel - laboratory blood test) and a UA (urinalysis) was ordered last evening. They have not been drawn yet. - 2/8/22 at 2:01 PM: General Progress Note: NP (Nurse Practitioner) ordered . labs . and to change out Foley. Writer and lab tech attempted three times to obtain labs from resident, refused each time. Writer attempted to change resident's Foley and refused. Resident's (family) came up to visit, writer informed (family) of the orders given by NP. Resident's (family) spoke with resident . Resident still refused. (Family) agreed to try again later in the week for labs, order entered. Writer did manage to change out Foley bag. Np and unit manager updated. - 2/9/22: Progress Notes Date of Service: 2/9/22 Visit Type: Follow Up Chief Complaint . Follow-up UA (Urinalysis) . UA came back with preliminary results positive for nitrates (indicative of bacterial UTI) and WBCs (White Blood Cells) quite elevated. Culture is still pending . patient is symptomatic with increased confusion and intermittent nausea and emesis . urine was also noted to be quite milky and had a foul (odor) . Foley catheter draining and significant sediment is noted in bag and tubing. To - 2/10/22: Progress Notes Date of Service: 2/10/22 Visit Type: Follow Up Chief Complaint . Follow-up labs and UTI . seen today to follow-up on UTI. Patient has a Foley (indwelling urinary) catheter with significant amount of sediment. Patient has refused to have Foley catheter replaced . has dementia at baseline . is quite confused and has some periods of agitation and refusal care . (Family) will be coming in today to try to encourage patient to allow nursing to change Foley catheter and allow labs to be drawn . Foley catheter-thick sediment output . - 2/14/22: Progress Notes Date of Service: 2/14/22 . Visit Type: Follow Up . Chief Complaint . Follow-up labs and UTI . follow-up on lab work and UTI. Urine sensitivity came back exhibiting sensitivity to Cipro patient antibiotic was changed to ciprofloxacin. Patient also had labs drawn which are noted for an elevated BUN (Blood Urea Nitrogen)/creatinine and GFR (Glomerular Filtration Rate - blood laboratory tests used to determine kidney function) . would like to start IV (Intravenous) fluids on this patient however (Resident #74) adamantly refused to have fluids initiated. Patient has a history of refusing IV fluids. Patient was encouraged to increase oral fluid intake of water . stated understanding. I will consult nephrology due to patient's declining GFR. Patient is resistant to cares and interventions at baseline. Review of Resident #74's MAR and TAR for January 2022 revealed the following: - Ertapenem (antibiotic) . Use 1 gram intravenously every 24 hours for UTI for 10 Days (Start: 12/30/21; Discontinued: 1/3/22). The medication was never administered at the facility. - Ertapenem . Use 500 mg intravenously one time only for UTI for 10 Days (Start: 1/3/22; Discontinued: 1/9/22). There was no documentation of the antibiotic being administered at the facility. - Change Foley Q (every) 4 weeks every 26th of the month every evening shift starting on the 26th and ending on the 26th every month (Start: 11/26/21; Discontinue: 1/9/22) (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Send to ER for PICC placement one time only . for 1 Day (Start: 1/4/22). Documented as completed on 1/5/22 - Foley Cath Care . every shift for Foley care (Start: 11/13/21; Discontinue: 1/9/22) Per the TAR, Catheter care was documentation was blank (not completed) on: -1/2/22 Day Shift -1/2/22 Midnight shift -1/3/22 Day Shift -1/3/22 Midnight Shift - 1/6/22 Day Shift - 1/6/22 Afternoon Shift - 1/7/22 Day Shift -1/8/22 Midnight shift An interview was completed with Licensed Practical Nurse (LPN) Z on 2/16/22 at 1:08 PM. When queried if they provided care to Resident #74's catheter and if they had observed the urine and tubing, LPN Z stated, The NP ordered it to be changed by they refused. LPN Z was asked when that had occurred and replied, 2/8. (The Resident) would only allow to change the bag. When queried regarding a UTI, LPN Z stated, We got the UA. (Resident #74) was started on Macrobid (antibiotic) and then changed to Cipro (antibiotic). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/16/22 at 1:14 PM, an observation of Resident #74 occurred in their room. The Resident was in bed, laying on their side. The Resident's bedding appeared wet, and their catheter drainage bag was not present on the side of the bed. The Resident was wearing pants and the outline of the circular end of the catheter was visualized. When asked where their catheter was, Resident #74 did not provide a response. Upon entering Resident #74's bathroom, the catheter drainage bag and tubing was observed hanging on a walker sitting in the room. The drainage bag contained was overfilled and contained greater than 2000 milliliters (mL) of dark, cloudy urine with significant amounts of sediment. CNA X was observed in the hall and was asked to enter the room. When asked, CNA X revealed they were not assigned to care for the Resident and that CNA EE was. CNA X was queried regarding Resident #74's urinary catheter location. CNA X looked at the Resident and noted the wet bed and missing catheter drainage bag. CNA X was then shown the drainage bag in the bathroom and expressed dismay. CNA X indicated the Resident probably disconnected the drainage bag because it was so heavy and overfilled. At 1:20 PM, LPN Z was brought into the room. When queried regarding Resident #74's catheter, LPN Z indicated they would attach a new drainage bag. When queried regarding the integrity of the closed catheter drainage system in relation to infection control when attaching tubing and a drainage bag to a catheter which had been exposed, LPN Z indicated the Resident would not allow them to insert a new catheter but did not ask and/or speak to the Resident regarding catheter insertion. When queried regarding the amount of urine in the drainage bag, LPN Z revealed the drainage bag must not have been emptied in a long time. At 1:29 PM on 2/16/22, an interview was completed with CNA EE. CNA EE was asked the last time they provided care to Resident #74 and when they last emptied their catheter drainage bag. CNA EE revealed they had not emptied the Resident's urinary catheter drainage bag but provided no further explanation. Review of Resident #74's Kardex (CNA care guide) did not include any instruction related to indwelling urinary catheter care. Review of Resident #74's care plans revealed a care plan entitled, (Resident #74) is at risk for infection/complications related to indwelling catheter . (Initiated and Revised: 11/24/21). The care plan included the interventions: - Document catheter output every shift (Initiated: 11/24/21) - Catheter . care at least every shift and as needed . (Initiated: 11/24/21) - Keep drainage bag and tubing below level of the bladder (Initiated: 11/24/21) - Observe for symptoms of urinary tract infection . (Initiated: 11/24/21) Resident #82: On 2/15/22 at 7:51 AM, Resident #82 was observed in their room. The Resident was positioned on their back in bed, wearing a hospital style gown. A urinary catheter drainage bag was present on the right side of the bed, towards the doorway of the room. The drainage bag was not covered/contained in a dignity bag and a large amount of sediment was noted in the tubing. When spoke to, Resident #82 did not respond, verbally or non-verbally. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #82 was originally admitted to the facility on [DATE] with diagnoses which included dementia, dysphagia (difficulty swallowing) gastrostomy (surgically created through the abdomen into the stomach for nutritional support), and pain. Review of MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required two-person extensive to total assistance to perform ADLs. Review of Resident #82's care plans revealed a care plan entitled, Use of indwelling urinary catheter needed due . pressure ulcer (wound caused by pressure) (Initiated and Revised: 4/29/21). The care plan included the interventions: - Catheter Care q shift (Initiated: 6/23/21; Revised: 8/28/21) - Change catheter per physician order (Initiated: 4/29/21) - Change urinary collection bag as needed (Initiated: 4/29/21) - Dignity bag for indwelling catheter (Initiated: 4/29/21; Revised: 8/28/21) - Secure catheter with securement device (Initiated: 4/29/21) On 2/16/22 at 9:03 AM, Resident #82 was observed in their bed, positioned on their back. Their indwelling urinary catheter drainage bag was noted on the right side of the bed, not contained in a dignity bag, and visible from the hallway. The urine was dark amber in color and a large amount of sediment was present in the tubing. An observation of ADL care was completed with CNA X, CNA Y, and LPN Z at this time. During care, it was noted that Resident #82 did not have a catheter securement device in place. An interview was completed with the facility Administrator on 2/16/22 at 11:30 AM. When queried regarding facility policy/procedure related to indwelling urinary catheter drainage bags being contained in a dignity bag, the Administrator replied, Some of the new ones (drainage bags) have a cover. When asked if the drainage bag should be covered or contained, the Administrator revealed they should. The Administrator was then asked why Resident #74 and Resident #82's urinary drainage bags were not covered/contained and stated, Should be. An interview was completed with LPN Z on 2/16/22 at 12:20 PM. When queried regarding Resident #82's catheter not having a securement device, LPN Z revealed it had been removed because it was digging in. When queried how long ago the securement device was removed, LPN Z revealed it had been quite some time but was unable to provide a specific date. When queried if they had observed the color and sediment in Resident #82's urine, LPN Z confirmed they had. LPN Z was then asked if Resident #82 had a UA and replied, I don't know. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/16/22 at 3:20 PM, an interview was conducted with the Director of Nursing (DON). When queried regarding observations of Resident #74's catheter drainage bag being disconnected and full in the bathroom, the DON stated, The NP (Nurse Practitioner) came to me with concerns regarding their cath (catheter) and we got a UA. When queried regarding the amount of urine in the drainage bag and the CNA stating they had not emptied the drainage bag, the DON revealed education is needed and staff need to make sure the Foley is getting emptied. The DON was asked what else needed to occur and replied, Needs a brand-new bag. When queried why they would only attach a new drainage bag, the DON replied, With me knowing this Resident's history. The DON was then asked about LPN Z stating they were going to attach a new catheter drainage bag to the disconnected insertion catheter and stated, (Resident #74) refused to change the cath. The DON was asked how the Resident was able to refuse when they were not asked but did not provide a response. When asked they there was a concern for infection by connecting a drainage bag to the catheter drainage system, the DON replied, Yeah. The DON was then asked if catheter drainage bags should be covered/maintained in a dignity bag and indicated they should. Review of facility provided policy/procedure entitled, Catheter Care, Urinary (Revised September 2014) revealed, The purpose of this procedure is to prevent catheter-associated urinary tract infection . General Guidelines . 1. Following aseptic insertion of the urinary catheter, maintain a closed drainage system. 2. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment, as ordered . Infection Control 1. Use standard precautions when handling or manipulating the drainage system. 2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag . b. Be sure the catheter tubing and drainage bag are kept off the floor. c. Empty the drainage bag regularly using a separate, clean collection container for each resident. Avoid splashing and prevent contact of the drainage spigot with the nonsterile container. d. Empty the collection bag at least every eight (8) hours . Changing Catheters 1. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. 2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site . Complications . b. Check the urine for unusual appearance (i.e., color, blood, etc.). c. Notify the physician or supervisor in the event of bleeding, or if the catheter is accidentally removed . e. Observe for other signs and symptoms of urinary tract infection or urinary retention .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 39059 Based on interview and record review, the facility failed to assess and monitor weights, weight loss and nutritional status, notify the dietician and physician of weight loss and provide assistance with eating for four residents (Resident #35, Resident #45, Resident #48 and Resident #70) of five residents reviewed for nutritional services, resulting in unassessed weights, unassessed nutritional status, no assistance with meals and untreated weight loss. Findings include. Resident #35: On 2/10/22, at 12:21 PM, Resident #35 was sitting in their bed eating their lunch. Resident #35 was not able to consume the peel on the cooked zucchini and complained they had a hard time chewing because they didn't have any teeth. Resident #35 was unable to answer if they had lost weight. There was no staff member present. On 2/14/22, at 9:30 AM, Resident #35 is lying in their bed still eating breakfast. There was no staff member present. On 2/15/22, at 9:41 AM, a record review of Resident #35's electronic medical record revealed an admission on 12/6/2021 with diagnoses that included Dementia, Tremors and protein-calorie malnutrition. According to the most recent Minimum Data set Assessment Date 1/06/2022 revealed Resident #35 required extensive assistance with eating and had severely impaired cognition. A review of the Weight Summary revealed only one weight listed Date 12/8/2021 Value 143.0 lbs (pounds) Resident #45: On 2/15/22, at 10:38 AM, a record review of Resident #45's electronic medical record revealed an admission on 6/9/21 with diagnoses that included Cerebral Infarction (stroke), age related physical debility and Dysphagia. According to the most recent Minimum Data set Assessment Date 12/23/2021, Resident #45 required extensive assistance with eating and had severely impaired cognition. A Review of the Weight Summary revealed 1/11/2022 Value 294.0 Lbs and on 1/25/2022 Value 272.0 Lbs a 22 pound weight loss. A review of the progress notes revealed no progress note notifying the physician or dietician of the weight loss. On 2/22/22, at 3:04 PM, Dietician B was asked if they were aware of Resident #45's recent weight loss and Dietician B stated, that the resident is on the list for a reweight. Dietician B was asked if they notified the physician and Dietician B was unsure. Dietician B stated, that they give the reweight list to nursing and tell them they need they weights done but either they don't get done or the list gets lost. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #48: On 2/10/22, at 1:54 PM, Resident #48 was lying in their bed and complained about the tough food the facility provided and had been having vomiting. Resident #48 offered that they couldn't eat the food because they had a lap band procedure in the past and are used to eating soft foods and soups. Resident #48 stated that they asked to see the dietician more than five times and the dietician had not been in. Resident #48 ended up having their lap band removed the day before because of the tough food offered. Resident #48 was asked if they had different foods to eat would they have had to remove the lap band and Resident #48 stated No, that they could eat soups and soft foods without difficulty. Resident #48 also complained that they felt they had lost weight but had not been weighed at the facility. On 2/22/22, at 11:57 AM, a record review of Resident #48's electronic medical record revealed an admission on 1/5/22 with diagnoses that included Sarcopenia, Lumbago and muscle weakness. Resident #48 required assistance with all Activities of Daily Living and had intact cognition. A review of the Dietician_Review Date: 1/10/2022 admission assessment revealed Dietician Review 1. Current Diet Order & supplements was left blank. 1.a. Does the resident have any food allergies/intolerance's The boxes for yes or no were not check marked. 4. Most recent Weight was left blank. There was a typed note that revealed Additional comments/recommendations . poor app (appetite) . lap band . The residents usual body weight was not listed. A review of the progress notes revealed 2/4/2022 17:19 (5:19 PM) . Aide states that there were several cups on patients table that appeared to have dark liquids in it. Upon emptying it, she saw that all cups were full of vomit. Aide states this has been going on for several weeks and that she reported it. Patient says she has a doctor appointment scheduled for Wednesday regarding removal of lap band. Will continue to monitor. There was no documented notification to the physician or the dietician regarding the vomiting. There were no other dietician/nutritional notes. A review of the weight summary revealed no weights were obtained since admission. On 2/22/22, at 3:07 PM, Dietician B was interviewed regarding Resident #48's request to see the dietician and Dietician B stated, that they did see the resident for the admission assessment, started it and had additional paper notes to add to the summary. Dietician B further offered that the dietary manager could have seen the resident and fixed the food problem. Resident #70: On 2/22/22, at 11:05 AM, record review of Resident #70's electronic medical record revealed an admission on 1/15/22 with a readmission on 1/26/22 with diagnoses that included end stage renal disease requiring dialysis, metabolic encephalopathy and Diabetes Type 2 with complications. A review of the weight summary revealed no weights were listed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/22/22, at 3:01 PM, Dietician B was asked why Resident #70 had not had a weight since admission and Dietician B stated, the resident came in on the 15th, went out and came back on the 26th and was aware there was no weight listed. Dietician B stated, that they provide the nursing department with a list of weights needed and when they return the following week and either the weights don't get done or the list gets lost. On 2/23/22, at 1:30 PM, a record review of the facility provided undated policy Weight Assessment and Intervention revealed The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents . Weight Assessment . The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter . Weights will recorded in each unit's Weight Record chart or notebook and in the individual's medical record . The Dietician will review the unit Weight Record by the 15th of the month .