STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235347	A. Building B. Wing	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Zeeland	285 N State St Zeeland, MI 49464

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 31771 Based on observation, interview, and record review the facility failed to respond timely to requests for assistance for one Resident (Resident #34 (R34)) resulting in frustration, anger, and the potential for all facility residents to experience loss of self-worth. Findings: R34 was admitted to the facility 11/11/19 with diagnoses that included: History of Stroke, Hemiplegia (paralyzed on one side of the body), and Anxiety. Review of the Minimum Data Set (MDS) dated [DATE] reflected R34 was independent with decision making but required extensive assistance with transfers and bed mobility. The MDS Section E reflected that R34 had not displayed any physical or verbal behaviors toward others. On 11/28/22 at 2:03 PM an interview was conducted with R34 in her room. R34 reported that call light response is often delayed especially on second shift. R34 reported that staff will come into the room, say they would be right back, turn off the call light, and not return. R34 reported that she would demonstrate the response time and initiated her call light. The surveyor remained at the bedside until staff responded at 2:44 PM, 41 minutes after the interview began. On 11/29/22 at 9:04 AM an interview was conducted with Licensed Practical Nurse (LPN) L. LPN L reported that R34 will sometimes send staff out of the room. LPN L reported that the Certified Nurse Aide (CNA) that responded to the call light on 11/28/22 when the surveyor was at bedside had come from another unit On 12/1/22 at 2:48 PM, R34 acknowledged that she has sent some staff away because I'm paralyzed. They don't know how to take care of me. R34 reiterated that the greater problem is the delayed response to her call light stating this makes me furious. R34 reported if she must wait too long, she will bang her trapeze handle. R34 reported that staff will complain to her that she is making too much noise. R34 reiterated that staff will turn off her call light to return later but leave the need unmet. R34 reported after a wait she will initiate the call light again and when staff respond the staff act like she had never turned it on the first time. R34 indicated she gets very frustrated. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy provided by the facility titled, Routine Procedure, Call Light, dated 7/11/2018, was reviewed. The policy reflected, It is the policy of this facility to provide a means a communication with nursing staff. Procedure: 1. All facility personnel must be aware of call lights at all times. 2. Facility shall answer call lights in a timely manner. 3. Answer all call lights in a prompt, calm, courteous manner; turn off the call light as soon as you enter the room and attend to the resident's needs On 12/1/22 at 11:36 AM an interview was conducted with the Director of Nursing (DON). The DON was informed of the 41-minute call light response observed by the surveyor and the frustration the Resident had conveyed that she experiences often. The DON indicated that R34 can be a challenging resident to provide care for but acknowledged that 41 minutes is a long time to not check on a resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 31771 Based on interview and record review, the facility failed to timely notify the Responsible Party of a change of condition for one Resident (Resident #44 (R44)) resulting in the Responsible Party not being informed of a change in R44's condition and care and the potential for all residents who have others responsible for making their medical decisions not fully informed of the status of the resident's whose care they are overseeing. Findings: R44 was originally admitted to the facility 3/22/21 with pertinent diagnoses that included Dementia and Hemiplegia (paralyzed or weakness to one side of the body). Review of the Minimum Data Set (MDS) reflected R44 was non-ambulatory and requires extensive assistance of two staff for transfers. The MDS reflected a Brief Interview for Mental Status (BIMS) score of 5 which indicated R44 was severely cognitively impaired. Review of the Electronic Medical Record (EMR) Face Sheet for R44 reflected the resident was not her own responsible party. Review of the EMR for R44 reflected documentation of a Skin Observation, Weekly dated 11/3/22 at 7:49 PM. The documentation reflected a pressure sore on left heel that measured 3.0 centimeters (cm) by 2.5 cm and was new. A treatment was put in place and the entry indicated the Dr. would be notified. The entry did not reflect that the Care Plan was updated or that the Responsible Party was notified of the new wound. Review of the Doctor's Communication Book reflected on the page dated 11/2/22 that R44 had a pressure sore found on Resident's left heel. Next to the entry were Physician's initials dated 11/5/22 which suggested the Physician had evaluated the Resident on that date. Review of the Physicians documentation dated 11/5/22 reflected an unstageable left heel wound had been evaluated. Review of the Doctor's Orders for R44 reflected a new medical treatment was initiated for the left heel wound on 11/6/22. Review of the EMR for R44 reflected an entry dated 11/11/22 at 4:06 PM by Unit Manager (UM) K that R44 had Left heel injury .stage 2 pressure ulcer .Family notified. An additional entry by UM K dated 11/11/22 at 4:07 PM reflected, .stage 2 Pressure Ulcer . We continue to monitor and treat as ordered. Care Plan updated. Review of the two entries on 11/11/22 by UM K indicated that the responsible party was not informed of the new stage 2 pressure sore until eight days after it was identified. These entries also reflect that it was eight days before the Care Plan was updated. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy provided by the facility titled Resident Rights, Change in a Resident's Condition or Status dated 7/11/2018 was reviewed. The policy reflected that, The facility shall promptly notify the resident, his or her Attending Physician and representative of changes in the resident's medical/mental condition and/or status. The policy further reflects that Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. And Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments. On 12/01/22 at 12:44 PM an interview was conducted with the DON and UM K in the conference room. The documentation of the identification, evaluation, and notification of the Responsible Party of R44 were reviewed. No new information was provided that changed the timeline of the documentation available.

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intakes #: MI00132481, MI00132243, MI00132497, and MI00132931 Based on interview and record review, the facility 1.) failed to ensure a comprehensive facility-wide assessment that included an assessment of the staffing needs, resident behaviors (wandering), resident acuity, and staff training and education requirements was complete and accurate, 2.) failed to evaluate the effectiveness of the interventions in place for residents with known behaviors, 3.) failed to identify increased behaviors and revise a care plan and 4.) failed to ensure there was sufficient staffing to supervise residents and prevent resident to resident abuse for 7 residents (Resident #9, #107, #32, #79, #24, #36, #1), resulting in a pattern of systemic neglect leading to resident to resident abuse and the decline in mental and psychosocial well-being. Findings: Resident #9 (R9) Review of an Admission Record revealed R9 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia and kidney disease. Review of a Minimum Data Set (MDS) assessment for R9, with a reference date of 9/2/22 revealed R9 was cognitively impaired. Resident #107 (R107) Review of an Admission Record revealed R107 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: restlessness and agitation, schizophreniform disorder, major depressive disorder, and dementia. Review of a Minimum Data Set (MDS) assessment for R107, with a reference date of 7/28/22 revealed a Brief Interview for Mental Status (BIMS) score of 4, out of a total possible score of 15, which indicated R107 was severely cognitively impaired. Review of R107's Care Plan for behaviors revealed, Focus-Resident has a behavior concern r/t (related to) dementia & depression. Has the potential to wander and may be friendly toward females (asks staff if they are married or make inappropriate/vulgar comments) Resident may touch female. May ask them for sex or make inappropriate gestures toward them (fondled self). May refuse to keep clothing and brief on. Date Initiated: 08/10/2021 . Indicating inappropriate sexual behavior was known and ongoing since the time of admission (greater than 1 year). Review of R107's Care Plan for behaviors revealed, Interventions-Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Put up stop barriers on the doors of female rooms on the same hallway. Date Initiated: 10/11/2021 .Redirect/distract res. from rooms and carts and offer assistance. Date Initiated: 11/17/2021 . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of R107's Care Plan for wandering/elopement revealed, Resident is an elopement risk and/or exhibits wandering behavior r/t dementia. Per wife, has a history of wander halls and rooms. May go into other resident rooms with or without clothing on (a sexually inappropriate behavior). Date Initiated: 08/09/2021 . Indicating behavior was known and ongoing since the time of admission (greater than 1 year). Review of R107's Progress Note dated 9/3/22 revealed, Behaviors all shift. Coming out of room and taking food from people and eating it. Unable to redirect or to stop behavior. Becomes aggressive with attempts to stop. Asking for multiple drinks, etc. Seems unable to notice when he has had sufficient food. Review of R107's Progress Note dated 9/7/22 revealed, Resident had multiple behaviors all shift. Looking for cigarettes and coffee. Became angry and striking out at staff with redirection. Resident required close supervision t/o (throughout) shift. Cena (CNA-Certified Nursing Assistant) was able to redirect resident to his bed at this time. Review of R107's Progress Note dated 9/12/22 revealed, resident very combative last night. Needed to be redirected several times. Verbally aggressive with room mate (sic). Moved to new room for the night so there was no confrontation with room mate (sic). R107's Care Plan was not updated to reflect verbal aggression with roommate/room change. Review of R107's Progress Note dated 9/14/22 revealed, Resident was up multiple times through out (sic) the night, seeking drinks and food. Very difficult to redirect, yelling and combative with staff. Required close supervision through out (sic) shift. Review of R107's Progress Note dated 9/18/22 revealed, Intrusive behavior in early morning . Review of R107's Progress Note dated 9/19/22 at 9:17 PM revealed, Resident was intrusive going into other resident rooms, looking for food and drinks. Angry and striking out at staff with redirection. Resident given food and drinks from pantry. But behaviors continues (sic). Required close supervision through night. Review of R107's Progress Note dated 9/20/22 at 2:00 PM revealed, Resident was intrusive going into other resident rooms, looking for food and drinks. Resident given food and drinks. Behaviors continue. Required close supervision throughout shift . Review of R107's Progress Note dated 9/23/22 at 1:56 AM revealed, Resident up walking in hallway since beginning of shift .Resident aggressive toward staff and making inappropriate statements, putting his fists up as if to hit staff. Demanding more drinks and snacks. Angry facial expression . Review of R107's Progress Note dated 9/23/22 at 9:37 PM revealed, Resident was walking up and down hallways and going into other residents rooms looking for food and drinks. Resident was very difficult to redirect. Angry with redirection. Striking out at staff and verbally abusive. Resident given food and drinks but behaviors continues (sic). Resident required close supervision due to intrusive behaviors . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of R107's Progress Note dated 9/24/22 at 2:43 PM revealed, Restlessness, seeking food and drinks throughout shift. Going into other resident rooms and taking med pass, applesauce, and pudding off med carts. Continuously hungry. Redirected with activities with little effect. Review of R107's Social Service note dated 9/15/22 revealed, IDT (Interdisciplinary Team) reviewed res. (resident) in behavior/psychotropic committee meeting today 9.15.22. This is a follow up from previous meeting 9.8.22 when res. Was started on Abilify. IDT reviewed medications and behaviors. No further concerns noted, therefore no further recommendations made by IDT at this time . Review of R107's Social Service note dated 9/22/22 revealed, IDT reviewed res. in behavior/psychotropic committee meeting today 9.22.22. This is a follow up from previous meeting 9.15.22 when resident had some increased appetite. IDT reviewed medications and behaviors. No further concerns noted, therefore no further recommendations made by IDT at this time . On 9/7/22, 9/14/22, 9/19/22, and 9/20/22 nursing staff documented in R107's Progress Notes that R107 required close supervision for his behaviors and on 9/12/22 R107 was verbally aggressive with his roommate which resulted in him moving to another room. The IDT met on 9/15/22 and 9/22/22 to review R107's medications and behaviors. There were no concerns noted and no recommendations made indicating the IDT team did not identify R107's escalating behaviors now required close supervision and a room change. R107's Care Plan was not updated with interventions to keep himself and/or other residents safe from his behaviors. Review of R107's Care Plan revealed, Encourage res. (resident) to be close to staff and/or eye sight (sic) when able (or when out of room). Date Initiated: 09/27/2022 . Indicating the Care Plan for his increase in behaviors was updated after the Resident to Resident incident occurred. Review of a Witness Statement written by Activity Assistant (AA) Q revealed, At the request of nursing, this is my account of (R107) behaviors 9/24/22. (R107) was very disruptive from morning up until the incident with (R9). Stealing res (resident) beverages. Entering res rooms + startling them . Review of the Facility Reported Incident revealed that on 9/24/22 at 4:00 PM, (R107) was witnessed with his pants pulled down on top of (R9) while she was laying in her bed fully clothed (gown and brief on and not tampered with) her bed sheets were pulled up covering her body . (R107) was sent out to the hospital for evaluation . Through the investigation it was determined that prior to this event, (R107) did not display sexually inappropriate behavior toward other residents, he had historically directed his comments toward staff members and had been making comments throughout the day to staff members . Administrator spoke with (Family Member FM O), wife/guardian on 9/24/22 to inform her of the incident that occurred and his transfer to the hospital for further evaluation. At this time (FM O) stated that (R107) had no history of sexual behaviors towards other residents in the past and was surprised to hear of the incident . CONTRIBUTING FACTORS/ROOT CAUSE ANALYSIS: The primary root cause of (R107) sexually inappropriate behavior is due to his dementia and impaired ability to control impulsive behavior. In addition to the root cause, there are multiple contributing factors relating to the allegations: (R107) is diagnosed with schizophreniform disorder, dementia with behavioral disturbance, major depressive disorder, and restlessness/ agitation. (R107) had a medication change on 8/25/2022 and started on Abilify for major depressive disorder, which was a new medication for him. (R107) recently had moved rooms . Indicating the facility identified possible agitators that caused an increase in R107's behaviors and no new interventions were implemented prior to the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 12/01/22 at 04:07 PM, FM O reported that the incident never should have occurred. FM O reported that the facility wasn't paying attention to this particular (dementia) unit and she could not understand how there were no staff supervising the residents, with known wandering behaviors, to prevent this type of situation. FM O stated, if they had been paying attention this wouldn't have happened. Review of the staffing schedule dated 9/24/22, the Gilead Unit had 1 support aide, 2 nurses, and 3 CNA's (Certified Nursing Assistant) scheduled at the time of the incident between R107 and R9. A 4th CNA was scheduled to work from 5-9 PM. Resident #32 (R32) Review of an Admission Record revealed R32 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: alcohol use with alcohol-induced dementia, major depressive disorder, and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for R32, with a reference date of 11/3/22 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated R32 was cognitively impaired. Review of R32's behavior Care Plan revealed, Resident has a behavior concern r/t Depression, anxiety, and Dementia (memory issues). He may exhibit refusals of care (showers/clothes changes), may become combative/aggressive (grab staff arm/hand, swat at staff, chest bump, push staff out of room). Res. may have boundary issues and/or walk up to another res. and/or talk to them while tapping or placing hand on their shoulder/arm. Resident may wander into other resident's rooms touch their belongings, stand over them while they sleep, lay in empty beds. Patient wanders, and may paces and rummage in his room, and at times in his roommate's personal space, putting him at risk for intruding on the privacy of others. Date Initiated: 06/11/2021 . Resident #79 (R79) Review of an Admission Record revealed R79 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: lung disease, heart failure, dementia. Review of a Minimum Data Set (MDS) assessment for R79, with a reference date of 10/25/22 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated R79 was moderately cognitively impaired. Review of the Staffing Schedule dated 11/20/22 for the shift 10 PM-6 AM revealed there were 2 CNA's and 1 nurse working on the Gilead Unit at the time of the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of R79's Witness Statement dated 11/21/22 revealed, Last night around 2am-3am, I was lying down in bed on my back, he came in and said them are mine referring to my breasts. He grabbed my breasts over the top of my pajama shirt and bra. I screamed for the nurse, she came in and got him out. Then he came back about 20 min later. I yelled at him you can't touch me, and I hit him on the head. I yelled for the nurse again and they took him out again .(R32) has been here too long, he goes in/out of rooms, he could rough anyone up at any time (interview with police officer) he came into my room [ROOM NUMBER] times last night. That man. (Could not provide a name or description after prompting from the officer). He said I want to feel you up and grabbed my breasts. I yelled Nurse, Nurse. Then he came back a second time and he grabbed them again and I yelled at him to get out and called for the Nurse. He didn't say anything the second time when he grabbed me. Then he came in another time and I yelled at him to get out. Review of CNA R's Witness Statement dated 11/21/22 revealed, (R32) walked into her room [ROOM NUMBER] times last night. The first time it was around 1:30am and I was in the middle of doing my rounds actively changing someone when I heard (R79) yell Nurse, nurse. The minute I could, I went in the room and directed (R32) out of the room. It took me maybe 1-2 minutes to get there from the time (R79) yelled for help, I was in the room next door .When I entered the room (R79) was lying in bed and (R32) was standing next to the recliner which is in the middle of the room. All (R79) said was if he comes in again I am going to kick his ass. From what I could see he was at least 10' away from her and not close enough to touch her .I went to change another person and again he went to her room and she got angry again. Less than 10 minutes had passed. He barely made it through the threshold of the door the 2nd time and I caught him immediately and redirected him .(R32) has a history of wandering and there were no allegations made last night . Review of CNA S's Witness Statement dated 11/21/22 revealed, I saw CNA R redirecting (R32) in the hallway last night and she (R79) came out and told me that the next time he came in her room I will beat his ass, or something to that effect. I said (R79) you aren't going to do that, he doesn't know any better . Review of LPN T's Witness Statement dated 11/21/22 revealed, .As far as I know I thought (R32) was in bed for the majority of my shift last night. The facility investigation indicated a lack of supervision for R32 when it was known he was entering R79's room. There were no immediate interventions put in place for R32's behaviors after he entered R79's room the first time causing R79 to be fearful and threaten physical violence against R32 when he attempted to enter her room the 2nd time. The FRI did not reflect that increased supervision or other interventions were implemented that would avoid psychosocial harm or physical abuse between R32 and R79. Additionally, the facility failed to affirm R79's fearfulness resulting in mental anguish despite the nature of the allegation (unwitnessed sexual assault). Review of R79's Police Report dated 11/22/22 revealed, .(R79) stated that she wanted (R32) out of the unit because she doesn't feel safe when he wanders . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of a Facility Reported Incident between R79 and R32 revealed, On 11/21/2022 around 3:30pm Administrator was notified of potential abuse allegation between (R79) and (R32). It was reported that (R32) entered (R79's) room and attempted to touch her. Facility to initiate investigation.(R79) was likely startled by (R32) wandering into her room and it caused her to change her story in various ways in hopes that it would cause him to be removed from the facility. (R79) has a history of making false accusations which are a part of her preexisting mood and behavior care plans. Her decision making and impulse control are both impaired due to her dementia diagnosis. (R32) also has an impairment in decision and impulse control, with a history of wandering, this likely caused him to wander into her room at various points throughout the evening. Both residents reside on the memory care unit, and both have diagnosis of dementia and poor decision-making abilities. DETERMINATION OF FINDINGS/CONCLUSION: Based on the findings of the investigation including interviews with the residents, review of the clinical record and interviews with staff members identified above, a decisive conclusion was made the occurrence was NOT the result of abuse, neglect, misappropriation, or harm. The event is determined to not have occurred. The abuse policy was followed . The facility determined the allegation did not occur although there were no witnesses present when R32 was alone in R79's room unsupervised. Review of the Quality Assessment and Assurance Committee minutes dated 11/22/22 revealed, Review & discuss outcomes of investigation of Abuse: 11/21/2022 (R32) vs. (R79) Abuse-Root Cause-(R32) entered (R79's) room and it startled her. she changed her story numerous times throughout the day in hopes that it would cause (R32) to get kicked out of the facility after talking with her friend (R36). She also changed her story again after speaking to administration and the police. *Immediate intervention-stop sign on (R79's) door, 15 minute checks for (R32) and (R79), encourage (R79) to sleep with her bedroom door shut in the evening. The Quality Assessment and Assurance Committee minutes did not address R32's wandering behaviors, staffing (required to redirect wandering behavior that impacts other residents), or supervision to prevent further abuse and/or allegations. Review of R79's mood Care Plan revealed, .Offer support visits to assist with any upset mood/behavior. Offer stop signs for doorway and suggest door is closed to reduce other resident's entering Date Initiated: 07/23/2021 Revision on: 09/27/2022 . prior to the facility reported incident of alleged resident to resident sexual assault. Review of R79's mood Care Plan revealed, .Offer support visits to assist with any upset mood/behavior. Offer stop signs for doorway and suggest door is closed to reduce other resident's entering Date Initiated: 07/23/2021 Revision on: 11/21/2022 . Indicating R79's Care Plan was not updated with new interventions following the incident. R79's Care Plan did not have an intervention related to 15 minute checks, invalidating the facility report to the state agency claiming meaningful changes to the plan of care had been implemented. Review of R32's behavior Care Plan revealed, .15-minute checks during the night x72 hours Date Initiated: 11/21/2022 . despite the fact that CNA R reported that R32 attempted to reenter R79's room when less than 10 minutes had passed. Resident #24 (R24) (continued on next page)

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Skld Zeeland	285 N State St Zeeland, MI 49464