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 37668 Based upon observation, interview and record review, the facility failed to operationalize policies and procedures to ensure administration of enteral nutritional solution (nutrition provided by means of surgically placed tube) per professional standards of practice for one resident (Resident #82) of one resident reviewed, resulting in a lack of comprehensive labeling of enteral tube feeding solution, lack of head elevation during feeding, administration of tube feeding after it should be disposed of, lack of administration of tube feeding as ordered, malnutrition, and the likelihood for food borne illness related to ingesting contaminated enteral feeding solution, aspiration, feelings of hunger/discomfort utilizing the reasonable person concept, and decline in overall health status. Findings include: Resident #82: On 2/15/22 at 7:51 AM, Resident #82 was observed in their room. The Resident's touch call light was on the floor behind the head of the bed. The Resident was positioned on their back in bed, wearing a hospital style gown. CNA J was standing on the left side of the Resident's bed obtaining the Resident's vital signs. When spoke to, Resident #82 did not respond, verbally or non-verbally. Resident #82's eyes were coated with a white colored, viscous appearing substance. A dark rusty brown colored dried substance with the appearance of dried blood was present on the Resident's lips. The Resident's mouth was open, and their tongue and mucous membranes were visibly dry. A tube feeding administration pump with Jevity 1.5 calorie solution and water flush were present in the room and connected to the Resident. The container of Jevity 1.5 nutritional solution was full and the water flush bag was over half empty. The Jevity container had the Resident's name and 2/15/22 written on it. The tube feeding was not labeled with the time when it was started not the ordered rate of administration. The tube feeding pump was programmed with the following: Running . Feed Rate: 0 mL (milliliter)/hr and Flush 50 mL every 1 hrs (hours). The information on the pump detailed Resident #82 had received 0 mL of feeding solution and 351 mL (water) flush. At this time, NP Q entered the Resident's room. When queried regarding Resident #82's non-responsiveness and wounds, NP Q revealed the Resident was more lethargic than when they had previously seen them. When queried regarding Resident #82's tube feeding pump only infusing the water flush and not the nutrition, NP Q revealed they were not familiar with tube feeding pumps. When asked if the Resident was supposed to receive tube feeding, NP Q reviewed the Residents medical record and orders and revealed the Jevity should be administered at 50 mL per hour. An interview was completed with Licensed Practical Nurse (LPN) R on 2/15/22 at 8:36 AM. LPN R was queried regarding Resident #82's tube feeding orders and replied, Up at 1500 (3:00 PM) and down at 11:00 (AM). When asked about the tube feeding solution, LPN R revealed the tube feeding rate was 50 mL/hour. An observation of Resident #82's tube feeding solution and pump was completed with LPN R in Resident #82's room at this time. LPN R looked at the pump and stated, That's not right. (Resident #82) hasn't even gotten any food. LPN R continued, They (staff) got it (pump) at 50 (mL) for the flush continuously. Resident #82's Medication Administration Record (MAR) was reviewed with LPN R at this time. Review revealed: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Enteral Feed Order two times a day continuous Feeding Formula: Jevity 1.5 CC (Cubic Centimeter)/Hour: 50 X 20 Hours. On: 1500 (3 PM) Off: 1100 (11 AM). Total Volume 1000 mL/24 hours (Start: 1/31/22). Per the MAR, the enteral feeding was last administered on 2/14/22 at 3:00 PM. - Enteral Feed Order one time a day flush tube with 65 cc water every hour of formula infusion (3:00 PM TO 11:00 AM) . Total of 1300mL/24 hours (Start: 10/2/21) Review of Resident #82's care plan revealed a care plan entitled, Need for feeding tube/ potential for complications of feeding tube use related to failure to thrive diagnosis (Initiated: 6/23/21; Revised: 6/28/21). The care plan included the interventions: - Administer tube feeding formula, hydration, and flushes per order (Initiated: 6/23/21; Revised: 6/24/21) - Elevate head 30-45 degrees (Initiated: 6/23/21; Revised: 6/24/21) - Provide oral hygiene daily and prn (as needed) (Initiated: 6/28/21) On 2/16/22 at 8:30 AM, Resident #82 was observed in their room in bed. Resident #82's tube feeding was infusing Jevity 1.5 calorie nutritional solution via pump at 50 mL/hour. The container was labeled as being started on 2/15/22 at 9:00 AM. The head of Resident #82's bed was positioned at 24 degrees. The Resident's mouth and oral cavity was dry with a visible build-up of an unknown substance observed on their teeth. Resident #82 was notably more alert than on 2/15/22 and responded verbally when spoke to. At 9:50 AM on 2/16/22, Resident #82 was observed in their room in the same position in bed. The same tube feeding, dated 2/15/22 at 9:00 AM, was infusing via tube feeding pump. On 2/16/22 at 12:19 PM, Resident #82 was observed in their room with the same tube feeding solution dated 2/15/22 at 9:00 AM infusing via pump. An interview was conducted with LPN Z on 2/16/22 at 12:21 PM. When asked how long tube feeding solution is able to infuse after initiation/being opened, LPN Z replied, 24 hours. When asked why Resident #82's current tube feeding solution had been infusing since 2/15/22 at 9:00 AM, LPN Z did not provide an explanation and stated, I'll take it down. When asked how high the head of the Resident's should be when receiving tube feeding, LPN Z indicated greater than 45 degrees. When queried why Resident #82's head of the bed was elevated 24 degrees, LPN Z did not provide an explanation. On 2/16/22 at 4:12 PM, an interview was conducted with the Director of Nursing (DON). When queried how long tube feeding can be administered for after opened, the DON replied, 24 hours. The DON was then asked what the head of bed elevation should be when tube feeding is being administered and revealed it should be at least 30 degrees. When asked about observations of Resident #82's tube feeding, the DON did not provide an explanation. When queried regarding observation of Resident #82 not receiving their tube feeding solution on 2/15/22, the DON indicated they were not aware the Resident did not receive any nutrition as ordered. No further explanation was provided. Review of provided facility policy/procedure entitled, Enteral Nutrition (Revised: November 2018) did not include information pertaining to administration of enteral nutrition.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 37668 Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures for Peripherally Inserted Central Catheter-(PICC- catheter inserted in the body through the arm that extends to the heart and utilized for long term administration of intravenous [IV] medications) care, maintenance, and medication administration for one resident (Resident #27) of one resident reviewed, resulting in a lack of dressing changes per professional standards and recommendations, medication administration monitoring, and the potential for insertion site infection, inaccurate laboratory monitoring results, inappropriate medication dosage modification, and ineffective infection resolution. Findings include: Resident #27: On 2/15/22 at 9:27 AM, a beeping sound was heard from the hallway outside of Resident #27's room. Upon entering the room, Resident #27 was observed in their bed, positioned on their back wearing a hospital style gown. The beeping was coming from an IV pump directly next to the Resident's bed. The IV pump was in use with the tubing connected to a line in the Resident's Right Upper Extremity (RUE). An interview was completed at this time. When asked how long the IV pump had been beeping, Resident #27 revealed they had tuned it out because it was beeping all night. Inspection of the alarming IV pump revealed the medication hanging for administration through the pump was Vancomycin (antibiotic which required the laboratory to reduce risk of underdosing and toxicity) 1 gram. The IV bag was full of medication and did not appear to have infused any medication. The IV pump screen error read, Pump unattended. Press any key to continue indicating the IV pump was not programmed/started. The IV tubing was connected to a PICC line in Resident #27's RUE. The PICC line dressing was dated 2/7 and the edges on the dressing were peeling. When queried why they had a PICC line and were receiving IV antibiotics, Resident #27 did not provide a specific answer but stated, I was in the hospital last week because I was throwing up and couldn't stop. An interview was completed with Licensed Practical Nurse (LPN) R on 2/15/22 at 9:44 AM. When queried what time Resident #27's Vancomycin was hung for IV administration, LPN R stated, I did not hang it yet. LPN R was asked when the last time the Resident received their dose and replied, It was night shift. With further inquiry regarding monitoring, LPN R revealed Lab had already been in the facility to obtain the Resident's Vancomycin level. When queried regarding the pump beeping and the IV antibiotic hanging and not infused, LPN R revealed they had not been in the Resident's room yet. LPN R went into the Resident's room and confirmed Resident #27 had not received the IV Vancomycin because the IV pump was not programmed/started. Review of Resident #27's Medication Administration Record (MAR) for February 2022 revealed the Vancomycin was last administered on 2/14/22 at 10:15 PM. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second interview was completed with LPN R on 2/15/22 at 11:06 AM. When queried regarding the frequency in which PICC line dressings needed to be changed per facility policy/procedure, LPN R replied, Not sure here. It shows up on the MAR when it needs to be done. With further inquiry, LPN R revealed PICC line dressings are typically changed every seven days. LPN R was then queried regarding Resident #27's PICC line and stated, I didn't look at the date. It might need to be changed. Resident #27's MAR and Treatment Administration Record (TAR) were reviewed with LPN R at this time. There was no task on the MAR or TAR to change the PICC line dressing. When asked, LPN R indicated there should be a task. Review of Resident #27's care plans revealed the Resident did not have an active care plan in place related to PICC line care. Review of facility provided policy/procedure entitled, Assessment, Care and Dressing Changes of Vascular Access Devices (Approved: 4/6/18) revealed, Policy: To establish guidelines for the assessment, care and dressing changes of vascular access devices . 3. A sterile dressing is applied and maintained . Review of facility provided policy/procedure entitled, Infusion Therapy (Approved: 4/6/18) revealed, Policy: To establish the guidelines to ensure intravenous infusion therapy is provided in accordance with laws, rules, and regulations as declared by the federal and state regulatory and accrediting bodies in all patient care settings. Procedure: 1. Intravenous infusion therapy practice is established in organization policies, procedures, and/or practice guidelines that describe the acceptable course of action, including performance and accountability, and provide a basis for the clinical decision making . 5) Facility must develop and implement resident care policies, based upon current professional standards of practice for the preparation, insertion, administration, maintenance and discontinuation of intravenous infusion therapy as well as the prevention of infection at the insertion site to the extent possible .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to operationalize policies and procedures to ensure professional standards of practice for nebulizer equipment storage and oxygen administration equipment labeling for two residents (Resident #22 and Resident #44) of two residents reviewed, resulting in unsanitary and inappropriate storage of nebulizer equipment, lack of dating of oxygen tubing, and the potential for respiratory infection and illness. Findings include: Resident #22: On 2/15/22 at 8:12 AM, Resident #22 was observed in their room in bed. The Resident was unshaven with an unkept appearance. The Resident was receiving oxygen therapy via nasal cannula (NC). An interview was conducted at this time. When asked if they received continuous oxygen therapy, Resident #22 indicated they did. Inspection of the oxygen concentrator revealed the oxygen delivery rate was set at 2 liters (L) per minute. The oxygen tubing was unlabeled. When queried regarding the frequency in which facility staff changed the tubing, Resident #22 revealed they had not noticed staff changing the tubing. At 3:57 on 2/15/22, Resident #22 was observed in their room in the facility. The Resident was in bed and remained dressed in a hospital gown. Resident #22's oxygen concentrator was set at 2L/minute and the tubing remained undated. Review of Resident #22's care plans revealed a care plan titled, (Resident #22) is at risk for respiratory distress related to respiratory failure (Initiated and Revised: 2/11/22). The care plan included the interventions: - BIPAP/CPAP as ordered - Nebulizer treatments as ordered - Oxygen as ordered Review of Resident #22's Electronic Medical Record (EMR) orders and order summary revealed the Resident did not have an order for oxygen therapy. Resident #44: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/15/22 at 11:37 AM, Resident #44 was observed in their room, laying in bed. The Resident was receiving supplement oxygen via NC. A nebulizer machine was sitting on the dresser to the left of the bed. The administration mouthpiece uncovered and connected to the nebulizer. Clear fluid was present in the medication administration cup of the nebulizer. There was no date present on the nebulizer tubing and/or equipment. An interview was completed at this time. When asked if they had recently completed a breathing treatment, Resident #44 indicated they had one earlier in the morning. When queried how staff clean the nebulizer after use, the Resident indicated they did not understand the question. The Resident was then asked if staff took apart the nebulizer, rinsed it, and let it sit to dry after they received a breathing treatment, Resident #44 revealed they had never seen staff clean their nebulizer. Inspection of the oxygen concentrator in the Resident's room revealed the rate of oxygen delivery was set at 2L/ minute. There was not date present on the tubing. Record review revealed the Resident #44 was admitted to the facility on [DATE] with diagnoses which included heart disease and Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, required extensive assistance for bed mobility, dressing, and personal hygiene. Review of Resident #44's care plan revealed a care plan titled, Has/At risk for respiratory impairment related to COPD with oxygen use . (Initiated: 4/21/21; Revised: 8/7/21). The care plan included the intervention, Administer medications/treatments per physician orders (Initiated: 4/21/21). Review of Resident #44's health care provider orders and Medication Administration Record (MAR) revealed: - Oxygen at 3 Liters/minute via nasal cannula . (Start: 4/21/21) - Ipratropium-Albuterol Solution 0.5-2.5 mg (milligram)/3mL (milliliter) 1 dose inhale orally two times a day for Wheezing . (Start: 8/24/21) [Nebulizer treatment] An interview was conducted with the Director of Nursing (DON) on 2/16/22 at 3:52 PM. When queried regarding facility policy/procedure related to changing and dating oxygen tubing, the DON stated, Changed every seven days and labeled. The DON was then asked about facility policy/procedure related to nebulizer medication equipment and replied, Should be cleaned, dried, and then contained in a bag. When told about observation of Resident #44's nebulizer and the Resident's statements, the DON stated, No and indicated they would follow up. When queried regarding Resident #27's oxygen tubing not being labeled and not having an order for oxygen, the DON did not provide an explanation. When asked about Resident #44's oxygen order being 3 L/minute when they were receiving 2 L/minute, the DON did not provide further explanation. Review of facility policy/procedure entitled, Oxygen Administration (Revised October 2010) revealed, The purpose of this procedure is to provide guidelines for safe oxygen administration . 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident . The policy did not address ongoing monitoring and assessment of oxygen therapy.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on interview and record review, the facility failed to provide pain medication timely for three residents (Resident #5, Resident #48, Resident #94) of three residents reviewed for pain, resulting in uncontrolled pain, calling 911 to go back to the hospital for pain control, and crying. Findings include. Resident #48: On 2/10/22, at 1:52 PM, Resident #48 was lying in their bed and complained that they went without pain medications for over twenty-four hours. Resident #48 offered that the pain was so bad they were sobbing and everyone she complained to would respond with statements like that's not my job; not my responsibility. On 2/14/22, at 11:57 AM, a record review of Resident #48's electronic medical record revealed an admission on 1/5/22 with diagnoses that included Sarcopenia, Lumbago and muscle weakness. Resident #48 required assistance with all Activities of Daily Living and had intact cognition. On 2/14/22, at 4:25 PM, a record review of the Medication Administration Record revealed HYDROCodone-Acetaminophen Tablet 7.5-325 MG (milligrams) Give 1 tablet by mouth every 4 hours as needed for Pain - Start Date- 01/052022 2300 . There was no pain med offered on the 5th or the 6th and with the first dose not offered until 1/7/22 0942 (9:42 AM) On 2/14/222, at 4:30 PM, the Administrator was asked to provide a list of medications that was in the back up medication storage and all HYDROCodone/narcotic reconciliation forms for Resident #48. Resident #94: On 2/22/22, at 1:04 PM, During a phone conversation with Resident #94 regarding their short stay at the facility was conducted. Resident #94 complained that they were admitted for a wound infection and had constant pain in their foot. Resident #94 complained that their pain level was a constant 10 the whole time I was there and kept asking for pain medication but never received any. Resident #94 further complained that nobody came and assessed the wound to their foot which was the reason for the pain. Resident #94 further offered I had to call 911 to get out of there because the pain was so bad. A review of Resident #94's the electronic medical record revealed an admission on 12/3/2021 18:14 (6:18 PM) with diagnosis of Type 2 Diabetes Mellitus with foot ulcer. A review of the Medication Administration Record December 2021 revealed HYDROCodone-Acetaminophen Tablet 5-325 MG Give 1 Tablet by mouth every 6 hours as needed for Pain -Start Date-12/03/2021 1745 (5:45 PM) There was no documented pain medication given. A review of progress notes revealed the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	12/3/2021 18:14 . Resident arrived to facility at around 5pm via ambulance. Vitals wnl (within normal limits), no c/o pain or discomfort at this time. (staff member) notified awaiting verification of medication. Will continue plan of care. 12/4/2021 21:17 . Resident asked this writer to use the phone at around 2000. About an hour later the ambulance came in the building to transport resident to the hospital. Resident states I called 911 to pick me up because I went to get out of here . 38471 Resident #5: On 2/14/22 at 1:52 PM, Resident #5 was observed lying in bed, this writer asked questions regarding her stay at the facility and Resident #5 explained their fulltime staff has resigned and she is not sure how the care will be affected. Resident #5 continued she has not been receiving her pain medications as ordered. Resident #5 expressed within the last month she has not received her Norco at least three times because it was unavailable at the facility, and they had to wait on pharmacy deliver it. She continued they did give her Tylenol but that was not effective, and her pain was not managed. Resident #5 reported she has arthritis, neuropathy and vascular issues and her pain was at an 8 (on a scale from 1-10) on the days her Norco was not available. On 2/14/22 at 2:00 PM, a review was completed of Resident #5's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Peripheral Vascular Disease, Chronic Pain, Polyneuropathy and Gastro-Esophageal Reflux Disease. Resident #5 is cognitively intact and able to make her needs know. Further review was completed of Resident #5's medical records and the following was revealed: Physician Order: Norco Tablet 5-325 MG (milligrams)- Give one tablet by mouth every 8 hours for pain. Care Plan: Focus: Pain in bilateral legs/generalized related to diagnosis of osteoarthritis . Interventions: .Administer paint medications as ordered . MAR (Medication Administration Record): January MAR: There were three blanks in the MAR, which indicated the resident did not receive her Norco. o 1/14/22-8 AM dose o 1/31/22- 12 AM and 8 AM dose (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	There were eleven entries with the code of 9 or 5 which directed this writer to look at the progress notes for more information. Progress Notes: Review was completed of the Medication Administration notes that correlated to the missed Norco doses in Resident #5's MAR. The overarching theme shown below is the medication was not available at the facility. 1/8/2022: - 4 PM: Medication administration note at 6:19 PM stated, not available. 1/11/2022: - 12 AM: Medication administration note at 1:02 AM stated, on order. - 8 AM: Medication administration note at 7:37 AM stated, waiting to be delivered. - 4 PM: There is no progress note related to this dose 1/12/2022 - 12 AM: Medication administration note at 2:53 AM stated, waiting on pharmacy drop in. - 4 PM: Medication administration note at 5:53 PM stated, in tonite's tote. 1/28/2022 - 12 AM: There is no progress note related to this dose 1/29/2022 - 12 AM: Medication administration note at 6:00 AM stated, waiting pharmacy to delivery. - 4 PM: Medication administration note at 10:13 PM stated, u able to get to capsa. 1/30/2022 - 12 AM: Medication administration note at 1:31 AM stated, on order. - 4 PM: Medication administration note at 7:42 PM stated, waiting on pharmacy deliver. It can be noted Resident #5 received her 8 AM dose of Norco on 1/30/22 but did not receive another dose until 1/31/22 at 4:00 PM. The resident went over 12 hours without receiving her scheduled pain medications. There was no documentation that facility/agency nurses contacted the physician to request other options. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 2/16/22 at approximately 2:15 PM, a review was completed of the facility's, Inventory Replenishment Report, dated 1/3/22. The inventory report is indicative of the medications available in the facility's back up machine. The nurses have access to the back up box to pull the required medication if it is not on their medication cart when needed. The medication that Resident #5 missed multiple doses of, was available in the back up machine: - Hydrocodone/APAP 5mg-325 mg Tab - Hydrocodone/APAP 7.5 mg-325 mg Tab - Hydrocodone/APAP 10 mg-325 mg Tab On 2/16/22 at 3:35 PM, an interview was conducted with the DON (Director of Nursing) regarding readily available medication in their back up machine. The DON explained they switched pharmacies recently, but they do have a backup machine in the facility. If a resident's medication is not on their cart they are able to go to the machine and request what medication is needed. The machine will alert them to contact the pharmacy and provide the required information. The nurse will then be provided with an authorization number to pull the medication from the machine. If a medication is not available, the pharmacy can drop-ship it the same or next day. The DON was not aware of the specific incident with Resident #5 but reported Norco is a readily available medication in their machine. The DON further explained many of the nurses (agency included) do not possess log-in credentials for the machine and may not be aware the facility has the back-up machine. The DON continued she is aware and working on the follow through with staff, ensuring they have the access, education on utilizing the machine and understanding they can always contact management to assist with resolving an issue. The DON reported if the medication had been ordered from pharmacy and would not arrive, they should have contacted the physician to request a different medication or place the medication on hold The DON expressed this all goes back to lack of education which they are working on. On 3/1/22 at 11:00 AM, a review was completed of the facility policy entitled, Pain Management, revised January 2020. The policy stated, To assess each resident for pain and maintain the resident as free of pain as possible .The physician will be notified of unrelieved or worsening pain .The licensed nurse will monitor the efficacy of the medication and notify the physician as needed.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 39059 Based on interview and record review, the facility failed to provide documentation and timely physician's visits for one resident (Resident #49) of two residents reviewed for physicians' visits, resulting in Resident #49 going 105 days without a documented physician's visit and the likelihood of unmet care needs. Findings include: On 2/22/22, at 11:48 AM, a record review of Resident #49's electronic medical record revealed an admission on 2/13/2014 with a readmission on 2/2/2019 with diagnoses that included Status post tracheostomy, Long term (current) use of anticoagulants and Diabetes Mellitus Type 2. Resident #49 required extensive assistance with Activities of Daily Living. A review of the miscellaneous tab revealed the most recent scanned physician visit was dated 11/6/2021. A review of the progress notes revealed no physician visit progress note. On 2/22/22, at 4:30 PM, The Director of Nursing (DON) was interviewed regarding Resident #49's most recent physician visit and the DON stated that they would check the hard chart for the most recent physician visit note. On 2/22/22, at 5:00 PM, a record review of the facility provided most recent physician visit revealed a date of 11/6/21. On 2/23/22, at 9:05 AM, a phone interview with Physician O was conducted regarding the most recent visit with Resident #49 and Physician O stated that they seen the resident over the weekend. Physician O further stated that they dictate their note and fax to the facility but with the changeover the facility has been losing the dictated notes. Physician O offered that their office manager calls the facility, faxes the note and the facility still loses it.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review, the facility failed to act upon recommendations regarding medication irregularities and produce pharmacy recommendation reports for two residents (Resident #41 and Resident #71), resulting in the potential for inadequate monitoring, missed gradual dose reductions of psychotropic medications, appropriate mental health diagnoses and adverse side effects of medication. Findings include: Resident #41: On 2/14/22, during initial tour Resident #41 was observed resting in bed, he did not appear to be in any distress and was in good spirits. On 2/16/22 at 8:46 AM, a review was completed of Resident #41's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included Anxiety Disorder, Major Depressive Disorder and Kidney Disease. On 2/16/22 at 1:24 PM, a review was completed of Resident #41's MRR's (Medication Regime Reviews) completed by the Pharmacist for the last year. The following was in Resident #41's medical record: 9/21/2021- No new irregularities noted 10/28/2021- Medication Regime Review (see report for complete information) 11/9/2021- Medication Regime Review (see report for complete information) 12/10/21- No new irregularities noted 1/19/2022- Medication Regime Review (see report for complete information) MRR's from February 2021-August 2021 were not located within the resident's chart. Furthermore, the specific pharmacy recommendation report and physician and/or nursing responses from October 2021, November 2021 and January 2022 were not able to be located. Resident #71: On 2/14/22, during initial tour Resident #71 was observed in bed watching old western shows. She spoke about how she just enjoyed some cookies and was waiting on lunch to arrive. On 2/16/22 at 8:50 AM, a review was completed of Resident #71's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses of Anxiety Disorder, Paranoid Schizophrenia and Parkinson's Disease. Further review was completed and the last. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/16/22 at 1:50 PM, a review was completed of Resident #71's MRR's (Medication Regime Reviews) completed by the Pharmacist for the last year. The following was in Resident #71's medical record: 9/2021- Medication Regime Review (see report for complete information) 10/2021- Medication Regime Review (see report for complete information) 11/2021- No new irregularities noted 12/10/21- No new irregularities noted 1/19/2022- Medication Regime Review (see report for complete information) MRR's from February 2021-August 2021 were not located within the resident's chart. Furthermore, the specific pharmacy recommendation report and physician and/or nursing responses from August 2021, October 2021 and January 2022 were not able to be located. On 2/22/22 at 12:52 PM, an interview was conducted with the Administrator regarding pharmacy recommendation for Resident #41 and #71. She was asked for the past year of pharmacy recommendation and physician responses. The Administrator reported prior to them switching to a new pharmacy provider the pharmacist would send the recommendations to the previous DON and it was the DON's job to ensure completion. The Administrator reported she would attempt to locate them. This survey team exited on 2/23/22 and the facility had not provided the pharmacy recommendation for the past year and subsequent physician responses for Resident #41 and #71. It can be noted it is unknown what the pharmacist recommendations were and the effect the facility this poses on all facility residents whose medications are not being managed and monitored appropriately. On 3/1/22 at 3:00 PM, a review was completed of the facility policy entitled, Drug Regimen Review and Reporting, dated 7/18/2018. The policy stated, .The clinical consultant will conduct a review of each resident's medication regime and medical chart as least once a month for skilled nursing facilities .the clinical consultant pharmacist will sign the resident's medical chart, either hard copy or electronically, after the drug regimen has been completed .The clinical consultant pharmacist will provide the Drug Regime Review Report to each facility within seventy-two (72) hours after visit. Reports with irregularities will be emailed to the Director of Nursing, printed and delivered .the Drug Regime Report must be acted upon .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 39059 Based on interview and record review, the facility 1) Failed to notify the Physician of an elevated Prothrombin Time/prothrombin ratio and an International Normalized Ratio (PT/INR) for one resident (Resident #49); and 2) Failed to monitor the thyroid function and give Levothroxine medication appropriately for one resident (Resident #35) of two residents reviewed for unnecessary medications, resulting in the continued administration of the blood thinner medication Warfarin, abnormal blood levels, the likelihood of decreased absorption of thyroid medication and with the likelihood of bleeding and increased symptoms of hypothyroidism. Findings include. Resident #35: On 2/15/22, at 9:41 AM, a record review of Resident #35's electronic medical record revealed an admission on 12/6/2021 with diagnoses that included Dementia, Tremors and Hypothyroidism. According to the most recent Minimum Data set Assessment Date 1/06/2022 revealed Resident #35 required extensive assistance with Activities of Daily Living and had severely impaired cognition. A record review of the Medication Administration Record February 2022 revealed Levoxyl Tablet 50 MCG (micrograms) (Levothyroxine Sodium) Give 1 Tablet by mouth at bedtime for low thyroid hormone related to OTHER SPECIFIED HYPOTHYROIDISM -Start Date-01/09/2022 2000 (8:00 PM) Along with the thyroid medication scheduled at 2000/8:00 PM, there were seven other medications including Aricept Tablet . Start Date- 02/15/2022 2000 Primidone Tablet -Start Date- 12/07/2021 2000 Quetlapine Fumurate Tablet . -Start Date 12/07/2021 2000 Singulair Tablet . -Start Date- 12/07/2021 2000 Apixaban Tablet . -Start Date- 12/07/2021 2000 Metoprolol Tartrate Tablet . -Start Date- 12/07/2021 2000 Hydralazine HCl Tablet . -Start Date-12/07/2021 2000 A review of the lab results tab in the electronic medical record revealed no lab result for the monitoring on the thyroid level or how the Levothyroxine medication is being tolerated. On 2/22/22, at 2:40 PM, the Administrator was asked to provide lab results for Resident #35 for their thyroid function. On 2/22/22, at 4:26 PM, the Administrator was reminded the need of the thyroid lab result for Resident #35. Upon exit, there was no TSH (thyroid stimulating hormone level) lab result offered for Resident #35. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the American Thyroid Association, . The absorption of levothyroxine in the gut is decreased when taking the hormone at the same time as calcium, iron and some foods and other drugs. Because of this, patients are usually instructed to take levothyroxine on an empty stomach 30-60 minutes before food intake to avoid erratic absorption of the hormone . Hypothyroidism: a condition where the thyroid gland is underactive and doesn't produce enough thyroid hormone. Treatment required taking thyroid hormone pills . patients with hypothyroidism are most often treated with Levothyroxine in order to return their thyroid hormone levels to normal. Replacement therapy means the goal is TSH in normal range . Resident #49: On 2/22/22, at 11:48 AM, a record review of Resident #49's electronic medical record revealed an admission on 2/13/2014 with a readmission on 2/2/2019 with diagnoses that included Status post tracheostomy, Long term (current) use of anticoagulants and Diabetes Mellitus Type 2. Resident #49 required extensive assistance with Activities of Daily Living. A review of the lab results revealed a lab resulted on 2/15/2022 with a PROTHROMBIN TIME 36.6 Ref. (reference range) 9.6- 12.2 and an INR 3.67 Ref. range 0.80-3.50. A review of the progress notes revealed no documented progress note notifying the Physician of the abnormal lab result. A review of physician orders revealed Warfarin Sodium Tablet 4 MG (milligrams) Give 2 tablet by mouth . Start Date 9/16/2021 . PT/INR to be drawn weekly every Thursday: Abnormal results to be sent to PCP . There was no medication change noted. On 2/23/22, at 9:05 AM, a phone interview with Physician O was conducted regarding Resident #49's most recent INR result was conducted. Physician O was asked if they were aware of the INR result of 3.67 and Physician O stated, No, I was not and further offered that if they were notified they would hold the Coumadin for a day and would redraw the INR lab.