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of an Admission Record revealed R24 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: alcohol induced dementia, post-traumatic stress disorder, alcohol dependence, psychotic disorder with delusions due to known physiological condition, and major depressive disorder. Review of a Minimum Data Set (MDS) assessment for R24, with a reference date of 8/31/22 revealed a Brief Interview for Mental Status (BIMS) score of 2, out of a total possible score of 15, which indicated R24 was severely cognitively impaired. Review of R24's behavior Care Plan revealed, Resident has a behavior concern d/t (due to) PTSD (Post Traumatic Stress Disorder), Dementia, Psychotic disorder w/ delusions. He may push/grab staff, use abusive/vulgar language (swear/use the F word), use hand gestures, slap at staff, May be physical with staff and/or others. May also have aggressive/threatening behavior and/or reject care (incontinence). Often above behaviors occur when he is rejecting care. May use tray tables or walkers inappropriately and throw things. May swing wet floor signs at others or throw walker. May try to stab at staff with pens May go into other resident's rooms when wandering the unit. Res. may also retaliate when feeling threatened. May be affectionate with female residents Date Initiated: 08/31/2021 Revision on: 11/21/2022 . Resident #36 (R36) Review of an Admission Record revealed R36 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: unspecified dementia, without behavioral disturbance Review of a Minimum Data Set (MDS) assessment for R36, with a reference date of 8/24/22 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated R36 was moderately cognitively impaired. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of the Facility Reported Incident for R36, R24, and R32 revealed, .On 10/13/2022 at 4:25 PM, staff witnessed resident (R36) in his room, using a walker to push resident (R32) away from him. Another resident, (R24) was also in the room at the time. (R36) stated when staff came in to assist, that he was trying to get (R32) and (R24) out of his room. (R36) said that (R24) took a swing at him .(R32) and (R24) have a history of wandering behavior due to their dementia diagnosis .(R36) was interviewed and gave an account for what happened in his room. He stated that (R24) took a swing at me and (R32) came down too, they were both in my room. He said that when (R24) took a swing at him, he said had no choice but to defend himself. He said he told them two times that they have to get out of here, that is when (R24) took a swing at him. (R36) said that he got (R24) away from him and then grabbed the walker that was in his room to put between himself and (R32) so he would not come near him .The root cause of the incident was (R24) and (R32) entering (R36's) room. This caused (R36) to become upset with the gentlemen. When he asked (R36) to get out of his room that is what triggered (R24's) response of, reportedly swinging at him. (R24's) cognitive status caused him to respond to (R36's) request to leave his room, in the manner in which he did. When (R32) started walking toward (R36), (R36) felt as though he had to protect himself, so his immediate response was to grab the walker and place it between them. Conclusion: Based on the findings of the investigation including interviews with the residents, review of the clinical record and interviews with staff members identified above, a decisive conclusion was made the occurrence was NOT the result of abuse, neglect, misappropriation or harm. It can not be substantiated that (R24) took a swing at (R36) as (R36) does have impaired cognition and the event was not witnessed. However, it was witnessed that (R36) did use a walker to push between himself and (R32). (R36) did not take this action with intent to cause harm to others, but with an intent to encourage (R32) to leave his room and to defend himself. The event did not result in harm, pain, or mental anguish and all three residents remain at their baseline. It is not substantiated that an intent to cause harm or intent for any lasting negative impact exists . R32's Care Plan was not updated following this altercation that resulted from his wandering behavior. Resident #1 (R1) Review of an Admission Record revealed R1 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: Unspecified dementia with behavioral disturbance and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for R1, with a reference date of 8/19/22 revealed a Brief Interview for Mental Status (BIMS) score of 6, out of a total possible score of 15, which indicated R1 was cognitively impaired. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of the Facility Reported Incident for R1 and R24 revealed, .On 10/16/2022 at 5:45 AM, facility administrator was notified of a potential resident to resident altercation. Staff witnessed (R1) yelling at (R24) to get out of her room. As he was wandering out (R1) hit (R24) .(R24) is independent with ambulation using a front wheeled walker, and frequently wanders throughout the unit . (R1) was heard yelling at (R24) to get out of her room. As he was leaving the room, she was seen hitting (R24) and losing her balance, in which point she fell . Root Cause Analysis/Contributive Factors: The investigation determined the event occurred and is likely related to (R24) wandering into (R1) room. (R24) wandered into (R1) room, this startled her and caused her to respond by yelling. As he was leaving her room, she hit him which was due to her lack of impulse control and poor decision-making abilities related her dementia diagnosis. Both residents have dementia and impairment related to decision making. DETERMINATION OF FINDINGS/CONCLUSION: Based on the findings of the investigation including interviews with the residents, review of the clinical record and interviews with staff members identified above, a decisive conclusion was made the occurrence was NOT the result of abuse, neglect, misappropriation or harm. The event is determined to have occurred but due to the residents impaired cognition, they were unable to form a willful intent to cause harm. (R1) was responding to (R24) wandering into her room, causing her to yelling and hit him. The IDT with input from frontline staff and developed new meaningful interventions for (R24). Both residents remain unchanged from baseline . R24's Care Plan was not updated following the altercation on 10/13/22 that resulted from his wandering behavior. There were no interventions implemented to prevent additional occurrences of resident to resident abuse due to R24's wandering behaviors. Review of R24's behavior Care Plan revealed, .Monitor/distract as able away from other rooms. Date Initiated: 10/16/2022 . Review of R24's behavior Care Plan revealed, .Monitor/distract as able from other rooms. Try to keep in common areas of the unit. Revision on: 10/17/2022 . During an interview on 11/28/22 from 10:31 AM-11:24 AM with R79 and R36, R36 reported that there are 2 residents that wander the units and like to go through people's rooms. R36 reported that the 2 residents that wander the halls and enter resident rooms are R32 and R24. R36 reported that both residents had recently entered his room without invitation (intake 132481). R36 reported that he raised my voice to get them to leave and R24 took a swing at me. R36 reported fear with 2 men trying to accost me. R36 reported that he pushed him away with my leg and then R32 came at me. R36 reported that he had to use his walker to protect himself and it took everything I could to get away from them. R36 reported that R24 and R32 are left unsupervised and they are dangerous together. R36 reported that residents that require supervision are not supervised. R36 reported that the facility had a couple other (residents) that were bad news. R36 reported that a few months ago R107 sexually assaulted a female resident (R36 was able to name R107 and R9-intake 132243). R36 stated the Gilead Unit is a vulnerable area. These women can't protect themselves from the residents with known behaviors. R79 reported that approximately 2 weeks prior she was in bed sound asleep and (R32) grabbed my boobs. I screamed! (intake 132931) R79 reported fear when she woke to a man standing over her and ongoing fear and anxiety that there have been no changes made to prevent another occurrence. R79 stated the facility needs to hire one person as a pair of eyes to watch the guys (R32 and R24). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	R79 reported that there were not enough staff to meet the needs of the residents and the staff can't keep up. R79 reported that there was recently a night shift where there was only 1 CNA for all of the residents on the Gilead Unit. R79 reported that there are 2 CNAs scheduled for 3rd shift and there's no way they can have 2 staff at night to watch those 2 guys (R24 and R32). It's not enough. They try hard but they can't do it (their jobs) with 2 guys that are extra trouble. R36 reported that they try to get R24 and R32 to stay out of other rooms by putting up stop signs (Velcro mesh across resident doorways) but R24 will remove the stop sign from the doors and enter the room. R36 reported that R32 recently went around peeing in garbage and sinks but not the toilet because of the lack of staff/supervision. R79 reported that she is fearful of R24 and if you say something (R24) doesn't like he (punching motion) and the nurses are scared of him. R79 stated, there's not enough staff to give care and attention to residents. If they could bring more staff on it would be perfect. During an interview on 11/29/22 at 08:45 AM, LPN A reported that the Gilead (name of locked dementia unit) Unit had a lot of residents that have wandering behaviors which require supervision and a locked unit. During an interview on 11/29/22 at 09:07 AM, CNA W reported that there was not sufficient staff to meet the physical and behavioral needs of the residents. CNA W reported that 2nd shift is scheduled to have 3 CNAs on the floor and 1 support CNA to monitor residents in the main area. CNA W reported that there are times when 2nd shift only has 2 CNAs on the floor and that is not enough to control (R32) and (R24) specifically. CNA W reported that there are many residents on the Gilead Unit that wander and there is no way to manage behaviors, prevent resident to resident altercations, and/or wandering in and out of the rooms. CNA W reported that R32 and R24 have wandering tendencies that need direction. During an interview on 11/29/2022 at 3:00 PM, LPN M reported that the Gilead Unit was staffed with 3 CNAs at that time and 1 CNA was pulled to another unit. LPN M reported that it was difficult to monitor residents that wander in and out of rooms, especially (R32) and (R24) and reported R32 and R24 were often involved in resident-to-resident altercations. LPN M reported that dinner time to bedtime was the most difficult time of the shift because the CNA's had to assist with feeding, changing, nighttime care, and getting residents to bed. LPN M reported the Gilead Unit needed additional staff to supervise residents that wander in and out of rooms and upset other residents. During an interview on 11/30/2022 at 12:40 PM, CNA X reported that residents were not receiving the care they required because of the lack of staff. CNA X reported that there were many residents on the Gilead Unit that required extensive assist or 2 assist with cares and the staff were expected to monitor and supervise (R32) and (R24). CNA X reported that when a resident that requires 2 persons assist for care is being helped, it takes 2 CNAs off the floor which results in even less supervision for R32 and R24. CNA X reported that because of the lack of staff available on the Gilead Unit she has seen an increase in resident falls and resident to resident altercations. CNA X reported that if there is a call off on another unit, they pull from the Gilead Unit. CNA X reported that second shift is the most difficult because they are expected to monitor R32 and R24 while also providing care to all the residents (incontinence care, toileting, repositioning), assisting with dinner (passing trays, feeding, picking up trays), monitoring residents that are sundowning (increased behaviors that occur in the evening), and putting the residents to bed. CNA X reported that there were many residents that required 2-person assistance to get to bed because of their use of a hoyer lift. CNA X stated it's not reasonable to expect that ADL care and supervision can be completed with the number of staff availabl[TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on observation, interview and record review, the facility failed to implement established abuse and neglect prevention policies and procedures for 2 residents (Resident #2 and Resident #15), resulting in the potential for ongoing abuse and neglect. Findings: Review of the facility policy Abuse and Neglect last updated 10/31/2022 reflected It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect, or mistreatment. This includes but is not limited to freedom from any physical or chemical restraint not required to treat the resident's medical symptoms. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. The policy also explained what an injury of unknown origin is as follows: An injury should be classified as an injury of unknown source when both of the following conditions are met: a. The source of injury was not observed by any person or the source of injury could not be explained by the resident; and b. The injury is suspicious because of the extent of the injury or the location of the injury (example: the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at a particular point in time or the incidence over time. The policy also defined abuse as follows: Abuse defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Resident #2 (R2) Review of an Admission Record reflected R2 admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, high blood pressure, bipolar 2 disorder, hypothyroidism, major depressive disorder, type 2 diabetes, schizophrenia, gastro-esophageal reflux disease, dysphagia and abnormalities of gait. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R2 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 5/15 and needed supervision and set up help for bed mobility, transfers, walking, dressing, toileting and personal hygiene. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Resident-to-Resident Incident Report dated 10/15/2022 reflected Resident was in the common area with a bag of clothes like she often does. Another resident accused (R2) of taking her clothes. (R2) told this resident that they were not taken from her, and she owned them. The other resident yelled at her and threw a glass of water, but the water did not hit (R2). (R2) was not upset and went about her business of watching activities going on around her. Review of an Incident Report dated 11/15/2022 reflected Resident was sitting in common area and c/o (complained of) to staff that she fell in her room earlier. During assessment resident (R2) was noted to have a 5x5 hematoma to right temple and c/o right arm pain. Resident stated, I fell and hit my head against the closet. No evidence in the State Agency facility reporting database reflected the facility reported the injury of unknown origin or conducted an investigation into the injuries of unknown origin to rule out neglect or abuse despite R2's severe cognitive impairment and history of resident to resident altercations. Review of an Incident Report dated 11/23/2022 reflected Resident stood up, took few steps away from chair, stumbled, took step back and fell to chair. Landed on right back and right elbow. Head hit recliner seat and arm of recliner. Combative with assessment. Transferred to recliner with hoyer (mechanical) lift and 3 staff members. During an observation and interview on 11/29/2022 at 8:32 AM, R2 was seated in a recliner in a common area on the unit with an over the bed table in front of her. R2's right temple area was bruised and R2's arm was in a splint as she was eating breakfast. When asked, R2 could not explain what had happened to her arm or how her face had become bruised. R2 then noticed a male resident in the area, asked who he was and then said that the male resident was engaged to be married to her (demonstrating severe cognitive impairment). Resident #15 (R15) Review of an Admission Record reflected R15 admitted to the facility on [DATE] with diagnoses that included dementia, lack of coordination, type 2 diabetes, cognitive communication deficit and a lack of relaxation and leisure. Review of a significant change Minimum Data Set (MDS) assessment dated [DATE] reflected R15 was severely cognitively impaired as evidenced by a BIMS score of 00/15. R15's assessment of mood revealed depression and delusions with behavior symptoms including physical, verbal and other behavioral symptoms not directed toward others. Section E - Behavior reflected that R15's behaviors did not place her at risk for physical illness or injury or interfere with R15's care. R15's behavior was coded as putting others at risk for physical injury, intruded on the privacy or activity of others and disrupted the care and living environment of others. R15 was found to have wandering behaviors that had worsened and significantly intruded on the privacy of activities of others. On 11/29/2022 at 4:05 PM, Incident and Accident/Unusual Occurrence reports pertaining to R15 for the month of October and November were requested from the Director of Nursing (DON). The incident reports provided reflected that R15 had an unwitnessed fall on 10/11/2022 and 10/31/2022. R15 had another fall on 11/4/2022 and 11/5/2022 without observation of a head injury or indication the falls were unwitnessed. An unwitnessed fall occurred on 11/9/2022 without evidence of a head injury, neurological assessments were completed. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an incident report dated 11/23/2022 reflected CNA (Certified Nurse Aide) notified nurses that resident had bruise to left eye. The incident was unwitnessed and R15 was not able to explain how the injury had been caused. During an observation on 12/01/2022 at 9:10 AM, R15 was observed seated in a recliner chair in the main dining room on the dementia unit. A faint yellow bruise approximately 2 inches wide and 2 inches long over R15's left eyebrow was noted. Staff in the area were asked about the bruise and did not know what had caused it. R15 did not respond when questioned about the bruise. During an interview on 12/01/2022 at 9:30 AM, Nurse Practitioner (NP) P reported he thought he knew about the bruise and assumed it was related to R15's history of falls. During an interview on 12/01/2022 at 10:45 AM, the Director of Nursing (DON) was asked about the injuries of unknown origin observed on R2 and R15. The DON said the injuries of unknown origin were not reported to the state agency but she thought she had investigations pertaining to R15's bruise. During an interview on 12/01/2022 at 2:00 PM, the Nursing Home Administrator (NHA) and Consultant Registered Nurse (CRN) V reported they did not have an investigation into the injuries of unknown origin for R2 and R15. CRN V reported that there was a brief note related to R15's injury of unknown origin that attributed the bruise to R15's history of falls.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake #: MI00132847 Based on observation, interview and record review, the facility failed to report allegations of abuse for 4 residents (Resident #2, #15, #24 and #58) resulting in the potential for ongoing abuse and neglect. Findings: Review of the facility policy Abuse and Neglect last updated 10/31/2022 reflected It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect, or mistreatment. This includes but is not limited to freedom from any physical or chemical restraint not required to treat the resident's medical symptoms. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. The policy also explained what an injury of unknown origin is as follows: An injury should be classified as an injury of unknown source when both of the following conditions are met: a. The source of injury was not observed by any person or the source of injury could not be explained by the resident; and b. The injury is suspicious because of the extent of the injury or the location of the injury (example: the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at a particular point in time or the incidence over time. The policy also defined abuse as follows: Abuse defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy specified reporting requirements, The abuse coordinator must submit a preliminary investigation report to the appropriate State Agencies immediately once assurances for the resident's or other resident's safety have been established. However, if the event that caused the allegation involved abuse or resulted in serious bodily injury, the allegation of abuse must be reported to appropriate state agencies immediately and not later than 2 hours after receiving the allegation of abuse or not later than 24 hours if the event that caused the allegation did not involve abuse and did not result in serious bodily injury. Resident #2 (R2) Review of an Admission Record reflected R2 admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, high blood pressure, bipolar 2 disorder, hypothyroidism, major depressive disorder, type 2 diabetes, schizophrenia, gastro-esophageal reflux disease, dysphagia and abnormalities of gait. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R2 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 5/15 and needed supervision and set up help for bed mobility, transfers, walking, dressing, toileting and personal hygiene. Review of a Resident-to-Resident Incident Report dated 10/15/2022 reflected Resident was in the common area with a bag of clothes like she often does. Another resident accused (R2) of taking her clothes. (R2) told this resident that they were not taken from her, and she owned them. The other resident yelled at her and threw a glass of water, but the water did not hit (R2). (R2) was not upset and went about her business of watching activities going on around her. Review of an Incident Report dated 11/15/2022 reflected Resident was sitting in common area and c/o (complained of) to staff that she fell in her room earlier. During assessment resident (R2) was noted to have a 5x5 hematoma to right temple and c/o right arm pain. Resident stated, I fell and hit my head against the closet. No evidence in the State Agency facility reporting database reflected the facility reported the injury of unknown origin or conducted an investigation into the injuries of unknown origin to rule out neglect or abuse. Review of an Incident Report dated 11/23/2022 reflected Resident stood up, took few steps away from chair, stumbled, took step back and fell to chair. Landed on right back and right elbow. Head hit recliner seat and arm of recliner. Combative with assessment. Transferred to recliner with hoyer (mechanical) lift and 3 staff members. During an observation and interview on 11/29/2022 at 8:32 AM, R2 was seated in a recliner in a common area on the unit with an over the bed table in front of her. R2's right temple area was bruised and R2's arm was in a splint as she was eating breakfast. When asked, R2 could not explain what had happened to her arm or how her face had become bruised. R2 then noticed a male resident in the area, asked who he was and then said that the male resident was engaged to be married to her (demonstrating severe cognitive impairment). Resident #15 (R15) Review of an Admission Record reflected R15 admitted to the facility on [DATE] with diagnoses that included dementia, lack of coordination, type 2 diabetes, cognitive communication deficit and a lack of relaxation and leisure. Review of a significant change Minimum Data Set (MDS) assessment dated [DATE] reflected R15 was severely cognitively impaired as evidenced by a BIMS score of 00/15. R15's assessment of mood revealed depression and delusions with behavior symptoms including physical, verbal and other behavioral symptoms not directed toward others. Section E - Behavior reflected that R15's behaviors did not place her at risk for physical illness or injury or interfere with R15's care. R15's behavior was coded as putting others at risk for physical injury, intruded on the privacy or activity of others and disrupted the care and living environment of others. R15 was found to have wandering behaviors that had worsened and significantly intruded on the privacy of activities of others. (continued on next page)

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	235347	A. Building B. Wing	12/05/2022

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/29/2022 at 4:05 PM, Incident and Accident/Unusual Occurrence reports pertaining to R15 for the month of October and November were requested from the Director of Nursing (DON). The incident reports provided reflected that R15 had an unwitnessed fall on 10/11/2022 and 10/31/2022. R15 had another fall on 11/4/2022 and 11/5/2022 without observation of a head injury or indication the falls were unwitnessed. An unwitnessed fall occurred on 11/9/2022 without evidence of a head injury, neurological assessments were completed. Review of an incident report dated 11/23/2022 reflected CNA (Certified Nurse Aide) notified nurses that resident had bruise to left eye. The incident was unwitnessed and R15 was not able to explain how the injury had been caused. During an observation on 12/01/2022 at 9:10 AM, R15 was observed seated in a recliner chair in the main dining room on the dementia unit. A faint yellow bruise approximately 2 inches wide and 2 inches long over R15's left eyebrow was noted. Staff in the area were asked about the bruise and did not know what had caused it. R15 did not respond when questioned about the bruise. During an interview on 12/01/2022 at 9:30 AM, Nurse Practitioner (NP) P reported he thought he knew about the bruise and assumed it was related to R15's history of falls. During an interview on 12/01/2022 at 10:45 AM, the Director of Nursing (DON) was asked about the injuries of unknown origin observed on R2 and R15. The DON said the injuries of unknown origin were not reported to the state agency but she thought she had investigations pertaining to R15's bruise. During an interview on 12/01/2022 at 2:00 PM, the Nursing Home Administrator (NHA) and Consultant Registered Nurse (CRN) V reported they did not have an investigation into the injuries of unknown origin for R2 and R15. CRN V reported that there was a brief note related to R15's injury of unknown origin that attributed the bruise to R15's history of falls. 39056 Review of the Facility Reported Incident between R58 and R24 revealed, .Date/Time Incident Occurred: 06/21/2022 10:00 PM . Date/Time Incident Discovered: 06/22/2022 10:11 AM .Submitted Date/Time: 06/22/2022 11:03 AM .Incident Summary (R24) was seen pushing (R58) . During an interview on 11/30/2022 at 8:10 AM, NHA reported that she was not the administrator at the facility at the time of the incident. NHA reported that after reviewing the FRI (intake 132847), it appears as though the incident between R58 and R24 was reported late. NHA reported she could not determine if the nursing staff reported it to the previous NHA late, or if the previous NHA reported it to the State Agency late.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake #: MI00131592, MI00131591, MI00131599, MI00132243, MI00132497, and MI00132499 Based on observation, interview and record review, the facility failed to thoroughly investigate alleged abuse, neglect and mistreatment and implement meaningful prevention measures in six cases reported to the State Agency (Intakes 131592, 131591, 131599, 132243, 132497 and 132499) and for 2 residents (Resident #2, #15 whose injuries of unknown origin were not recognized as allegations of abuse or neglect), resulting in the potential for ongoing abuse and neglect. Findings: Review of the facility policy Abuse and Neglect last updated 10/31/2022 reflected It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect, or mistreatment. This includes but is not limited to freedom from any physical or chemical restraint not required to treat the resident's medical symptoms. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. The policy also explained what an injury of unknown origin is as follows: An injury should be classified as an injury of unknown source when both of the following conditions are met: a. The source of injury was not observed by any person or the source of injury could not be explained by the resident; and b. The injury is suspicious because of the extent of the injury or the location of the injury (example: the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at a particular point in time or the incidence over time. The policy also defined abuse as follows: Abuse defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy specified reporting requirements, The abuse coordinator must submit a preliminary investigation report to the appropriate State Agencies immediately once assurances for the resident's or other resident's safety have been established. However, if the event that caused the allegation involved abuse or resulted in serious bodily injury, the allegation of abuse must be reported to appropriate state agencies immediately and not later than 2 hours after receiving the allegation of abuse or not later than 24 hours if the event that caused the allegation did not involve abuse and did not result in serious bodily injury. Resident #2 (R2) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record reflected R2 admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, high blood pressure, bipolar 2 disorder, hypothyroidism, major depressive disorder, type 2 diabetes, schizophrenia, gastro-esophageal reflux disease, dysphagia and abnormalities of gait. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R2 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 5/15 and needed supervision and set up help for bed mobility, transfers, walking, dressing, toileting and personal hygiene. Review of a Resident-to-Resident Incident Report dated 10/15/2022 reflected Resident was in the common area with a bag of clothes like she often does. Another resident accused (R2) of taking her clothes. (R2) told this resident that they were not taken from her, and she owned them. The other resident yelled at her and threw a glass of water, but the water did not hit (R2). (R2) was not upset and went about her business of watching activities going on around her. Review of an Incident Report dated 11/15/2022 reflected Resident was sitting in common area and c/o (complained of) to staff that she fell in her room earlier. During assessment resident (R2) was noted to have a 5x5 hematoma to right temple and c/o right arm pain. Resident stated, I fell and hit my head against the closet. No evidence in the State Agency facility reporting database reflected the facility reported the injury of unknown origin or conducted an investigation into the injuries of unknown origin to rule out neglect or abuse. Review of an Incident Report dated 11/23/2022 reflected Resident stood up, took few steps away from chair, stumbled, took step back and fell to chair. Landed on right back and right elbow. Head hit recliner seat and arm of recliner. Combative with assessment. Transferred to recliner with hoyer (mechanical) lift and 3 staff members. During an observation and interview on 11/29/2022 at 8:32 AM, R2 was seated in a recliner in a common area on the unit with an over the bed table in front of her. R2's right temple area was bruised and R2's arm was in a splint as she was eating breakfast. When asked, R2 could not explain what had happened to her arm or how her face had become bruised. R2 then noticed a male resident in the area, asked who he was and then said that the male resident was engaged to be married to her (demonstrating severe cognitive impairment). Resident #15 (R15) Review of an Admission Record reflected R15 admitted to the facility on [DATE] with diagnoses that included dementia, lack of coordination, type 2 diabetes, cognitive communication deficit and a lack of relaxation and leisure. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a significant change Minimum Data Set (MDS) assessment dated [DATE] reflected R15 was severely cognitively impaired as evidenced by a BIMS score of 00/15. R15's assessment of mood revealed depression and delusions with behavior symptoms including physical, verbal and other behavioral symptoms not directed toward others. Section E - Behavior reflected that R15's behaviors did not place her at risk for physical illness or injury or interfere with R15's care. R15's behavior was coded as putting others at risk for physical injury, intruded on the privacy or activity of others and disrupted the care and living environment of others. R15 was found to have wandering behaviors that had worsened and significantly intruded on the privacy of activities of others. On 11/29/2022 at 4:05 PM, Incident and Accident/Unusual Occurrence reports pertaining to R15 for the month of October and November were requested from the Director of Nursing (DON). The incident reports provided reflected that R15 had an unwitnessed fall on 10/11/2022 and 10/31/2022. R15 had another fall on 11/4/2022 and 11/5/2022 without observation of a head injury or indication the falls were unwitnessed. An unwitnessed fall occurred on 11/9/2022 without evidence of a head injury, neurological assessments were completed. Review of an incident report dated 11/23/2022 reflected CNA (Certified Nurse Aide) notified nurses that resident had bruise to left eye. The incident was unwitnessed and R15 was not able to explain how the injury had been caused. During an observation on 12/01/2022 at 9:10 AM, R15 was observed seated in a recliner chair in the main dining room on the dementia unit. A faint yellow bruise approximately 2 inches wide and 2 inches long over R15's left eyebrow was noted. Staff in the area were asked about the bruise and did not know what had caused it. R15 did not respond when questioned about the bruise. During an interview on 12/01/2022 at 9:30 AM, Nurse Practitioner (NP) P reported he thought he knew about the bruise and assumed it was related to R15's history of falls. During an interview on 12/01/2022 at 10:45 AM, the Director of Nursing (DON) was asked about the injuries of unknown origin observed on R2 and R15. The DON said the injuries of unknown origin were not reported to the state agency but she thought she had investigations pertaining to R15's bruise. During an interview on 12/01/2022 at 2:00 PM, the Nursing Home Administrator (NHA) and Consultant Registered Nurse (CRN) V reported they did not have an investigation into the injuries of unknown origin for R2 and R15. CRN V reported that there was a brief note related to R15's injury of unknown origin that attributed the bruise to R15's history of falls. 39056 Review of intake #'s MI00131599, MI00132243, MI00132497, and MI00132499 revealed the facility failed to identify that abuse occurred due to the facility failure to understand the term willful. Because of the facility failure to identify that abuse occurred, no root cause was identified, no corrective action was implemented, and no preventative measures were implemented to prevent ongoing abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Intake Information involving R107 and R52, submitted to the State Agency revealed, .Incident Summary DON (Director of Nursing) inform (sic) Administrator that nurse on duty reported that (R107) was attempting to take a drink from the supper tray. CNA while (sic) CNA was redirecting (R107), (R107) lifted his fist to his (sic) the CNA. From no where (R52) came behind (R107) and wrapped his hands around (R107) to prevent him from hitting the CNA .The following were done during the investigation *Social worker followed up with both residents to follow up with psychosocial wellbeing *Care plan updated *Medication reviewed for both residents *Therapy assessed (R68) and gave her a new wheelchair same as (R74) *Both residents doing okay *Both residents continue to be in baseline with activities *Social worker *BIM & PHQ assessed . Indicating the investigation was not related to R107 and R52 and an inaccurate investigation was submitted to the State Agency. Review of the Intake Information involving R46 and R87, submitted to the State Agency revealed, .Incident Summary Administrator received a call from nurse on duty stating that CNA did inform her that she heard a noise from (R87's) room when she went in to check she saw resident on the floor when asked how resident got to the floor CNA reported that resident stated his room mate (sic) (R46) pushed him. Investigating started immediately .The following were done during the investigation *Social worker followed up with both residents to follow up with psychosocial wellbeing *Care plan updated *Medication reviewed for both residents *Therapy assessed (R68) and gave her a new wheelchair same as (R74) *Both residents doing okay *Both residents continue to be in baseline with activities *Social worker *BIM & PHQ assessed . Indicating the investigation was not related to R46 and R87 inaccurate investigation was submitted to the State Agency. During an interview on 12/05/2022 at 3:25 PM, NHA (Nursing Home Administrator) reported the investigation notes were pulled from a previous FRI between R74 and R68 and documented in R46 and R87's investigation and R107 and R52's investigation. NHA reported this was done by the previous NHA. NHA verified that it appeared as though it was copied and pasted.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #: MI00132243 Based on interview and record review, the facility failed to 1.) allow a resident to return to the facility after an emergency room (ER) evaluation and 2.) notify the residents DPOA (Designated Power of Attorney) in writing of their appeal rights for 1 resident (Resident #107) reviewed for facility initiated transfers, resulting in Resident #107 being denied return to the facility, the inability of Resident #107's DPOA to appeal the involuntary discharge, and the decline in R107's psychological wellbeing. Findings: Resident #107 (R107) Review of an Admission Record revealed R107 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: restlessness and agitation, schizophreniform disorder, major depressive disorder, and dementia. Review of a Minimum Data Set (MDS) assessment for R107, with a reference date of 7/28/22 revealed a Brief Interview for Mental Status (BIMS) score of 4, out of a total possible score of 15, which indicated R107 was severely cognitively impaired. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility Reported Incident revealed that on 9/24/22 at 4:00 PM, (R107) was witnessed with his pants pulled down on top of (R9) while she was laying in her bed fully clothed (gown and brief on and not tampered with) her bed sheets were pulled up covering her body . (R107) was sent out to the hospital for evaluation . Through the investigation it was determined that prior to this event, (R107) did not display sexually inappropriate behavior toward other residents, he had historically directed his comments toward staff members and had been making comments throughout the day to staff members . Administrator spoke with (Family Member FM O), wife/guardian on 9/24/22 to inform her of the incident that occurred and his transfer to the hospital for further evaluation. At this time (FM O) stated that (R107) had no history of sexual behaviors towards other residents in the past and was surprised to hear of the incident . CONTRIBUTING FACTORS/ROOT CAUSE ANALYSIS: The primary root cause of (R107) sexually inappropriate behavior is due to his dementia and impaired ability to control impulsive behavior. In addition to the root cause, there are multiple contributing factors relating to the allegations: (R107) is diagnosed with schizophreniform disorder, dementia with behavioral disturbance, major depressive disorder, and restlessness/ agitation. (R107) had a medication change on 8/25/2022 and started on Abilify for major depressive disorder, which was a new medication for him. (R107) recently had moved rooms (Indicating the facility identified possible agitators that caused an increase in R107's behaviors). On 9-26-2022 QAPI committee reviewed the incident and investigation .There was no deficient practice identified .DETERMINATION OF FINDINGS: Based on interviews with staff and like residents, families, schedule review, clinical record review, a decisive conclusion has been made the occurrence was NOT a result of abuse, neglect or misappropriation. (R107) and (R9) are both significantly cognitively impaired and are unable to consent to sexual activity. Neither resident has a prior history of sexual tendencies towards other residents, and neither resident has had negative interactions with one another in the past. Per staff interviews, neither resident has previously intentionally sought out the other. Neither resident was able to develop a willful intent to cause harm. The incident did not result in harm, pain or mental anguish towards either resident. Review of R107's Hospital Social Work Progress Notes dated 9/24/22 at 7:46 PM revealed, Case discussed with (physician name omitted). Per his information, patient is from (facility) Memory Care Unit. He was found on top of a female resident, allegedly attempting to sexually assault her. Per the doctor's information, (facility) is refusing to have this pt (patient) return. I have sent a text the (facility) liaison, (name omitted) with no success . (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R107's Hospital Social Work Progress Notes dated 9/24/22 at 10:21 PM revealed, .Patient was sent to the ED (emergency room) from (facility) for allegedly attempting to sexually assault a female resident. I have attempted to talk with the patient via Telemed. He is able to tell me his name and birthdate but that he doesn't know how old he is or give any other details at all. He has a hx (history) of dementia with behavioral disturbances. No family in the ED. I was able to speak with (NHA). Initially she said that he needed to be seen by psychiatry before he could return to the facility. She said that they have a psych team that sees him in their facility and that he's had increased behaviors recently and that there were med changes but she didn't know what they were. She states this is the first time that he's attempted to sexually assault another resident. When I called (NHA), back to talk further about it, she told me that they would never be able to have him return to the