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38471 Based on observation, interview, and record review the facility failed to document a clinically pertinent rationale for triple drug therapy, attempt a Gradual Dose Reduction (GDR), monitor for signs of symptoms for psychotropic medications and complete informed consents, resulting in Resident #71's and Resident #29's informed consents not being completed, Resident #41 receiving three antidepressant medications and GDR's not being attempted and the facility not monitoring Resident #58's Invega injections which he receives at the Veterans' Hospital. Findings Include: Resident #41: On 2/14/22, during initial tour Resident #41 was observed resting in bed, he did not appear to be in any distress and was in good spirits. On 2/16/22 at 8:46 AM, a review was completed of Resident #41's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included Anxiety Disorder, Major Depressive Disorder and Kidney Disease. Further review was completed of Resident #41's chart and the following were revealed: Physician orders of psychotropic medications: Lexapro- 10 MG (milligrams) once a day for Major Depressive Disorder- - Start date: 1/11/2022 Cymbalta-60 MG once a day for Major Depressive Disorder - Start date: 1/6/2021 Clonazepam 0.5 MG- one tablet every 12 hours for anxiety - Start date: 5/18/2020 Bupropion HCl tablet 100 Mg - once a day for Major Depressive Disorder - Start date: 5/1/2020 Physician Progress Note: Review was completed of the Physician progress note dated 11/29/21 and there was nothing documented regarding the residents' psychotropic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plan: Focus: Suicidal risk as evidenced by passive suicidal ideation and past suicide attempts r/t (related to) major depressive d/o recurrent without psychotic features, other depressive episodes, adjustment d/o with mixed anxiety and depressed mood and disease process . Interventions: .Attempt psychotropic drug reduction per physician orders .Inform nurse of all suicidal statements .Offer resident to listen to music when depressed, he enjoys R&B and hip hop . Focus: At risk for changes in mood r/t major depressive d/o recurrent without psychotic features, other depressive episodes, adjustments d/o with mixed anxiety and depressed mood . Interventions: .Assess for physical/environmental changes that may precipitate change in mood .Attempt psychotropic drug reduction per physician orders. Observe for mental status/mood state changes when new medication is started on with dose changes . Within Resident #41's chart there was no monitoring for signs/symptoms or adverse reactions of the psychiatric medications located. There was no charting located regarding any depressive or anxiety symptoms the resident displayed. Furthermore, there was no documentation of GDR (gradual dose reductions) completed by the facility for the resident's Cymbalta and Clonazepam. Resident #41 has been prescribed Cymbalta for 1 year and Clonazepam for almost 2 years with no documentation regarding contraindications, effectiveness and continued need for the medications. Resident #41 is prescribed three medications for his diagnoses of Major Depressive Disorder. There was no documentation located that indicated the residents need for triple therapy. Resident #71: On 2/14/22, during initial tour Resident #71 was observed in bed watching old western shows. She spoke about how she just enjoyed some cookies and was waiting on lunch to arrive. On 2/16/22 at 8:50 AM, a review was completed of Resident #71's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses of Anxiety Disorder, Major Depressive Disorder, Paranoid Schizophrenia and Parkinson's Disease. Further review was completed of Resident #41's chart and the following were revealed: Physician orders of psychotropic medications: Duloxetine HCl Capsule 30 MG take once a day for Major Depression - Start date: 1/16/2021 Risperdal Tablet 0.5 MG take once a day for bipolar disorder - Initial start date of 12/11/2019 Xanax Tablet 0.25 MG by mouth every 24 hours for anxiety - Initial start date on 12/10/2019 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Psychiatric Group Progress Notes: 2/11/2022 .Increase Risperdal to 0.5 MG BID (twice a day) for delusions . Care Plan: Focus: At risk for changes in mood r/t cognitive loss, dx of bipolar disorder, major depressive disorder, anxiety . bipolar type .Resident has an extensive history of mental illness. She has a history of seeing things that are not there, make accusatory statements, suspicious thinking, hallucinations/delusional thoughts . Initiated on 12/14/2020 At risk for adverse reaction effect related to: use of antianxiety/anxiolytic medication, use of antidepression medication, and use of antipsychotic medication as ordered . Interventions: AIMS testing per facility guidelines .Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs .Observe and report behavior symptoms . After review of Resident #71's chart there was no informed consent found for the resident's usage for Risperdal (Antipsychotic medication). On 2/22/22 at 2:30 PM, an interview was conducted with Social Services Director C regarding triple therapy, GDR's, consents and monitoring of medications for Resident #41 and #71. Director C reported she did not complete a consent usage of Risperdal for Resident #71. She explained they do not currently have a clinical team and there are some items that have been missed. She reported she was not aware Resident #41 had three medications for depression. Director C further stated their consulting psychiatric group provides them with a list of medications that need to be adjusted and that list is provided to the DON (Director of Nursing). Director C stated she cannot attest if their previous DON was acting upon those recommendations. Director C reported if the information is not located in the chart, then they do not have it. She added they are aware of the issues with psychotropic medications program, and they are working to solve it. Resident #58: On 2/14/22 during initial tour, Resident #58 was observed enjoying his lunch that was just delivered and appeared to be in good spirits. On 2/15/22 at approximately 8:50 AM, a review was completed of Resident #58's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included, Aphasia, Schizophrenia, Vascular Dementia and Major Depressive Disorder. Resident #58 is independent in most of his daily care but does require supervision or limited assistance for some. Further review was completed of his chart and the following was revealed: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician Orders: - FYI: Invega injection is given at the VA (Veterans Hospital). Do not order. This order was initiated on 12/16/2019. Care Plan: Focus: At risk for behavior symptoms r/t mental illness due to diagnoses of schizophrenia. Interventions: .Resident will continue to follow with the VA for mental health services . There is no mention of Resident #58 being administered Invega at the VA hospital. There was no other documentation located in Resident #58's chart that indicated the following related to his Invega Injection: - Dosage - Frequency - Site of administration - Monitoring for adverse signs/signs at injection site upon return - Any GDR's attempted - Who administers the Invega - Collaboration with the VA Hospital Mental Health team - Who his mental health team is at the VA Hospital - When his last injection was On 2/16/22 at 11:35 AM, an interview was conducted with Social Services Director C regarding Resident #58's Invega injection. Director C was queried as to why the resident required such a potent antipsychotic. She reported she was not certain why he received Invega. Director C additionally was not able to tell this writer the frequency of his injections, dosage, site of injection and who is monitoring the resident upon his return from receiving his injection. Director C denied their being any collaboration between the facility and the VA. On 2/22/22 at 10:20 AM, Director C reported Resident #58's mother schedules his appointments and transports him to the VA for his injections. She verified there is no monitoring of any sort occurring regarding his Invega. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/22/22 at 2:23 PM, this writer requested the psychotropic medications policy to include duplicate therapy, GDR's, monitoring and consents from the Administrator. The same policy was again requested on 2/23/22 at 7:26 AM. At the conclusion of the survey the polices requested were not received. According to the SOM (State Operations Manual).Duplicate therapy is generally not indicated, unless current clinical standards of practice and documented clinical rationale confirm the benefits of multiple medications from the same class or with similar therapeutic effects .Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated .Monitoring of Psychotropic Medications: When monitoring a resident receiving psychotropic medications, the facility must evaluate the effectiveness of the medications as well as look for potential adverse consequences. After initiating or increasing the dose of a psychotropic medication, the behavioral symptoms must be reevaluated periodically (at least during quarterly care plan review, if not more often) to determine the potential for reducing or discontinuing the dose based on therapeutic goals and any adverse effects or functional impairment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 39059 Based on observation, interview and record review, the facility 1) Failed to store medications in a safe and organized manner and monitor medication storage refrigerator temperatures for three of three medication rooms reviewed , 2) Failed to lock a medication cart leaving the narcotic drawer opened five inches with the keys in the lock, 3) Failed to date an opened vial of insulin for Resident #46, 4) Failed to document proof of narcotic shift-to-shift reconciliation and 5) Failed to store an inhaler and nasal spray properly for Resident #87, resulting in unsafe medication storage, the likelihood of increased cost to residents, the likelihood of decreased efficacy of medications stored in refrigeration and the likelihood of narcotic drug diversion. Findings include. On 2/10/22, at 1:05 PM, an observation of the medication cart on the central short hallway was conducted. The medication cart was observed unlocked with the keys in the narcotic lock with the narcotic drawer opened five inches. There were no staff members near the cart. On 2/10/22, at 1:06 PM, Unit Manager C and CNA M were standing at the nurses station talking. CNA M was asked if they had seen the nurse. CNA M stated, that they hadn't seen the nurse in about 10 minutes. Unit Manager C turned and walked toward the medication cart and was asked if they normally leave the keys in the narcotic drawer with the narcotic drawer opened and Unit Manager C stated, No and instructed CNA M to go find the nurse. On 2/10/22, at 1:08 PM, Nurse N walked through the doorway that lead from the back hallway and stated they had walked off the unit for an emergency phone call. Nurse N was asked if they had left the narcotic keys in the drawer unlocked and open and Nurse N stated they must have left the keys in the drawer and they recently gave a narcotic medication to a resident prior to taking their phone call. On 2/10/22, at 1:10 PM, a record review of the NARCOTIC and CONTROLLED SUBSTANCE SHIFT-TO-SHIFT COUNT SHEET along with Unit Manager C and Nurse N revealed that Nurse N had not signed the reconciliation form that morning. On 2/10/22, at 1:13 PM, Unit Manager C and Nurse N conducted a narcotic count reconciliation for the central short hallway medication cart that revealed no missing narcotics. On 2/10/22, at 1:20 PM, Nurse N was asked how long they were off the floor and Nurse N stated, just long enough for the phone call. Nurse N was asked how long their phone call was and Nurse N stated, they couldn't review the history on their phone as the call kept dropping. Nurse N refused to offer how long they were off the floor on the phone. (continued on next page)

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Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/22, at 10:15 AM, an observation of medication room in the central hall was conducted along with Nurse G. There were 5 large gray tubs that housed numerous medications some in pharmacy bags, some in clear plastic bags, some were in bottles brought in from home, some in small, labeled boxes, some in pharmacy sleeves, some loosely scattered without labels or resident names, numerous loosely stored bottles of liquids, inhalers and eye drops. There were no pharmacy forms noted with the medications. Nurse G was asked who the medications belonged to and Nurse G opened up each of the five tubs of medications and stated, some of these people aren't here anymore and offered, I don't know why some of these are still in here because we don't even use this pharmacy anymore. On 2/14/22, at 10:39 AM, an observation of medication room in the east hall was conducted along with Infection Control NurseF. There were numerous blue pharmacy bags piled on top of the counter. The medication refrigerator housed numerous medications. There was a urine specimen on the bottom of the refrigerator dated 2/2/22. Nurse F was asked if they normally store urine specimens along with refrigerator medications and Nurse F stated, No we shouldn't. There was a gray tub that housed numerous loose medications without resident names and labels. There were eleven intravenous antibiotics in a pile on the back of the handwashing sink. On exit of the medication room, there was a gray tub noted on the counter behind the east nurses station. There were various types of snacks. There was a blue pharmacy bag in the tub surrounded by the food items. Inside the blue pharmacy bag was a vial of insulin that was labeled with a fill date of 1/11/22. Nurse F was asked why the insulin was in the blue pharmacy bag and Nurse F stated, the pharmacy delivers medications that require refrigeration in the blue pharmacy bags. Nurse F was asked if the insulin should have been in the refrigerator and Nurse F stated, yes. Nurse F was asked if the blue pharmacy bag was normally stored in the snack tub and Nurse F stated no and dumped out all the snacks into the trash. On 2/14/22, at 11:00 AM, an observation of the north medication room was conducted along with Nurse P. There was a thermometer hanging from the top shelf that revealed a temperature of 54 degrees Fahrenheit. There were 3 plastic containers of medications on the top shelf of the refrigerator. There was a clip board with a document labeled REFRIGERATION AND ROOM TEMPERATURE LOG Month and Year January 2022 with a highlighted written note that stated, Checked twice a day. There were no entries for the month of January 2022 noted on the document. There were no other temperature logs observed. On 2/14/22, at 11:05 AM, the Administrator was asked if the refrigerator in the North Medication room was broken and offered they would have Maintenance lead A check the function of the refrigerator. On 2/14/22, at 11:10 PM, Maintenance lead A entered the medication room, opened up the refrigerator and aimed the temperature gun quickly all over the refrigerator with temperatures ranging from 43 to 55 degrees Fahrenheit. Maintenance lead A was asked to aim the temperature gun at the top shelf and the temperature read 55 degrees Fahrenheit. Maintenance lead A moved a plastic tub off the top shelf and stated this shouldn't be blocking the fan, turned down the refrigerator and stated that they will recheck the temperature shortly. On 2/14/22, at 11:55 AM, an observation of the North medication refrigerator along with Maintenance lead A was conducted. The temperature read 43 degrees Fahrenheit. The three plastic tubs of medications remained in the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/22, at 12:05 PM, a record review of MEDICATION/VACCINE REFRIGERATOR TEMPERATURE LOG February 2022 for east medication refrigerator revealed no temperature entries for the following dates: 2nd, 3rd, 6th, 7th, 8th, 9th, 10th, 11th, 12th, 13th and 14th. There was a clip board with the following logs for the following months [DATE] [DATE] November 2021 all with missing dates. On 2/22/22, at 1:00 PM, a record review of the facility provided Medication and Biological Storage Requirements Review Date: 1/5/2018 revealed The pharmacy dispenses medication (s) in containers that meet legal requirements, including the standards set forth by the Unites States Pharmacopeia (USP). Medications are to be kept in these containers . Oral medication (s) are stored separate from other mediation (s) or biological's such as suppositories, eye drips, nasal spray, insulin, lotions and liquids . Controlled medication (s), narcotics, are stored separately form other medication (s) in a locked drawer or compartment designated for that purpose . Medication (s) requiring storage in a refrigerator are kept at temperatures maintained between 2 and 8 C (Celsius) (36 and 46 F (Fahrenheit)) Medication (s) requiring storage in cold are kept at temperature not exceeding 8 C (46 F) Medication storage areas are to be kept clean, well lit, free of clutter and free of extreme temperatures . A review of facility provide policy Medication Returns, Credits, and Destruction Review Date: 1/12/2018 revealed When medication (s) are discontinued, the facility should evaluate the medication (s) for return to the pharmacy for credit or destruction and disposal at the facility . All items returned to the pharmacy, regardless of credit status, MUST be logged on a Medication Return Form . Medication (s) being returned to the pharmacy MUST be bundled neatly with the Medication Return Form copies and placed in the pharmacy return tote (i.e. placed in a bag, rubber banded together). 28834 Resident #46: On 02/22/22 at 10:56 AM, Licensed Practical Nurse (LPN) G was observed as she prepared the insulin or Resident #46. The lispro insulin had no pharmacy label on the bottle and no date it was opened. LPN G stated It must have fallen off. LPN G drew 12 units of the insulin into a syringe and administered it into the right upper arm of Resident #46 who was lying in her bed. The Food and Drug Administration regulates the requirements of drug labels. Prescription labels should include a name of the person, the drug, the dosage, the directions for taking and storing the medication, the number of doses in the bottle, the prescribing practitioner, information about the pharmacy that filled the prescription, the prescription number, the date it was filled, the number of refills allowed, and the date it should no longer be used. At the website Drugs.com on 2/24/2022, when lispro is in use and open, it is only good for 28 days. Therefore, the date opened would be important to know since it should be disposed in 28 days. 38471 Resident # 87: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/22 at 12:25 PM, Resident #87 was observed resting in her room. On her bedside table in a pink basin was a Symbicort inhaler and Flunisolide nasal spray. Resident #87 was queried as to how long the medication has been in her room and she reported it had been there for about 5 days. She stated the nurses leave it with her to use when needed. She reported the nurses have never asked her the frequency of her usage of these medications. The Symbicort inhaler did not have a label on it that indicated whom the inhaler was for. On 2/14/22 at 12:35 PM, a review was completed of Resident #87's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Atrial Fibrillation, Dysphagia, Polyneuropathy and Congestive Health Failure. Resident #87 is cognitively intact and able to make her needs known. Further review was completed of Resident #87's medical record and it showed the following: Physician Orders: Symbicort Aerosol- 2 puffs inhale orally two times a day for COPD (Chronic Obstructive Pulmonary Disease) - Ordered on 10/27/21 Flunisolide Solution 25 MCG (microgram) /ACT - 2 sprays in both nostrils two times a day for allergies. - Ordered on 10/27/21 MAR (Medication Administration Record) Review was completed of Resident #87's February 2022 MAR and it indicated the resident was administered Flunisolide and Symbicort 29 times. It unknown how many of those times Resident #87 administered the medication herself. There was not a physician order, facility evaluation or care planned intervention for self-administration of medications. On 2/15/22 at 8:45 AM, the Symbicort inhaler and Flunisolide nasal spray was still in the pink basin on Resident #87's bedside table. On 2/15/22 at 2:40 PM, Resident #87 reported the nurse administered her medications prior to lunch and took the inhaler to reorder it. On 2/15/22 at 2:45 PM, an interview was conducted with the Infection Preventionist (previously ADON (Assistant Director of Nursing) regarding Resident #87 administering her own medications. The Infection Preventionist expressed he was not aware Resident #87 had an inhaler and allergy spray at bedside. This writer and the ICP reviewed Resident #87's care plan, physician orders and assessments and there was nothing in her record that indicated she was able to self- administer her medications. He reported in this case the medications should not have been at her bedside for her to administer. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/15/22 at 3:10 PM, Nurse G was queried about Resident #87's having her medications at her bedside. Nurse G explained when she worked last week the resident's Symbicort was secured in the medication cart. She reported today she was preparing to administer Resident #87's medications and saw her Symbicort was not in the designated box on the medication cart. She reported the Flunisolide was in there, so she did take that into the room with her. Nurse G reported once in the residents' room she saw the Symbicort and Flunisolide in the pink basin on her bedside table. She explained the resident can administer her inhaler but not the Flunisolide. Nurse G expressed she is an agency nurse and is not sure for the process at this facility for self- administration of medications. On 2/16/22 at 3:55 PM, an interview was conducted with the DON (Director of Nursing) regarding the observation related to Resident #87's medications at bedside. The DON reported if the resident was able to administer her own medications she would have a physician order, assessment, and care-planned intervention. The DON stated to her recollection there are no residents at the facility that are able to self-administer medications. On 3/1/22 at 1:00 PM, a review was completed of the facility policy entitled, Self-Administer of Medications. The policy stated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so .In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment . Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the residents' room, the medications of residents permitted to self-administer will be stored on central medications care or in the medication room .

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview, and record review the facility failed to timely address one resident's (Resident #2) dental needs, resulting in Resident #2's teeth having a copious amount of milky white, build them on them and the possibility of requiring tooth extractions. Findings include: Resident #2: On 2/14/22 at 10:52 AM, Resident #2 was observed resting in bed and reported she needed a dentist appointment as her teeth her falling out. Resident #2 continued when she last saw the dentist, they told her to brush her teeth (due to the buildup). There was a milky white build-up on Resident #2's teeth that covered about 1/3rd of her teeth (starting at the gums). She reported staff are not completing oral care and while informing this writer of this she began to cry. On 2/14/22 at approximately 2:30 PM, a review was completed of Resident #2's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder, Atrial Fibrillation, Kidney Disease and Heart Disease. Resident #2 is cognitively intact and can express her needs. On 2/16/22 at 11:30 AM, an interview was conducted with Social Worker C regarding Resident #2's dental needs. Social Worker C explained their dental company comes quarterly. She reported if a referral is needed, the nursing staff will alert the Social Worker and a referral will then be completed. Social Worker C was questioned if Resident #2 had recently been seen by their dental group and she reported she had, and the dental group identified Resident #2 had a lot of buildup on her teeth but does not remember the exact recommendation. She reported the buildup appeared to be from Resident #2's teeth not being brushed adequately. The note from that set of dental group visits were emailed to Director of Nursing (different from their current Director of Nursing) and the Social Worker reported she will try to locate them. On 2/22/22 at 9:15 AM, a review was completed of Resident #2's hard chart for the dental records. There was nothing found in the hard chart relating to her most recent visit with the dental group. Review was completed of the electronic chart, and it was noted she was seen on 9/28/2021 but the dental group but there were no other supporting documentation located. A 30-day look back of oral care was completed and facility staff were documenting Resident #2 was receiving oral care on almost a daily basis. It is unknown how this was documented as occurring with the observation of Resident #2's teeth. On 2/22/22 at 10:20 AM, Social Worker C reported the last time dental was in the building was 9/24/21. The Social Worker was not able to locate the dental notes form Resident #2's visit and stated she was informed their dental group does not send their notes to the facility timely. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/23/22 at 10:00 AM, a review was completed of the facility policy entitled, Dental Services. The policy stated, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care .All dental services provided are recorded in the resident's medical record .

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 39059 Based on observation, interview and record review, the facility failed to provide coffee, tea and other beverage choices during the lunch meal for the Unit Medbridges/North hallway, resulting in 37 residents not having an alternative or preferred beverage choice for hydration. Findings include. On 2/14/22, at 12:30 PM, an observation of a lunch tray from the Medbridges/North hallway tray cart revealed no coffee, tea or other beverage offered. On 2/15/22, at 12:45 PM, an observation of the kitchen provided lunch cart was conducted for the Medbridges/North hallway. There were numerous trays of food in Styrofoam disposable containers and trays. There were cartons of milk noted with no coffee, tea or other beverages seen. There was no coffee cart offered. ON 2/15/22, at 12:50 PM, an observation of lunch meal was conducted. The meal ticket provided with the tray stated honey glazed ham orange twist seasoned roasted potatoes braised red cabbage dinner roll margarine lemon pudding whipped topping whole milk hot coffee or hot tea cream 1 pepper 1 sugar. There was no coffee, hot tea, or any other fluid choice offered on the tray. On 2/15/22, at 12:55 PM, Nurse P was asked if the facility offered coffee or tea during lunch and Nurse P stated, that they hadn't seen coffee offered in quite some time. On 2/15/22, at 1:00 PM, a record review of the facility provided Daily Census Unit: MedBridge revealed a total of 37 residents. On 2/22/22, at 2:42 PM, a phone interview with Dietician B was conducted. Dietician B was aware of tray observations and that only milk was offered for a fluid choice. Dietician B was asked if the kitchen was offering coffee, tea and other beverage choices during meals and Dietician B stated, they should be.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 39083 Based on observation, interview, and record review, the facility failed to properly dispose of garbage, resulting in pest harborage conditions, affecting the facility premises. Findings include: On 2/14/22 at 1:52 PM, approximately 30 trash bags were observed on the ground outside of the trash compactor. At this time, Maintenance Director A stated that they have been educating staff to properly dispose of the trash but are still having issues, specifically with agency staff that are new to the facility. Maintenance Director A continued to say the trash bags pile up over the weekend when management is not present. Maintenance Director also stated that the trash compactor can be unfamiliar to some staff and that might be a reason why trash bags end up on the ground. According to the facility's, Garbage Disposal, policy, not dated, it notes, It is everyone's responsible for the proper management of waste . 5. Take all trash to dumpster and deposit it inside and shut the lid . Do not put Trash on ground around Dumpster.

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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. 37668 Based on observation, interview and record review, the facility failed to institute and operationalize policies and procedures to ensure comprehensive administrative oversight of facility programs and knowledge of residents' conditions and care needs for all 97 residents residing in the facility. This deficient practice pertains to multiple levels of facility management and oversight and resulted in a lack of administrative knowledge of current and past medical conditions and histories of residents including, but not limited to, inaccurate and conflicting knowledge of residents' pressure ulcers, contractures, lack of safe medication administration and storage, lack of oversight and the assurance of the provision of nutrition, withholding of residents' personal belongings, the lack of the provision of necessary services, and the likelihood of current and ongoing psychosocial distress, utilizing the reasonable person concept, and a decline in the overall health and well-being for all 97 facility residents. Findings include: On 2/10/22, at 11:53 AM, during entrance conference with the Administrator, the Administrator was asked what the Resident Census was, and the Administrator stated that the census was 97 residents. Review of the facility-provided CMS-672 Form, Resident Census and Conditions form, detailed the following: - Facility Census was 97 residents - Six residents with pressure ulcers, excluding Stage I (intact skin, non-blanchable redness usually over a bony prominence) pressure ulcers. The CMS-672 form detailed that three of the six residents had pressure ulcers upon admission, meaning that three residents developed pressure ulcers in the facility. - 35 residents were diagnosed with Dementia - 36 residents in the facility with contractures. The form detailed 14 of the 36 residents had contractures upon admission, which meant that 22 residents developed contractures at the facility. Review of the facility-provided CMS-802 Resident Matrix form revealed the following: - Facility Census was 95 - 32 residents diagnosed with dementia - Two residents had pressure ulcers (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/10/22, at 3:30 PM, this surveyor entered Administrator's office. The Director of Nursing (DON) and the Corporate [NAME] President (VP) T were also present. The Administrator was asked if the CMS 672 and 802, which were provided upon entry, were accurate and the DON answered Yes. The Administrator was asked to provide an alphabetized list of all residents in the building. On 2/10/22, at 3:35 PM, a record review of the facility-provided alphabetized resident list revealed a total of 100 residents which did not match CMS forms 672 (97 residents) and the 802 (95 residents.) On 2/10/22, at 3:40 PM, a record review was conducted with the DON of the facility-provided CMS 672, CMS 802 and the alphabetized census. The DON was asked to review the documents and offer the actual census of the building. The DON explained that residents will stay on the census list until they are moved to the bed hold list. The DON explained, utilizing actual resident names, seven residents had a bed hold and an additional resident, who discharged the day before, that resident would move to the bed hold list after 24 hours has passed. The DON was alerted that the alphabetized census sheet shows 100 residents and that the one resident who left the day before minus that number equals 99, which still does not match any of the provided census numbers. The DON was unable to explain. On 2/10/22, at 4:00 PM, this surveyor entered the Administrator's office. Corporate VP T and the DON were also present. The Administrator was asked who completed the 672 and 802 and were the documents completed on site or at the corporate office, which is out of state. The DON answered that she had completed the documents today with the help of Corporate VP T. The Administrator was alerted that the CMS 672 form, the CMS 802 form and the alphabetized census sheet all did not match. The DON was asked to walk the building with the surveyor and count the residents one by one. The Administrator stated that wasn't necessary and was confident that the census of 97 was accurate. On 2/15/22 at 7:51 AM, a tube feeding observation occurred. The tube feeding tube was programmed incorrectly and infusing the water flush continuously at the incorrect rate. The pump settings detailed that the resident had received no nutritional tube feeding solution since it was started at 3:00 PM on 2/14/22. The resident was dependent upon the tube feeding solution for all their nutrition. An interview was completed with Licensed Practical Nurse (LPN) R on 2/15/22 at 8:36 AM. When queried who had initiated the resident's tube feeding, on 2/14/22, LPN R indicated it was another agency nurse who was a new LPN. When queried regarding orientation to the facility and equipment for agency staff, LPN R revealed they do not receive a real orientation to assess ability and educate as needed regarding equipment. When queried why the pump was not checked by any other nursing staff throughout the night and day, an explanation was not provided. On 2/15/22 at 1:35 PM, the requested list of residents with wounds was received from the DON. The list was titled, Wound Rounds and included 12 residents. A list of Residents with contractures was requested from the facility Administrator on 2/16/22 at 8:21 AM. The Administrator was asked to indicate on the list which residents had facility-acquired and/or worsened contractures. An interview was conducted with the facility Administrator on 2/16/22 at 11:51 AM. The Administrator was queried regarding facility policy/procedure regarding alternating air mattresses including initial set up, settings, and monitoring. The Administrator replied, Not sure. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted with the facility Administrator and the [NAME] President (VP) of Operations CC on 2/16/22 at 11:57 AM. The Administrator was asked the name of the facility Restorative Nurse and stated, We don't have one. With further inquiry, both the Administrator and VP CC revealed they did not have a restorative program. VP CC then stated, No one has one. When asked what they meant, VP CC revealed no skilled nursing facilities have a restorative program and/or nurse at this time. The Administrator requested an interview for clarification be completed with Corporate Consultant Registered Nurse (RN) DD. On 2/16/22 at 12:03 PM an interview was completed with RN DD. When queried regarding restorative nursing services and program in the facility, RN DD stated, When we do daily care, we incorporate restorative with that. RN DD was then asked where tasks including ROM and splint/brace application are documented and replied, The CNA's document. An interview was completed with CNA Y on 2/16/22 at 12:13 PM. When queried regarding completion and documentation of ROM activities and splint brace application as it pertains to a restorative nursing program, CNA Y stated, Never told to do ROM. When asked if they provided ROM activities to any of the facility residents, CNA Y revealed that they did not. On 2/16/22 at 12:23 PM, an interview was completed with CNA X. When asked if they completed ROM for Resident's they were assigned to care for, CNA X replied, No. With further inquiry, CNA X revealed they were never taught ROM at the facility. An interview was completed with CNA EE on 2/16/22 at 1:29 PM. When queried if they completed ROM and/or restorative activities with facility Residents, CNA EE replied, No, we don't do that. A list of residents was received from the Administrator on 2/16/22 at 3:27 PM. The list included 35 residents but did not distinguish which residents had facility-acquired and/or worsened contractures. An interview was conducted with the DON on 2/16/22 at 3:29 PM. When queried who is responsible to monitor and ensure alternating air mattresses were functioning and set to the appropriate settings, the DON stated, I don't know. On 2/16/22 at 4:12 PM, an interview was conducted with the Director of Nursing (DON). When queried regarding observation of a resident's tube feeding pump being programmed incorrectly, the resident not receiving any nutrition, and training/competency assessment for agency nursing staff, the DON indicated they were not aware the resident did not receive any nutrition as ordered. No further explanation was provided. Upon request for information regarding facility residents with pressure ulcers, the facility Administrator provided a list of three residents with pressure ulcers on 2/17/22 at 10:52 AM via email. When queried, the Administrator revealed that three residents present on the list had facility-acquired or worsened pressure ulcers. The email elaborated, We take responsibility for the worsening. So, they are in turn considered acquired. This is as many as I found. I will have to look deeper for any others. The Administrator was asked to identify and provide documentation of all facility residents with pressure ulcers. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A list of residents with alternating air mattresses and a policy/procedure pertaining to the use, care, and monitoring of alternating air mattresses was not received by the conclusion of the survey. The policy was requested on 2/16/22 at 11:51 AM and 2/22/22 at 1:25 PM. The Administrator provided a list residents with contractures on 2/17/22 at 3:42 PM. Upon review of the list, it was noted the list included nine residents with pressure ulcers. An interview and review of provided information of residents with contractures was conducted with the facility Administrator on 2/22/22 at 11:15 AM. The Administrator was queried regarding the discrepancies in the number of residents with contractures and stated, I'm not sure why the contracture doc is different numbers. The Administrator was asked why the facility documentation provided did not include the requested information of which residents had facility-acquired and/or worsened contractures. The Administrator did not provide an explanation. With further inquiry, the Administrator revealed the facility did not have an MDS nurse at the facility. On 2/22/22 at 12:53 PM, an interview was completed with Regional MDS Nurse AA. MDS Nurse AA was asked how many residents within the facility have contractures and replied, The MDS looks at deformities, disuse or pain causing limitations in ROM. When queried if regarding the discrepancies in the number of residents with contractures on the lists provided and the number on the CMS-672 form, MDS Nurse AA revealed the number provided on the CMS-672 form is pulled from the MDS data but was unable to provide an explanation related to the discrepancies. When asked how resident ROM and/or contractures are assessed, evaluated, and monitored, MDS Nurse AA replied, Definitely need to know if it is a true contracture. When queried how the facility ensured residents maintained their current level of functioning and mobility when they are maintaining and completing accurate records of current function level, MDS Nurse AA stated, We have therapy that does their screening. When queried regarding a Restorative Nursing Program in the facility, MDS Nurse AA stated, I haven't seen any restorative myself. MDS Nurse AA was then queried regarding completion and documentation of ROM activities and splint/brace application and replied, I definitely see where there is room for improvement with that. MDS Nurse AA did not provide a number of residents with contractures and/or limitations in ROM when asked. An interview was conducted with Therapy Director BB on 2/22/22 at 2:36 PM. When asked, Therapy Director BB stated there were 10 people (residents) that they were aware of with contractures in the facility. With further inquiry regarding a Restorative program and the provision of ROM to prevent decline in function, Therapy Director BB confirmed the facility does not have a Restorative program. Therapy Director BB indicated CNA staff complete ROM activities and brace/splint application for residents. When queried regarding training for CNA staff, Director BB revealed they do not provide training. When asked how the facility identifies, prevents, and monitors residents to prevent decline in ROM, function, and contractures, Director BB indicated residents are screened by therapy. When queried if Therapy measures the degree of flexion and extension in residents' joints, Director BB stated, No, we usually don't. When asked how they determine worsening in ROM if they do not measure and/or document degree of movement, Director BB revealed therapy staff only document if ROM is Within Normal Limits (WNL) or impaired. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Director BB was then asked how many residents had limitations in ROM and replied, I doubt anyone has full ROM. With further inquiry, Director BB stated, No (Residents) had had to change their device, that is what I would consider when looking for decreases in ROM. When queried any residents had developed new limitations in ROM, Director BB revealed one resident, who is at the hospital and not currently in the facility, is the only one. Director BB stated, They are getting tighter, and we had to order braces, but they aren't contracted so we don't count them. When asked if tightening is considered a contracture, a response was not provided. Director BB then revealed another resident also had one finger that was getting tighter. All available therapy evaluation documentation was requested at this time but not received by the conclusion of the survey. On 2/22/22 at 5:27 PM, an interview was conducted with the Administrator. When queried why residents, who had pressure ulcers, were included on the facility-provided list of residents with contractures and why the residents listed as having pressure ulcers on that list were did not match the information provided on the CMS 672 and CMS 802, the Administrator was unable to provide an explanation. When asked how the facility monitored and assessed skin integrity and pressure ulcers when they where not aware of who had alterations in skin integrity, an explanation was not provided. An interview was completed with the facility Administrator on 2/23/22 at 8:39 AM. When queried regarding the lack of facility knowledge of residents with contractures and limitations as well as the discrepancies noted in facility-provided documentation, the Administrator was unable to provide further explanation. 39059 On 2/10/22, at 11:53 AM, during the entrance conference with the Administrator, the Administrator was asked what the Resident Census was and the Administrator stated that the census was 97 residents. The Sunnyside dining room, across from the administrator's office was noted to be full of piles of boxes and bags. The Administrator stated that it was residents belongings that were stored there during their COVID-19 outbreak. There was a plethora of observations of resident rooms, during the survey that were bare of personal affects that would provide the room with a homelike setting versus institutional sense. On 2/10/22, at 3:24 PM, a record review of the facility-provided CMS 672 revealed 35 residents were diagnosed with Dementia and a census of 97 Total Residents. A review of the facility provided CMS 802 revealed only 32 residents were diagnosed with Dementia and a total of only 95 residents. Medication Storage: On 2/14/22, at 10:15 AM, the central hall medication room was observed unkept with medications stored in boxes on the floor. There were 5 large grey tubs that housed numerous medications some in pharmacy bags, some in clear plastic bags, some were in bottles brought in from home, some in small, labeled boxes, some in pharmacy sleeves, some loosely scattered without labels or resident names, numerous loosely stored bottles of liquids, inhalers and eye drops. There were no pharmacy forms noted with the medications. Nurse G was asked who the medications belonged to and Nurse G opened up each of the five tubs of medications and stated, some of these people aren't here anymore and offered, I don't know why some of these are still in here because we don't even use this pharmacy anymore. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/22, at 10:39 AM, an observation of medication room in the east hall was conducted along with Infection Control NurseF. There were numerous blue pharmacy bags piled on top of the counter. The medication refrigerator housed numerous medications. There was a urine specimen on the bottom of the refrigerator dated 2/2/22. Nurse F was asked if they normally store urine specimens along with refrigerator medications and Nurse F stated, No we shouldn't. There was a grey tub that housed numerous loose medications without resident names and labels. There were eleven intravenous antibiotics in a pile on the back of the handwashing sink. On exit of the medication room, there was a grey tub noted on the counter behind the east nurses station. There were various types of snacks. There was a blue pharmacy bag in the tub surrounded by the food items. Inside the blue pharmacy bag was a vial of insulin that was labeled with a fill date of 1/11/22. Nurse F was asked why the insulin was in the blue pharmacy bag and Nurse F stated, the pharmacy delivers medications that require refrigeration in the blue pharmacy bags. Nurse F was asked if the insulin should have been in the refrigerator and Nurse F stated, yes. Nurse F was asked if the blue pharmacy bag was normally stored in the snack tub and Nurse F stated no and dumped out all the snacks into the trash. On 2/14/22, at 11:00 AM, an observation of the north medication room was conducted along with Nurse P. There was a thermometer hanging from the top shelf that revealed a temperature of 54 degrees Fahrenheit. There were 3 plastic containers of medications on the top shelf of the refrigerator. There was a clip board with a document labeled REFRIGERATION AND ROOM TEMPERATURE LOG Month and Year January 2022 with a highlighted written note that stated, Checked twice a day. There were no entries for the month of January 2022 noted on the document. There were no other temperature logs observed. Nutrition Services: During resident record reviews, the facility failed to obtain weights and ensure nutritional oversight per policy for resident care needs, resulting in Resident #35, Resident #45, Resident #48 and Resident #70 having incomplete weight records. On 2/15/22, at 9:41 AM, a record review of Resident #35's electronic medical record revealed an admission on 12/6/2021 with diagnoses that included Dementia, Tremors and protein-calorie malnutrition. A review of the Weight Summary revealed only one weight listed Date 12/8/2021 Value 143.0 lbs (pounds) On 2/15/22, at 10:38 AM, a record review of Resident #45's electronic medical record revealed an admission on 6/9/21 with diagnoses that included Cerebral Infarction (stroke), age related physical debility and Dysphagia. A Review of the Weight Summary revealed 1/11/2022 Value 294.0 Lbs and on 1/25/2022 Value 272.0 Lbs a 22 pound weight loss. A review of the progress notes revealed no progress note notifying the physician or dietician of the weight loss. On 2/22/22, at 11:05 AM, record review of Resident #70's electronic medical record revealed an admission on 1/15/22 with a readmission on 1/26/22 with diagnoses that included end stage renal disease requiring dialysis, metabolic encephalopathy and Diabetes Type 2 with complications. A review of the weight summary revealed no weights were listed. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/22/22, at 11:57 AM, a record review of Resident #48's electronic medical record revealed an admission on 1/5/22 with diagnoses that included Sarcopenia, Lumbago and muscle weakness. A review of the Dietician_Review Date: 1/10/2022 admission assessment revealed Dietician Review 1. Current Diet Order & supplements was left blank. 1.a. Does the resident have any food allergies/intolerances The boxes for yes or no were not check marked. 4. Most recent Weight was left blank. There was a typed note that revealed Additional comments/recommendations . poor app (appetite) . lap band . The residents usual body weight was not listed. A review of the progress notes revealed no other dietician/nutritional notes. A review of the weight summary revealed no weights were obtained since admission. On 2/22/22, at 3:01 PM, Dietician B was asked why Resident #70 had not had a weight since admission and Dietician B stated, the resident came in on the 15th, went out and came back on the 26th and was aware there was no weight listed. Dietician B stated, that they provide the nursing department with a list of weights needed and when they return the following week and either the weights don't get done or the list gets lost. On 2/22/22, at 3:04 PM, Dietician B was asked if they were aware of Resident #45's recent weight loss and Dietician B stated, that the resident is on the list for a reweigh. Dietician B was asked if they notified the physician and Dietician B was unsure. Dietician B stated, that they give the reweigh list to nursing and tell them they need they weights done but either they don't get done or the list gets lost. On 2/22/22, at 3:07 PM, Dietician B was interviewed regarding Resident #48's request to see the dietician and Dietician B stated, that they did see the resident for the admission assessment, started it and had additional paper notes to add to the summary. On 2/23/22, at 1:30 PM, a record review of the facility provided undated policy Weight Assessment and Intervention revealed The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents . Weight Assessment . The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter . Weights will recorded in each unit's Weight Record chart or notebook and in the individual's medical record . The Dietician will review the unit Weight Record by the 15th of the month .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28834 Based on interview and record review, the facility failed to track, measure, investigate, and develop goals and identify and prioritize deviations from performance standards for quality standards, resulting in systemic problems that led to adverse events for individuals and all 97 of the residents in the facility. Findings include: The review of the Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement Plan (QAPI) took place on 2/22/22 beginning at 3:39 PM with the Nursing Home Administrator (NHA). The NHA had not provided a QAA committee information or the QAPI plan when requested upon entrance to the facility on [DATE] at 11:53 AM. The QAPI plan was requested again on 02/22/22 at 12:10 PM and not received by the end of the survey. The NHA stated that she had limited information about the QAA and QAPI programs as she had only been in the facility since October 21, 2021. On 02/22/22 beginning at 03:39 PM, the NHA stated that she was not aware of issues with pain, pharmacy reviews, respiratory equipment or feeding tubes but she was aware of issues with the infection control program and staffing. The NHA had thought the Director of Nursing was handling infection control as we didn't have an infection preventionist. We did not know the extent of the issues. We were focusing on COVID-19 and keeping track of that, was unaware they were not doing antibiotic stewardship. We were also focusing on staffing. We were not aware that the kitchen was not sanitizing floors and we thought they had taken care of the ceiling issues and roof leak. The NHA also reported on 02/22/22 at 03:39 PM that the company is very big on QAPI. I have not seen protocols yet for QAPI. We haven't had the opportunity to set goals and do performance evaluations as of yet.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28834 Based on interview and record review, the facility failed to implement an Antibiotic Stewardship program and protocols for the prescription of antibiotics resulting in the potential for the growth of antibiotic resistant organisms and opportunistic organisms affecting all residents of the facility. Findings include: The facility policy Antibiotic Stewardship, dated December 2016 (more than five years ago), stated that antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The purpose of the program was to monitor the use of antibiotics in our residents. The policy started with training and education of nursing staff on the importance of antibiotic stewardship, the appropriate use of antibiotics, and how inappropriate use of antibiotics affects individual residents and the overall community. The training was to include emphasis on the relationship between antibiotic use and Opportunistic infections (e.g. C difficile, candida albicans, etc.); Medication interactions; and the evolution of drug-resistant pathogens. The prescriber was to provide complete antibiotic order including the drug name; Dose; Frequency of administration; Duration of treatment; start and stop date, or Number of days of therapy: Route of administration; and Indications for use. Discharge or transfer records must include all of the above drug and dosing elements when a resident is admitted from another facility. This was the only document provided when the information related to antibiotic stewardship was requested on 2/22/2022 at 9:00 AM and 1:00 PM, although at the bottom of the policy, other related policies were available: Antibiotic Stewardship - Orders for Antibiotics; Antibiotic Stewardship -Review and Surveillance of Antibiotic Use and Outcomes: and Antibiotic Stewardship -Staff and Clinician Training and Roles. According to the Centers for Disease Control and Prevention, Candida normally lives on the skin and inside the body, in places such as the mouth, throat, gut, and vagina, without causing any problems. Candida can cause infections if it grows out of control or if it enters deep into the body (for example, the bloodstream or internal organs like the kidney, heart, or brain). Candida albicans is considered an opportunistic organism. On 2/22/22 beginning at 10:51 AM, a review of the infection control program was conducted with the designated Infection Control Registered Nurse (RN), Staff F. RN F stated that he was starting from scratch and had started at the facility on 1/17/2022. RN F indicated that the facility was using the McGeer criteria to define infections. The intent for the development of McGeer criteria was to provide standardized guidance for infection surveillance activities and research studies in nursing homes and similar institutions. (Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria, October 2012.) The facility did not provide any information related to antibiotic stewardship when asked for policies, procedures and protocols for infection prevention and control on 2/22/2022 at 9:00 AM. The RN Staff F stated there were no known meetings for Antibiotic Stewardship and he had no records for the previous ownership for infection control when the new corporation started running the facility in October 2021. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	RN F stated that he had just started the line listing for the facility for February 2022. The February line listing was presented. Not all of the columns were complete. There were eight names listed. The column for Date of Onset of Symptoms was not filled out for two residents. There was a key for Types of infections in a box at the top of the page, there was information in the column labeled Types of Infection that did not match the KEY. For example, the first resident listed was listed as having a phlebitis type of infection, that was not in the KEY. The second resident listed, was listed twice for bacteremia that was also not listed in the KEY. There were two more, conjunctivitis and Otitis media that were also not listed in the KEY. Four of the eight residents listed had no Signs & Symptoms of Infection listed in the column designated, two residents had a UA C & S listed in the column for Specific Diagnostic/lab testing, and none of the eight residents had anything in the column labeled for Causative Organism. Only the first of the eight residents listed had a checkmark in the column labeled Meets McGeer's Criteria? and no checkmarks were in the columns labeled Meets Loebs Criteria?, Meets Antibiogram Criteria?, Transmission-Based Precautions Other than Standard, and Repeat Diagnostic Testing if any/Date. During the interview on 2/22/2022 beginning at 10:51 AM, RN Staff F reported that a nurse practitioner had written orders for the antibiotic Ciprofloxacin for what she described as an infection, which was vague and did not meet the McGeer criteria. RN F further stated that he could find no signs and symptoms of infections or diagnostic criteria. RN F stated that he was going to have to educate her. RN F indicated that he last two entries for February 2022 were Resident #50 for a UTI and Resident #85 also for a UTI and were prescribed by the nurse practitioner. According to the KEY UTI was a Urinary Tract Infection. Resident #50: According to the Admission Record, printed 2/22/2022, Resident #50 was at [AGE] year old male originally admitted to the facility on [DATE] with diagnoses that included irregular heartbeat, high blood pressure, acute kidney failure, Covid-19 infection, and a stomach disorder. Resident #50 was listed with no date of onset of Symptoms, no signs & symptoms of infection were listed, the column meets McGeer's Criteria? was not checked, and no causative organism was listed. According to the line listing, the antibiotic Ciprofloxacin was started on 2/14/2022 and was to be administered for seven days. According to the Urinalysis performed on 2/11/2022, Resident #50 had slightly cloudy urine, the results were abnormal, indicating an infection, the final culture grew yeast. On 2/17/2022 the nurses notes indicated that Resident #50 had been switched to an antifungal drug, Fluconazole tablet 100 milligrams once a day for 10 days for the yeast in the urine and the Ciprofloxacin was discontinued. This was not reflected in the line listing. As noted above, yeast is considered an opportunistic organism. There was no individual report for the resident, one that would describe his risk factors. RN F was correct, the nurses notes were reviewed, the only entry was on 2/6/2022 at 10:07 PM stating Resident #50 stated that he thinks that he had blood in his urine. He was asked to provide a sample, blood pressure and pulse were recorded, the nurse noted that he had no complaints of pain. The next entry concerning his status for a UTI was an entry by the Nurse Practitioner on 2/14/2022 at 12:00 AM, when she noted that he had had blood in his urine. No other signs or symptoms were recorded, just that he had a positive urinalysis. She indicated that the Ciprofloxacin was started. On 2/14/2022 at 10:18 AM, a nurses note indicated that he had received the first dose of his antibiotic an had no pain or complaints. There was no note about his urine or his urinary tract signs or symptoms. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #85: According to the Admission Record, printed 2/22/2022, Resident #85 was an [AGE] year old female originally admitted to the facility on [DATE] with diagnoses that included chronic lung disease, dementia, irregular heartbeat, anxiety, heart failure, Covid-19 infection, depression, and a stroke. According to the Order Summary Report, printed 2/22/2022, Resident #85 had a gastrostomy tube inserted into her stomach for feeding and the nursing progress note on 2/5/2022 indicated Resident #85 had an indwelling urinary catheter. Resident #85 was on the line listing, the antibiotic Macrobid 100 milligrams one every six hours for 10 days was listed as beginning on 2/16/2022. There was no Date of onset of Symptoms, Signs & symptoms of Infection, causative organism, or Meets McGeer's Criteria listed in the columns. There was no individual report for the resident, one that would describe her risk factors. According to the progress note written by the Nurse Practitioner on 2/10/2022 at 12:00 AM for Resident #85, a urinalysis had been ordered a few days ago and it is still pending. The note indicated that Resident #85 had been on the antibiotics Augmentin Tablet 875-125 milligrams every 6 hours and Bactrim Double Strength 800-160 milligrams one tablet every 12 hours from 1/28/2022 to 2/1/2022 for both a UTI and pneumonia. The urinalysis noted was performed on 2/11/2022 and reported on 2/16/2022. The culture of the urine resulted in growth of the organism Vancomycin resistant enterococcus faecium. According to the Centers for Disease Control and Prevention, antibiotic resistance is when germs (bacteria, fungi) develop the ability to defeat the antibiotics designed to kill them. Enterococci bacteria are constantly finding new ways to avoid the effects of the antibiotics used to treat the infections they cause. Antibiotic resistance occurs when the germs no longer respond to the antibiotics designed to kill them. If these germs develop resistance to Vancomycin, an antibiotic that is used to treat some drug-resistant infections, they become Vancomycin-resistant enterococci (VRE). In 2017, VRE caused an estimated 54,500 infections among hospitalized patients and 5,400 estimated deaths in the United States. Those most likely to be infected with resistant organisms include those who have been on antibiotics before and those with medical devices. According to the Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria published in October 2012 on the website of the National Institutes of Health, the criteria for listing an infection as a UTI in a patient with a catheter includes a Urinary catheter specimen culture with the presence of any organism and symptoms that include: fever, new onset hypotension (low blood pressure), acute change in mental status or acute functional decline, new-onset suprapubic pain or tenderness, or a white discharge from around the catheter. None of these symptoms were documented for Resident #85. Resident #27: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the Admission Record, Resident #27 was a [AGE] year old female admitted to the facility on [DATE] and readmitted following a brief hospital stay on 1/28/2022. Resident #27 was ordered to be started on Vancomycin 1 Gram once a day for ten days to be given intravenously on 2/5/2022. The diagnosis provided on the February Medication Administration Record was BACTEREMIA which was also listed on the log and as described above, not defined in the KEY, in the McGeer's definitions of infections, or ordered as specified in the facility policy for Antibiotic Stewardship, dated 12/2016. There were no laboratory cultures to identify the organism that was being treated or if it was sensitive to the Vancomycin. On 2/22/2022 at 10:51 AM RN F stated that he had not attempted to retrieve information regarding the culture results from the laboratory where they were taken. There were no signs and symptoms described or a description of the laboratory tests performed in the progress notes. According to the Agency for Healthcare Research and Policy, a Division of the US Department of Health and Human Services, an Antibiogram A nursing home-specific antibiogram may be an effective and inexpensive tool for improving appropriate antibiotic prescribing. An antibiogram is a report that displays the organisms present in clinical specimens that nursing homes send for laboratory testing-aggregated across all residents for a certain time period-along with the susceptibility of each organism to various antibiotics. Referring to an antibiogram report enables prescribing clinicians to make prompt, empirically based decisions. Because antibiograms provide information on local susceptibility patterns, they may help to reduce prescribing of antibiotics with high resistance rates in nursing homes and emergency departments. RN Staff F had no antibiogram for the facility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28834 Based on interview and record review, the facility failed to implement and document administration of influenza and pneumonia vaccines and implement the influenza and pneumonia vaccination policies for eight residents (#87, #7, #82, #56, #8, #46, #25, and #35) out of ten residents reviewed for influenza and pneumococcal vaccinations, resulting in the potential for inaccurate documentation and inaccurate or missed administration of vaccines with resultant infectious respiratory diseases. Findings include: The facility policy Pneumococcal Vaccine, dated 2/2018, stated that All residents will be offered the Pneumococcal Vaccination(s) to aid in preventing pneumococcal infection (e.g., pneumonia) unless contraindicated. To avoid confusion, current recommendations recommend to wait at least 1 year should separate PCV13 (13-valent pneumococcal vaccine) and PPSV23 (23-valent pneumococcal polysaccharide vaccine). The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) had issued new recommendations in November 2019 and January 2022 so this policy was not updated to reflect the current recommendations. Residents were to be assessed for vaccination status within five working days of admission and offered vaccination within thirty days of admission. The residents were to be educated on the benefits and potential side effects of the pneumococcal vaccines and the provision of the education documented in the resident's medical record. The policy noted it was the resident's right to refuse vaccinations and the documentation would be entered into the medical record indicating the date of the refusal of the pneumococcal vaccinations. The administration of the pneumococcal vaccine would be made in accordance with current CDC or ACIP recommendations at the time of the vaccination. The facility policy for Influenza Vaccine, dated 2/2018, directed that all residents and employees who have direct contact with residents will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. Before the vaccination, the resident, or the resident's representative, or the employee would be provided information and education about the benefits and potential side effect of the influenza vaccine. the education was to be documented in the medical record. All resident and employees shall have documented evidence of information and education regarding the current year's influenza vaccine including the risk/benefits, and the administration or refusal of the influenza vaccine. The policy also stated, The Infection Preventionist (or designee) will maintain surveillance data on influenza vaccine coverage and reported rates of influenza among residents and staff. Surveillance data will be made available to staff as part of educational efforts to improve vaccination rates among employees. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Beginning at 10:51 AM on 2/22/22, The Registered Nurse (RN) who was responsible for infection control, Staff F, was interviewed. RN F stated that he had no information on influenza or pneumococcal vaccination rates. According to the facility data on the CMS form 672, dated 2/10/2022, the facility had a census of 97 residents. Just 16 residents were counted as having had an influenza vaccine or a rate of 16% and just 41 residents had been recorded as having had the pneumococcal vaccine or a rate of 42%. RN F stated that he had not had the opportunity to further investigate the residents' influenza and pneumococcal vaccines and that the previous person responsible for infection control had left sparse information for him. RN F stated that all vaccine refusals should have documented information about education, risk/ benefits, and the signed refusal uploaded to the medical record under the miscellaneous tab. Resident #87: According to the Admission Record, printed on 2/22/2022, Resident #87 was a [AGE] year old female admitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia, chronic heart failure, irregular heartbeat, chronic lung disease, morbid obesity, and a urinary tract infection. Under the Immunization tab of the electronic medical record (EMR), Resident #87 was documented Resident #87's refusal of the Influenza vaccine and no information about pneumococcal vaccines. Under the miscellaneous tab of the EMR, there was no information about influenza or pneumococcal vaccines. RN F was asked about this Resident #87 during the review of the infection control program which began at 10:51 AM on 2/22/2022, and stated that he also saw no vaccine information in her EMR. Resident #7: According to the Admission Record, printed on 2/22/2022, Resident #7 was a [AGE] year old male admitted on [DATE] with diagnoses that included an irregular heartbeat, delirium, high blood pressure, psychotic disorder, depression, personal history of COVID-19, and history of brain cancer. Under the Immunization tab of the EMR, Resident #7 had refused the influenza and pneumonia vaccines, but had been administered the Prevnar 13 immunization in 6/16/2021. There was no evidence of education about the vaccines and the declinations in the EMR. Resident #82: According to the Admission Record, printed on 2/22/2022, Resident #87 was an [AGE] year old female admitted on [DATE] with diagnoses that included dementia, difficulty swallowing chronic kidney disease, history of a heart attack, and a history of COVID-19. Under the Immunization tab of the EMR, Resident #82 had received the influenza vaccine on 12/10/2021 and 10/19/2020. There was no evidence that Resident #82 had been offered or received the pneumococcal immunizations, either the PCV or PPSV23. Resident #56: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the Admission Record, printed on 2/22/2022, Resident #56 was a [AGE] year old male admitted on [DATE] with diagnoses that included a stroke, a cognitive communication deficit, difficulty talking, high blood pressure, depression, heart disease, a history of a heart attack, history of COVID-19, and a contracture of his right hand. Under the Immunization tab of the EMR, Resident #56 had refused the influenza and pneumonia vaccines. There was no evidence of education about the vaccines and the declinations in the EMR. Resident #8: According to the Admission Record, printed on 2/22/2022, Resident #8 was a [AGE] year old female admitted on [DATE] with diagnoses that included a history of Covid-19, pneumonia due to Coronavirus disease 2019, Diabetes Mellitus, high blood pressure, arthritis, epilepsy, dementia, and anxiety. Under the Immunization tab of the EMR, Resident #8 had an influenza vaccine for the current year and had a Prevnar 13 vaccine that was historical. Resident #8 had no PCV23 listed and should have been offered a PCV23 according to the recommendations. Resident #46: According to the Admission Record, printed on 2/22/2022, Resident #46 was a [AGE] year old female admitted on [DATE] with diagnoses that included Type 1 Diabetes Mellitus, depression, bipolar disorder, schizophrenia, multiple pressure ulcers, a history of Covid-19, heart disease, and high blood pressure. Under the Immunization tab of the EMR, Resident #46 had no immunizations. There also was a record from the Michigan Care Improvement Registry where all immunizations can be found, and this report indicated that Resident #46 was DUE NOW for the Influenza vaccine. Resident #25: According to the Admission Record, printed on 2/22/2022, Resident #25 was a [AGE] year old female admitted on [DATE] with diagnoses that included Covid-19, anxiety, depression, high blood pressure, and arthritis. Under the Immunization tab, the influenza was documented as given for the previous year on 10/15/2020 and Not Eligible on the next line, although it was not explained why she was not eligible. The Prevnar 13 had been documented as Complete on 10/14/2020 and Consent Refused on the next line. The PPSV23 was documented as Not Eligible on two lines, although no explanation was provided. There was no information under the miscellaneous tab of the EMR. According to the CDC and ACIP current recommendations, she would have been eligible for both influenza and PPSV23 vaccines. Resident #35: According to the Admission Record, printed on 2/22/2022, Resident #35 was an [AGE] year old female admitted on [DATE] with diagnoses that included chronic lung disease, acute respiratory failure, arthritis, depression, anxiety, high blood pressure, dementia, and a history of Covid-19. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Under the Immunization tab, it was documented that the Influenza vaccine had been refused and there was no documentation regarding pneumonia vaccines in the EMR. There was no documentation uploaded in the miscellaneous tab for vaccines.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 39083 Based on observation, interview, and record review, the facility failed to maintain the dish machine to properly sanitize dishware, resulting in the potential contamination of dishware affecting all residents that consume food from the kitchen. Findings Include: On 2/9/22 at 12:00 PM, during an inspection of the alternative temporary kitchen, a dish machine cycle was ran using the facility's irreversible color changing test strips. The wash cycle temperature measured at 150 degrees Fahrenheit, the rinse cycle temperature measured at 200 degrees Fahrenheit, by the gauges. During this cycle, it did not change the test strip color to indicate dishware was reaching 160 degrees Fahrenheit for proper sanitization. Two more dish machine cycles were ran with the test strips not changing color. At this time, Certified Dietary Manager U stated that they thought they had the wrong test strips and were going to get new test strips. The proper test strips were provided but were indicating the dish machine was not sanitizing. Certified Dietary Manager stated at this time they will contact a service company to look at the dish machine. According to the 2013 FDA Food Code Section 4-703.11 Hot Water and Chemical. After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: (A) Hot water manual operations by immersion for at least 30 seconds and as specified under S 4-501.111; P (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 71oC (160oF) as measured by an irreversible registering temperature indicator; P or (C) Chemical manual or mechanical operations, including the application of SANITIZING chemicals by immersion, manual swabbing, brushing, or pressure spraying methods, using a solution as specified under S 4-501.114. Contact times shall be consistent with those on EPA-registered label use instructions by providing: (1) Except as specified under Subparagraph (C)(2) of this section, a contact time of at least 10 seconds for a chlorine solution specified under 4-501.114(A), P (2) A contact time of at least 7 seconds for a chlorine solution of 50 MG/L that has a PH of 10 or less and a temperature of at least 38oC (100oF) or a PH of 8 or less and a temperature of at least 24oC (75oF), P (3) A contact time of at least 30 seconds for other chemical SANITIZING solutions, P or (4) A contact time used in relationship with a combination of temperature, concentration, and PH that, when evaluated for efficacy, yields SANITIZATION as defined in 1-201.10(B). P