facility and he needed to go to a different long term care facility. She states she has told the wife. I did request that his records indicating his behaviors and the meds/changes be faxed to the ED. She said that she would have the (sic) done .I did talk with (physician name omitted), psychiatrist who initially stated that he would be willing to evaluate the patient on Sunday but that he really had no interventions that would change the situation, and that he could not guarantee that the patient wouldn't have behaviors again. He has also been told that the patient is no longer able to return to the facility .At this time, there is no indication that he'd need to go to inpt (inpatient) psych placement. Pt is pleasant and calm in the ED tonight . Review of R107's Emergency Department Progress Notes dated 9/24/22 at 6:58 PM revealed, This is a [AGE] year-old male presenting today with behavioral disturbance with reports of sexual assault at his care facility. They do not feel comfortable taking him back at this time. On my exam, he seems to be at his baseline, he is alert and oriented . Review of R107's Hospitalist Progress Note dated 9/26/22 revealed, .Continue abilify (increased from 5 to 10mg). Review of R107's Hospitalist Progress Note dated 9/27/22 revealed, .Facility will not allow patient to return . Continue Abilify 10mg . Patient is currently calm and redirectable, food motivated .Medically stable for discharge when facility and bed secured . Review of R107's Hospitalist Progress Note dated 10/5/22 revealed, .Patient allegedly attempted to sexually assault another resident at his facility-Facility will not allow patient to return-Social work consulted, in the process of finding new placement (>500 referrals sent)-Telemdicine Psychiatry evaluation noted, medications optimized Patient is currently calm and redirectable, food motivated Medications as per psych recommendation . Review of R107's Hospital Records revealed no documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility during the appeal process. During an interview on 12/01/22 at 04:07 PM, FM O reported that she was never given appeal paperwork and was not aware there was an appeal process. FM O reported that had she known she had a right to appeal the involuntary discharge she would have done so. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FM O reported that she was not notified that R107 was being sent to the hospital due to the incident that occurred on 9/24/22. FM O reported that she had contacted the facility to see if we (family) could visit and they told me he was in the hospital. FM O reported that she wanted R107 to return to the facility. FM O stated he doesn't know what he's doing because of his advanced dementia. FM O reported that she had never agreed with the NHA to have him sent to another facility. FM O reported that she contacted the facility to see if he would be allowed to return and was told by the NHA that they would not allow R107 to return to the facility. FM O reported that she was told he would not be permitted to return for the safety of the other residents. FM O stated what about his safety? What about his mental wellbeing. How do you think his mind is feeling right now? He doesn't know what's going on. FM O reported that even after R107 had a psychiatric evaluation completed in the hospital, and he was at his baseline, the facility would not allow him to return. FM O reported that she had visited him while he was in the hospital, and he was not combative or inappropriate and he was the same as when he was at (facility.) FM O reported that prior to the incident R107 seemed to be doing alright and was at his baseline. FM O reported that family was able to visit him while at the facility. FM O reported that he was sent to a facility in Detroit after he was not permitted to return to the facility and family can no longer visit because of the distance. FM O reported that she works night shift and cannot drive 3 hours each way to visit him in Detroit often. FM O reported that since his transfer to Detroit her visits with R107 have decreased significantly. FM O reported that it did not benefit him moving across the state and the new environment has caused him fear. FM O stated, all these transfers (to hospital and then to new facility) is messing with his head and because of the transfers she has noted a decline is his psychosocial wellbeing. FM O stated it's not doing his disease any good to not see family at all. FM O reported that between the transfers and the inability for him to see his family, he has had increased confusion, increased fear, and a decline in his mental health. FM O reported that the incident never should have occurred. FM O reported that the facility wasn't paying attention to this particular (dementia) unit and she could not understand how there were no staff supervising the residents, with known wandering behaviors, to prevent this type of situation. FM O stated, if they had been paying attention this wouldn't have happened. During an interview via email on 12/1/22 at 1:22 PM, NHA reported that R107's DPOA and the LTC Ombudsman were not given notification of appeal rights regarding R107's transfer that occurred on 9/24/22. Review of R107's Electronic Medical Record revealed no documentation of the specific resident needs that could not be met at the facility to allow R107 to return, facility attempts to meet those needs, or the services available at the receiving facility to meet those needs. Review of R107's Care Plan for behaviors revealed, Focus-Resident has a behavior concern r/t (related to) dementia & depression. Has the potential to wander and may be friendly toward females (asks staff if they are married or make inappropriate/vulgar comments) Resident may touch female. May ask them for sex or make inappropriate gestures toward them (fondled self). May refuse to keep clothing and brief on. Date Initiated: 08/10/2021 . Indicating inappropriate sexual behavior was known and ongoing since the time of admission (greater than 1 year). (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R107's Care Plan for behaviors revealed, Interventions-Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Put up stop barriers on the doors of female rooms on the same hallway. Date Initiated: 10/11/2021 .Redirect/distract res. from rooms and carts and offer assistance. Date Initiated: 11/17/2021 . Review of R107's Care Plan for wandering/elopement revealed, Resident is an elopement risk and/or exhibits wandering behavior r/t dementia. Per wife, has a history of wander halls and rooms. May go into other resident rooms with or without clothing on. Date Initiated: 08/09/2021 . Indicating behavior was known and ongoing since the time of admission (greater than 1 year). Review of the State Operations Manual revealed, The facility must not evaluate the resident based on his or condition when originally transferred to the hospital. If the facility determines it will not be permitting the resident to return, the medical record should show evidence that the facility made efforts to .Ascertain an accurate status of the resident's condition (or) . Find out from the hospital the treatments, medications, and services the facility would need to provide to meet the resident's needs upon returning to the facility . Review of the facility policy Discharge or Transfer dated 1/28/20 revealed, It is the policy of this facility to provide the Resident with a safe organized structured transfer and or discharge from the facility to include but not limited to hospital, another healthcare facility or home that will meet their highest practical level of medical, physical and psychosocial well-being. Expiration of Resident within facility is known as a Discharge. A transfer and or discharge shall be considered for the following reasons as regulated by Federal, State and other Regulatory Agencies. 1. Transfer/Discharge: Emergency .e. Provide Transfer Notice and Bed Hold Policy to the resident and/or an immediate family member or legal representative f. Document entire process in Nursing Progress Note.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to accurately complete Minimum Data Set (MDS) assessments in 2 residents (Resident #9 and #25) reviewed for accuracy of assessments, resulting in an inaccurate reflection of the resident's status and the potential for inaccurate care plans and unmet care needs. Findings: Resident #9 (R9) Review of an Admission Record revealed R9 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia and palliative care. Review of R9's Progress Note dated 8/7/22 revealed, CNA notified this nurse to come to resident room. CNA was providing peri care and repositioning and noted skin issue to right coccyx. Site assessed and noted blister to right coccyx. Site measures 2x1.6x0.1cm . (Indicating a new pressure ulcer). Review of R9's (contracted wound care agency) Progress Note dated 11/22/22 revealed the date of onset of the pressure ulcer was August 2022 (Indicating ongoing pressure ulcer treatment and current pressure ulcer concerns). Review of R9's Skilled Nursing note dated 8/22/22 revealed, MDS note: Resident signed on with Hospice services 8/20/22. Significant change MDS initiated with ARD (Assessment Reference Date) 9/2/22. Review of a Minimum Data Set (MDS) assessment for R9, with a reference date of 9/2/22 revealed no documentation that R9 had a pressure ulcer or that she was receiving hospice services. During an interview via email on 11/30/22 at 7:54 AM, Nursing Home Administrator (NHA) stated, MDS coding was not accurate for both pressure ulcers and hospice. Resident #25 (R25) Review of an Admission Record revealed R25 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease and lung disease. Review of R25's Progress Note dated 8/30/22 revealed, 2.0 x 3.0 open area to bottom of right heel. Left heel 2.0 x 2.0 black discoloration lateral side of left heel . (Indicating 2 new pressure ulcers). Review of R25's Wound Evaluation dated 11/23/22 revealed, Left Heel is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed . Left, Medial Foot is a Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed . (Indicating ongoing pressure ulcer treatment and current pressure ulcer concerns). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for R25, with a reference date of 10/25/22 revealed no documentation that R25 had a pressure ulcer. During an interview via email on 11/30/22 at 7:54 AM, NHA verified the MDS coding was not accurate for R25's pressure ulcer. NHA stated, We are providing education to the MDS prn (as needed) coverage team. During an interview on 12/05/22 at 01:01 PM, regarding the QAPI program (Quality Assurance and Performance Improvement), NHA reported that MDS accuracy was somewhat of a challenge due to the primary MDS nurse being off on leave intermittently. NHA reported that they had nurses covering the MDS nurse while she was off, and those nurses had been educated on accurate MDS assessments when the concern was identified during the survey. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Long-term health care settings include skilled nursing facilities (SNFs), in which patients receive 24-hour-a-day care, including housing, meals, specialized (skilled) nursing care, treatment services, and long-term care facilities, in which patients with chronic conditions receive 24-hour-a-day care, including housing, meals, personal care, and basic nursing care. Requirements for documentation in these facilities are governed by individual state regulations, TJC, and CMS. CMS mandates use of the Resident Assessment Instrument (RAI), which includes the Minimum Data Set (MDS) and the Care Area Assessment (CAA) to document data in long-term care facilities. MDS assessment forms are completed on admission and then periodically within specific guidelines and time frames for all residents in certified nursing homes (Ahn et al., 2015). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 377). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Nursing centers must comply with the Omnibus Budget Reconciliation Act of 1987 and its minimum requirements for nursing facilities to receive payment from Medicare and Medicaid. Government regulations require that staff members in nursing centers comprehensively assess each resident and that care planning decisions be made within a prescribed period. A resident's functional ability (such as the ability to perform activities of daily living and instrumental activities of daily living) and long-term physical and psychosocial well-being are the focus. A nursing facility must complete the Resident Assessment Instrument (RAI) for each resident. The RAI helps nursing facility staff gather definitive information on a resident's strengths and needs, which must then be addressed in an individualized care plan (CMS, 2015b). The RAI has three components: the Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process, and the RAI Utilization Guidelines. The components of the RAI yield information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified (CMS, 2015b). The MDS Version 3.0 is an initial overview of a resident's health care needs. It is a preliminary assessment to identify the resident's potential problems, strengths, and preferences. The CAAs are triggered by individual MDS item responses that reveal the need for additional assessment. These item responses identify problems, known as triggered care areas, which form a critical link between the MDS and decisions about care planning. CAAs enable facilities to identify and use tools that are grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 21). Elsevier Health Sciences. Kindle Edition.