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. 39059 Based on observation, interview and record review, the facility failed to provide a dining room for the use of all residents for two of two dining rooms reviewed, resulting in residents not being able to consume their meals in a dining room setting, the inability to socialize with others and with the likelihood of weight loss. Findings include. On 2/10/22, at 3:00 PM, the Sunnyside dining room was observed to be filled with numerous boxes and bags of personal belongings. On 2/15/22, at 12:55 PM, Nurse P was asked if the facility offered coffee or tea during lunch and Nurse P stated, that hadn't seen coffee offered in quite some time. ON 2/15/22, AT 1:55 PM, an observation of the main dining room revealed a sign stating the dining room is closed. On 2/22/22, at 2:42 PM, a phone interview with Dietician B was conducted. Dietician B was asked if the facility had an open dining room for resident use and Dietician B stated, There is the main dining room and then Sunnyside and to my knowledge we haven't had enough staff to open the dining rooms. On 2/22/22, at 3:30 PM, a phone interview with the Administrator was conducted. The Administrator was asked why the dining rooms were closed and the Administrator stated, they were closed when they got there and that it was due to COVID. The Administrator was asked if they have reviewed the newest CMS memo regarding COVID-19 and dining room use and the Administrator stated they do recall the memo.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 This Citation has two Deficient Practice Statements (DPS). DPS #1: Based on observation and interview the facility failed to provide residents in Rooms 10, 20, 22, 23, 24, 27, and 29 with a clean, sanitary, and homelike environment and ensure that the routine cleaning of Resident #41's motorized wheelchair, resulting in Rooms 10, 20 and 22 having large blistering in their walls, a crack in the wall from the ceiling to the floor and streaks of brown substance on the wall from the roof leak in November 2021; rooms [ROOM NUMBERS] having holes in their ceiling tiles, extremely soiled privacy curtains, wall, and door jamb damage; Rooms 27, 29 and 77 being unsanitary and malodorous; and Resident #41's motorized wheelchair being covered with thick layers of debris, dust and other unknown particles. Findings include: During initial tour on 2/14/22 the following was observed in multiple resident rooms: room [ROOM NUMBER]B: The ceiling tile above Resident #41's bed had brown discoloration to it and coming diagonally from the tile was large buckling in the dry wall. The buckling resembled large air pockets but within the wall that were visible. The buckling stopped before the affixed horizontally hung light fixture and picked back up underneath the light fixture and stopped right before Resident #41's headboard. Resident #41 had a motorized wheelchair that was sitting in the corner of his room and the following was observed: - The wheelchair cushion was spackled with stains - The boarder around the cushion had a film of debris around it - Inside the wheelchair arms, there was debris and other particles in a thick layer. - The controls of the wheelchair were covered with a particles - The wheelchair wheels were covered in dust and brown sticky-like substance - The seatbelt was stained Resident #41's wheelchair was unsanitary, and he was unable to tell this writer the last time his chair was cleaned. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room [ROOM NUMBER] B: The tiles above Resident #90's bed had about 10 streaks of brown substance coming from the tile to the top of the residents' light fixture, above the bed. Resident #90 reported the Maintenance Director informed him there was water coming into the rooms as there was a roof leak. The water was coming down the walls and the brown streaks are the residual from the roof leak. There is blistering in the drywall on the wall in between bed A and B. The blistering is shaped as like the number 7 and spans about half of the wall from the ceiling to about mid-way down the wall. room [ROOM NUMBER] A: In the middle of beds A and B there is a crack in the wall that starts at the ceiling travels the length of the wall to the floor. room [ROOM NUMBER] A: By Bed A, the window, and the middle of the room by the storage are holes in the tile. Both privacy curtains were stained with black dots, large brown tan substance and cognac-colored streaks going down the curtain. The stains were all large and easily visible to facility staff. room [ROOM NUMBER] A: There were multiple stains on both privacy curtains that were visible. The wall next to Resident #26 was completely scratched and discolored from the rest of the wall. The area spanned half the wall and by the door jamb there is missing paint that travels up the length of the door jamb. On 2/15/22 at 2:40 PM, this writer and Maintenance Director A observed the rooms in questions. Upon entering Resident #41's room (10 B) Maintenance Director A was asked who is responsible for cleaning motorized wheelchair. He reported they have a wheelchair cleaner for their regular ones but is uncertain who is responsible for motorized ones. Maintenance Director A explained they had a roof leak as there was ice on top of roof and it caused holes in the roof. They had to clear all residents out the East Hall even rooms. He stated the issue has been rectified and they are gathering proposals for anew roof. Maintenance Director A stated they replaced all the ceiling tiles, and he is aware of the buckling in the paint, in many of the rooms, that were affected by the roof leak. He expressed his goal is fix the issues quickly, but he is the only Maintenance worker at the building. 20 B: Maintenance Director A explained the water from the leak was able to get behind the paint and caused it to blister. He reported the puckering from the ceiling to the floor is considered blistering and bubbling crack. Maintenance Director A continued the roof has a membrane layer, then tar and the water rolled down through the tar layer and into the walls. He stated the discoloration on the walls above 20B is the discoloration from the water damage. 24 A: The soiled privacy curtains were pointed out to Maintenance Director A and he reported laundry/housekeeping is going to be begin alternating cleaning curtains in the room. He reported the scratches on the wall look like it is from the resident's wheelchair. Maintenance Director A stated there is no current maintenance work order for this, but reported these rooms are on the list to be fully upgraded. 23 A: Maintenance Director A reported the holes in the tiles are from when the facility used to run TV cable wires through the ceiling, before they installed the extendable televisions. He reported there are many rooms that have the holes in the tile for the same reason and this is also on his radar to fix. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/16/22 at 2:50 PM, an interview was conducted with Housekeeping/Laundry Supervisor D regarding cleaning of privacy curtains and motorized wheelchairs. Supervisor D reported when residents are discharged , housekeeping does a deep clean of the chair. Wheelchairs that are in use by residents are taken to the wheelchair washer in the shower room, by aides. Supervisor D stated he is not certain regarding motorized wheelchair cleaning or who is responsible. Supervisor D stated his staff pull down privacy curtains every quarter to launder them and if housekeeping staff observers any that are soiled, they alert him and they will have taken down and cleaned. On 2/16/22 at 3:00 PM, an interview was conducted with the Administrator regarding her expectation for cleaning or motorized wheelchairs and she reported she would expect it to be completed on night shift. On 2/22/22 at 10:44 AM, an interview was conducted with Maintenance Supervisor A regarding their roof leak. Maintenance Supervisor A was notified of the leak on 11/13/21 and was able to remove all the water from the inside of the resident rooms. He reported there was standing water on the roof, and he removed it. Maintenance Supervisor A stated he moved residents out of five rooms and was able to prevent any further water from leaking into the building. On 11/16/21 the roofing company provided a quote, on 11/17/21 he sent the quote to corporate for approval and the roof was repaired prior to Thanksgiving. Maintenance Supervisor A expressed the company put vinyl repair on the defective areas but they still require a new roof. 37668 Resident #27: On 2/15/22 at 9:27 AM, Resident #27 was observed in their room in bed. The Resident was wearing a hospital style gown. Upon entering the room, the air temperature was notably higher and uncomfortable. When asked if they were comfortable with the temperature, Resident #27 revealed they were hot but were unable to get out of bed independently. The Resident's roommate also indicated the room was too hot and asked to please turn down the temperature on the thermostat in the room. The floor in the room near the Resident's bed was covered with multiple candy wrappers. There was no garbage can near the Resident. The floor throughout the room was noted to be sticky and an unknown substance was observed on the divider curtains in the room. Record review revealed Resident #27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia, diabetes mellitus, kidney disease, and heart failure. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive two-person assistance for bed mobility, transferring, dressing, toileting, and personal hygiene. Resident #29: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/15/22 at 12:41 PM, an observation and interview with Resident #29 was completed in their room. Upon entering the room, an overpowering and exceeding foul urine odor permeated the air. A garbage bag was on the floor, directly next to the door of the room. The bag was tied and contained garbage. The floor in the room near the Resident's bed was sticky with an unknown substance. When walking, this Surveyor's shoes stuck to the floor. Debris was present on the floor throughout the room. The Resident was sitting in a wheelchair, directly next to their bed. The Resident was wearing a shirt and brief with no pants and their lower extremities exposed. When asked, Resident #29 revealed they wanted to talk. An interview was conducted at this time. When asked about care received in the facility, Resident #29 stated, They don't give a shit about us here. During the interview with Resident #29, Unit Manager Licensed Practical Nurse (LPN) E opened the door to the Resident's room without knocking and left the room door open without speaking to the Resident. With the door open, Resident #29's bare lower extremities and brief were visible to individuals in the hallway. The foul, urine odor was present in the hallway emanating from Resident #29's room after exit. An interview was conducted with Unit Manager LPN E on 2/15/22 at 12:50 PM. When queried regarding Resident #29 and the urine odor, Unit Manager LPN E indicated they called housekeeping because they noticed the smell as soon as they opened the Resident's door into the hallway. When asked how the odor became that pungent and why the floor in the Resident's room was sticky if the room was being cleaned regularly, Unit Manager LPN E was unable to provide an explanation. Record review revealed Resident #29 was admitted to the facility on [DATE] with diagnoses which included hypothyroidism, depression, and weakness. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to limited assistance to perform all Activities of Daily Living (ADLs). 39083 DPS #2: Based on observation, interview, and record review, the facility failed to maintain ceiling tiles free from stains, maintain exterior sidewalk, maintain ventilation, and maintain plumbing system, resulting in a non-homelike environment, potential compromised safety systems, and potential for contamination of the domestic water supply affecting all residents and staff in the facility. Findings include: On 2/9/22 at 12:15 PM, two ceiling tile stain, located in the hall by the Nourishment room, were observed to be approximately six inches in diameter. On 2/9/22 at 3:35 PM, three ceiling tile stains, located in the hall by the Internet cafe, were observed to be approximately eight inches in diameter. On 2/9/22 at 3:41 PM, two ceiling tile stains, located in the hall by the lounge, were observed to be approximately six to eight inches in diameter. (continued on next page)

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/9/22 at 3:43 PM, the side walk, located outside of the emergency exit doors near room [ROOM NUMBER], were observed to be cracked along the width of the sidewalk, resulting in potential difficulty exiting the facility during an emergency evacuation. During an interview on 2/14/22 at 1:15 PM, Maintenance Director A was queried on the ceiling tile stains and stated that there was an old roof leak, and that they are working on scheduling for a new roof. According to a new roof quote, provided by the facility from [roofing company], the quote was dated for 12/6/2021. On 2/9/22 at 3:46 PM, the central hall exhaust vent, outside of room [ROOM NUMBER], was observed to have dust hanging from the grate. On 2/14/22 at 1:27 PM, the mop sink fixture, located in the janitors closet near room [ROOM NUMBER], was observed to have an atmospheric vacuum breaker (a plumbing device used to prevent the backflow of contaminated liquid into the potable water supply system). A shutoff valve was observed downstream from the atmospheric vacuum breaker, resulting in the potential for the atmospheric vacuum breaker to remain under pressure for an extended period of time, which can cause the device to fail. No pressure relief valve was observed on the mop sink fixture at this time. According to the Michigan Plumbing Code, Incorporating the 2015 edition of the International Plumbing Code, Section 608 Protection of Potable Water Supply, 608.13.6 Atmospheric-type vacuum breakers. Pipe applied atmospheric-type vacuum breakers shall conform to ASSE 1001 or CSA B64.1.1. Hose-connection vacuum breakers shall conform to ASME A112.21.3, ASSE 1011, ASSE 1019, ASSE 1035, ASSE 1052, CSA B64.2, CSA B64.2.1, CSA B64.2.1.1, CSA B64.2.2 or CSA B64.7. These devices shall operate under normal atmospheric pressure when the critical level is installed at the required height. On 2/14/22 at 1:31 PM, the central bath was observed to have a power washer attached to the shower head water supply with no backflow protection device. On 2/14/22 at 1:37 PM, the bathroom call light, in room [ROOM NUMBER], was observed to be only two inches long. Additionally, the PTAC filter screen (packaged terminal air conditioning unit) in the wall of room [ROOM NUMBER] was observed to be caked with dust. On 2/14/22 at 1:50 PM, the exhaust vent, located in the north shower room, was observed to not be functioning, determined by using a paper towel to test the suction of the vent. At this time, the shower room was observed to have an unpleasant odor. On 2/14/22 at 1:12 PM, the annual controls and safety devices inspection (CSD-1) paperwork was posted near the boilers and dated 10/15/2020, next inspection due 10/15/2021. At this time, Maintenance Director A stated they will see if they have a more recent CSD-1. According to the work invoice, Annual Boiler Peak Performance Inspection Including CSD-1 Requirements, for boiler serial # 0828191N50127, it was dated for 10/28/2019. The boiler has exceeded one year without inspections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235132	A. Building B. Wing	02/23/2022

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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	According to the work invoice, Annual Boiler Peak Performance Inspection Including CSD-1 Requirements, for boiler serial # C027517, it was dated for 10/15/2020. The boiler has exceeded one year without inspections.