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F 0684 Level of Harm - 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** 29073 This citation pertains to intake MI000132486 Based on interview and record review, the facility failed to assess, monitor, and notify the physician of new onset behavioral changes (refusing care, crying, screaming/yelling), immobility and difficulty transferring for one resident (Resident #108), resulting in a 4 day delay in care and treatment of a severe right hip fracture. Findings: Resident #108 (R108) Review of an Admission Record reflected R108 originally admitted to the facility on [DATE] with diagnoses that included Down Syndrome, adjustment disorder, insomnia, edema, primary generalized osteoarthritis, dysphagia, constipation, major depressive disorder, delusional disorder, hallucinations, high blood pressure, pain and dementia. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R108 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3/15. Section E-Behavior indicated R108 did not exhibit behavioral symptoms and did not reject care. Section G - Functional Status reflected R108 needed supervision and one-person physical assistance for bed mobility, walking in room and in the corridor as well as for locomotion on and off the unit. R108 needed extensive assistance from one person for toilet use, personal hygiene and dressing, did not have functional limitations in Range of Motion (ROM) and did not use mobility devices (cane, walker, wheelchair). Review of a Nurse Practitioner 60 Day mandatory visit progress note dated 10/5/2022 reflected Pt (patient, R108) seen today sitting in the common room. Pt is without any acute concerns and does not appear to be in any distress. Pt is a poor historian and the bulk of this history of presenting illness was deferred to nursing staff and chart review. Nursing staff denies any concerns for the patient. They state that he has been content and easily directed by staff with a calm approach. They deny any clinical concerns for the patient at this time. In terms of ADLs (activities of daily living), pt. does require assistance with bathing and grooming. He is able to ambulate independently. He has maintained adequate intake with food and fluids and is both continent and incontinent of bowel and bladder. We will continue with this plan and follow up with him periodically. Review of a General Progress Note dated 10/24/2022 at 3:30 PM reflected 3:30 - Loud scream heard. Resident (R108) having Grand Mal seizure while sitting in recliner. Muscles became rigid, loss of consciousness, breathing was slow and labored, seizure lasted approximately 5 minutes. 4:40 - Breathing normal, VS (vital signs) 125/50 (blood pressure), 69 (heart rate), 98% (oxygen saturation). Talking with staff. DPOA (durable power of attorney) and NP (Nurse Practitioner) notified. A full physical assessment to of R108 after the seizure was not documented. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 11/29/2022 at 4:05 PM, Incident and Accident/Unusual Occurrence reports pertaining to R108 for the month of October were requested from the Director of Nursing (DON). An incident report was not completed for R108 after the seizure on 10/24/2022. Review of a Documentation Survey Report v2 (a Certified Nurse Aide (CNA) task and resident functional status documentation) for the month of October 2022 reflected that prior to 10/24/2022, R108 was typically independent with transfers and required only supervision and/or limited support to complete transfers occasionally. On 10/25/22 and 10/26/2022 R108 was coded as being totally dependent on two people for transfers. On 10/27/22 R108 needed extensive assistance from one person to transfer and was again totally dependent on two people for transfers on 10/28/2022. R108 was independent with walking in his room or in the corridor the majority of the time during the month of October until 10/24/2022 when it was documented R108 was either totally dependent of two staff members for locomotion or did not walk at all between 10/24-10/28/2022. Behavior documentation reflected that R108 exhibited yelling/screaming and rejected care on 10/25/22, had frequent crying and rejected care on 10/26/22 and had frequent crying, yelling/screaming and rejection of care on 10/27/2022. Review of a General Progress Note dated 10/28/2022 at 12:06 PM reflected Complaining of pain in Right hip. Screaming in pain when being turned. NP notified N.O. (new order) for Xray of right and left hip and abdomen. Miralax (laxative) given for constipation. Review of a General Progress Note dated 10/28/2022 at 7:12 PM reflected Xray results showing R (right) hip fx (fracture). Notified on call (name of on call provider), receiving order to send to the ED (Emergency Department) for eval and further tx (treatment). Guardians notified and will meet him there. On call manager notified. Report called to (name of local hospital), all necessary documentation sent with resident and (ambulance company). Further review of progress notes from 10/24/2022 -10/28/2022 did not reflect evidence of a nursing assessment or physician notification related to the documented change in R108's behavior, transfer or mobility status as noted in the CNA charting. Review of R108's hospital records from 10/28/2022-10/31/2022 reflected the Chief Complaint: HIP PAIN (Patient had seizure 4 days ago and has been unable to ambulate since. Xray of right hip was completed and fracture of right hip was found.) The History of Present Illness reflected [AGE] year-old male with history of Down syndrome and a seizure disorder presents (to) emergency department with hip pain after a fall. Patient had seizure 4 days ago. Since that time has been refusing to walk. X-rays obtained at the facility showed a right-sided acetabular fracture. Patient was sent to the emergency department for evaluation. Patient's cousins are here with him for his power of attorney. They are not aware of any other recent illness. They saw him last week and he was doing well. When the patient is in bed at rest, he has no complaints of pain. The final result from the CT Abdomen and Pelvis Without IV Contrast reflected 1. Complex comminuted and displaced fractures of the right acetabulum involving both the anterior and posterior columns. Extension of the anterior column fracture into the iliac wing with a displaced fracture fragment into the iliacus muscle resulting in a small volume intraperitoneal hemorrhage. Additional fracture extension into the superior pubic ramus. The hospital record indicated that R108 was not a good surgical candidate and family was planning on hospice care. Review of Progress Notes from 11/01/2022-11/14/2022 reflected that R108 readmitted to the facility and elected hospice care. R108 was treated for pain and comfort and passed away at 11:46 AM on 11/14/2022. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/01/2022 at 9:39 AM, NP P reported that he was likely in the facility on 10/24/2022 and would have been made aware of R108's seizure at that time. NP P said he was not made aware R108 had a change in condition after 10/24/2022 until he was told R108 had a severe hip fracture. NP P reported that the facility staff are very good at documenting when a resident is doing well or are doing very poorly but that identifying and reporting changes in condition as they occur needs improvement.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on observation, interview and record review, the facility failed to 1.) provide care following professional standards of practice and facility policy to prevent the development/worsening of avoidable pressure ulcers, 2.) assess, monitor, and provide ordered treatment for residents with new/worsening pressure ulcers, and 3.) promptly notify the physician of a change in condition for 2 residents (Resident #21 and #9), reviewed for alterations in skin integrity/pressure ulcers, resulting in unrecognized changes and the worsening of skin impairments, a delay in treatment and the potential for prolonged wound healing, infection, and overall deterioration in health status. Findings: Review of the Quality Assessment & Assurance Committee-AD HOC MINUTES dated 10/19/22 revealed, Plan of Correction-Wound & Skin Management Program (from previous F-Tag 686 citation issued on 8/23/22) .Education *Licensed Nurses and CENAs (Certified Nursing Assistant) were educated by the DON (Director of Nursing)/designee on the policies and procedures for Skin Monitoring and Management program, specifically assessment of wounds, communication from providers, updating and implementing plans of care, turning and repositioning, and appropriate physician orders for treatments .Chief Nursing Officer will educate DON and Administrator on the IDT (Interdisciplinary Team) Skin Committee Weekly meeting. *DON and Administrator educated the IDT on the IDT Skin Committee Weekly meeting expectations. Monitoring *Audits will be completed on 5 random residents with wounds weekly x4 weeks then monthly x2 months, or until substantial compliance has been achieved, by ensuring appropriate assessment of wounds, communication from providers, updating and implementing plans of care, turning and repositioning, and appropriate physician orders for treatments. Any concerns will be corrected immediately. *The results will be present to the QAA committee for review and consideration of further corrective actions. Alleged Compliance- The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 10/19/2022 and for sustained compliance. Resident #21 (R21) Review of an Admission Record revealed R21 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: Alzheimer's Disease. Review of a Minimum Data Set (MDS) assessment for R21, with a reference date of 9/16/22 revealed R21 was severely cognitively impaired. Review of the Functional Status revealed that R21 required extensive 1 person assist for bed mobility, toileting, and personal hygiene, and extensive 2 person assist for transferring. Review of the Skin Conditions revealed R21 did not have a pressure ulcer but was at risk for the development of pressure ulcers. Review of R21's Physician Order dated 11/10/21 revealed, Apply border foam dressing to coccyx every 3 days and prn (as needed) for protection. Review of R21's Physician Order dated 2/8/22 revealed, Desitin Paste (Zinc Oxide) Apply to buttock topically every shift for incontinence dermatitis. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R21's ADL (Activities of Daily Living) Care Plan revealed, Turn and reposition frquently (sic) Date Initiated: 11/02/2021 . Review of R21's Skin Observation Tool dated 11/16/22 revealed no alterations in skin integrity. Review of R21's Skin Observation Tool dated 11/22/22 revealed, .MASD (Moisture Associated Skin Damage), continue zinc as ordered .Res is turned and repositioned Q (every) 2 HRS and PRN (as needed). R21's Care Plan was not updated to reflect repositioning every 2 hours). Review of R21's Skin Observation Tool dated 11/23/22 revealed, .Resident has MASD on bilateral buttocks and her coccyx area, continuing zinc as ordered. Resident has pressure area on coccyx, continuing with treatment order for mepilex dressing. Resident is turned and repositioned Q2hrs and PRN. No other skins (sic) concerns for resident at this time . Review of R21's Progress Notes revealed no documentation that the provider was notified of R21's skin breakdown on 11/22/22 or 11/23/22. Review of R21's Progress Notes revealed no documentation that the Unit Manager or Director of Nursing were notified of R21's skin breakdown on 11/22/22 or 11/23/22. Review of the Provider Communication Book located in the Gilead (name of locked dementia unit) Unit Nursing Station revealed no documentation/communication of R21's skin breakdown on 11/22/22 or 11/23/22. Review of R21's Physician Orders revealed no new orders or order changes regarding R21's MASD or Pressure Area identified on 11/22/22 or 11/23/22. Review of R21's Care Plans revealed no new interventions were implemented and/or no changes made regarding R21's MASD or Pressure Area identified on 11/22/22 or 11/23/22. During an observation and interview on 11/30/2022 at 12:40 PM, Certified Nursing Assistant (CNA) X reported that R21's buttocks had skin breakdown that had been worsening over the week. CNA X reported that she had notified the facility nurse of the worsening of R21's skin breakdown. R21 was turned to her left side and her coccyx area had a border gauze that was heavily soiled (unable to determine if it was drainage from the wound or stool/urine) with the edges of that dressing rolled up/not secure to skin (falling off). The border gauze did not have a date to indicate when it was applied and did not have initials to indicate the facility nurse that placed the border gauze on R21. CNA C removed the dressing. R21's skin was red approximately 2-2.5 inches in diameter. Inside the area of redness there were 3 open areas, with bright pink wound beds exposed, indicating a measurable length and width. CNA C and CNA X verified that there were 3 open areas and they both reported those open areas were new for R21. There was an unused border gauze dressing with a handwritten date of 11/30 and initials of Registered Nurse (RN) I on R21's nightstand. CNA C placed zinc barrier cream on R21's coccyx area/skin breakdown and then placed the border gauze over the zinc barrier cream/skin breakdown. CNA C was not a licensed nurse and performing wound care and/or treatment administration was outside CNA C's scope of practice. (Reference 4) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	CNA X reported that residents were not receiving the care they required from licensed nurses or support staff because of the lack of facility staff. CNA X reported that there were many residents on the Gilead Unit that required extensive assist or 2 assist with cares. CNA X stated it's not reasonable to expect that ADL care and supervision can be completed with the number of staff available. Review of R21's Treatment Administration Record (TAR) immediately following R21's skin injury observation on 11/30/2022 at 12:40 PM revealed an order Apply border foam dressing to coccyx every 3 days .for protection and was documented as being completed by RN I. Review of R21's Progress Notes revealed no documentation of R21's skin injury or that R21's treatment had been performed by CNA C. During an interview on 11/30/2022 at 1:42 PM, RN I verified that the girls did it (R21's dressing change) and reported that CNA C and CNA X reported that there were 3 areas but not open (on R21's coccyx). RN I reported that she had not done a skin assessment on R21 but would document the pressure injury concern. Review of R21's Electronic Health Record revealed no documentation that RN I documented R21's pressure injury or that she notified the R21's provider of the pressure injury. Review of R21's Skin Observation Tool dated 11/30/22 (lock time 8:23 PM) revealed Section 1 was completed with no new skin issues identified. Section II ALTERATIONS IN SKIN INTEGRITY and Section III ADDITIONAL INFORMATION were blank. Review of the Provider Communication Book on 12/1/22, located in the Gilead Unit Nursing Station, revealed no documentation/communication of R21's pressure injury identified on 11/30/22. During an interview on 12/01/2022 at 10:15 AM, Nurse Practitioner (NP) P reported that he was not aware of any skin integrity concerns (MASD/pressure ulcer) for R21. NP P reported that the expectation is to notify the provider immediately if there are concerns with a resident's skin integrity. NP P reported that he would want to be notified of the smallest area; even redness so he could order an intervention and/or treatment to prevent the worsening of the condition. NP P reported that if a resident has MASD he would not order border gauze as a treatment because removing the border gauze could cause the fragile skin to tear and worsen the condition of the wound. NP P reported that he would assess R21's skin and modify/implement a treatment today. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview on 12/01/2022 at 12:45 PM with Licensed Practical Nurse (LPN) K and the DON highlighted aspects of the skin/wound monitoring program's ineffectiveness. LPN K reported that he was the Unit Manager as well as the nurse responsible for wound monitoring/care. LPN K reported that he was not Wound Care Certified. DON reported that the wound care program was new and started because of the citation that the facility had recently been issued (citation issued 8/23/22 with alleged compliance date of 10/19/22). DON reported that LPN K had been responsible for the wound care program for approximately 1 month. DON reported that the IDT (Interdisciplinary Team) met weekly regarding identified skin integrity concerns for all residents in the facility. LPN K reported that he was aware of MASD that was identified and documented approximately 1 week prior on a Skin Assessment. LPN K reported that (contracted wound care agency) was providing care to R21's roommate and consulted with LPN K concerning R21's documented MASD at that time (there was no order for consultation with the contracted wound care agency). LPN K reported that (contracted wound care agency) reported that if there was MASD on R21's buttocks, zinc topical cream and border gauze was okay to treat R21 (this recommendation conflicts with the recommendation for treatment made by NP P). Review of R21's Electronic Health Record (EHR) revealed no consultative notes/documentation regarding R21's skin breakdown and/or treatment recommendations. LPN K reported that he was under the impression that R21's provider was aware of R21's skin breakdown based on R21's active treatment orders. LPN K was not aware that R21's border foam dressing (ordered for protection) and zinc oxide topical was ordered on 11/10/21 and 2/8/22 respectively, and not because of the newly documented skin breakdown on R21's 11/22/22 and 11/23/22 Skin Assessments. LPN K and DON reported that R21 was not being followed by the IDT Weekly Skin Committee (despite the Plan of Correction outlined above). DON reported that she was made aware of R21's skin breakdown this morning (more than a week after the development of actual skin breakdown) and an order for (contracted wound care agency) consult was placed. Review of R21's Physician Provider Note dated 12/1/22 at 1:40 PM revealed: .(R21) is seen today as concerns expressed by the state surveyor regarding an open wound on her coccyx area. The patient is seen with the nursing staff and the state surveyor in her room. The patient was turned on to her left lateral position and the patient's coccyx area is noted and she has a superficial thin layer of skin is eroded and there are three small open areas that are hard to measure, has a second layer eroded, in fact it could be classified as not open as the patient has not had third layer of the skin is not open as subcutaneous tissue is not exposed. The patient does have a delicate skin and occlusive dressing would be difficult to manage so we will not use occlusive dressing and we will only use a barrier cream to protect the delicate skin and I have notified the staff to not wipe and only pat dry the area and keep it clean and dry as much as possible. We will continue to monitor. She was treated with antibiotic for pneumonia recently and she does not appear toxic. We will continue to monitor. She has recovered very well from pneumonia. She is dependent on staff for all ADL. Remains incontinent of bowel and bladder. Physical Exam- SKIN: Skin over sacral/coccyx area examined with ancillary nursing staff and state surveyor. Pt is thin with no subcutaneous tissue. She has a small area of erosion of superficial layer of skin measuring approximately about 2 inches in diameter. with in (sic) that area, there are 3 small spots that is too small to measure has lost next layer of skin and still does not appear to have lost full thickness loss. It started as Started as (sic) MASD .Instructed nursing to treat with barrier cream and to avoid occlusive dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Assessment / Plan- 1. Open wound of sacroiliac region - erosion of superficial layer of skin with out (sic) damage to all layer of skin .Unspecified open wound of lower back and pelvis without penetration into retroperitoneum, initial encounter . (References 1-I, 2, and 3). Review of R21's Progress Note written by DON revealed, LATE ENTRY (written on 12/2/22 at 2:49 PM) Resident wound assessed/evaluated by (NP P). No concerns noted. Superficial area breakdown (3 small pinpoint areas clustered together) noted to coccyx. Orders to apply barrier cream q (every) shift and prn. Also, staff educated on not wiping with wash cloth to avoid further disruption of fragile skin. Will continue to monitor. DON's late entry note does not correlate with NP P's documented assessment and diagnosis of Open wound of sacroiliac region - erosion of superficial layer of skin without damage to all layer of skin . Unspecified open wound of lower back and pelvis without penetration into retroperitoneum . Review of R21's Progress Note dated 12/2/22 at 4:05 PM, written by DON revealed, Full head to toe assessment completed by nursing staff. No new areas of concern. There is a noted reddened area to coccyx that is blanchable. There is also a noted chronic scar to left hip. Care plan updated as needed. Orders reviewed. Indicating R21's no longer had an Open wound of sacroiliac region - erosion of superficial layer of skin without damage to all layer of skin as documented by NP P approximately 26 hours prior. (Reference 3) Review of R21's Physician Order dated 12/2/22 at 4:04 PM revealed, Desitin Paste (Zinc Oxide) Apply to buttock topically every shift for incontinence dermatitis apply every shift and with all peri care. Do not wipe with washcloth. Indicating NP P's order was not completed/processed until approximately 26 hours later. Review of R21's Physician Order dated 12/1/22 revealed, Border foam discontinued. Indicating NP P's order was not completed/processed until approximately 26 hours later. Review of R21's skin integrity Care Plan revealed, Do not wipe fragile skin on sacrum/coccyx with wash cloth until area is healed Date Initiated: 12/02/2022 . Indicating provider-initiated intervention was not immediately updated on R21's Care Plan following his assessment and recommendation. Review of R21's Care Plan revealed turning/repositioning was not updated with a turn schedule and remained unchanged from 11/02/2021. Resident #9 (R9) Review of an Admission Record revealed R9 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia and kidney disease. Review of a Minimum Data Set (MDS) assessment for R9, with a reference date of 9/2/22 revealed R9 was severely cognitively impaired. Review of the Functional Status revealed that R9 required extensive 1 person assist for bed mobility and personal hygiene, and extensive 2 person assist for transferring and toileting. Review of the Skin Conditions revealed R9 did not have a pressure ulcer but was at risk for the development of pressure ulcers. During an observation on 11/30/2022 at 9:16 AM, R9 was sitting up in her broda chair leaning towards the left in the main activity/dining area on the Gilead Unit. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 11/30/2022 at 12:00 PM, R9 was sitting up in her broda chair leaning towards the left in the main activity/dining area on the Gilead Unit. During an observation on 11/30/2022 at 12:20 PM, R9 was sitting up in her broda chair leaning towards the left in the main activity/dining area on the Gilead Unit. CNA C reported that she was going to bring R9 back to her room to provide incontinence care and lay R9 down in her bed. CNA C asked another CNA to assist her with getting R9 to bed (R9 utilized a hoyer lift for transferring which required 2 staff assistance) but the CNA was assisting another resident on the unit and was unable to help at that time. CNA stated it'll (R9's incontinence care and chair to bed transfer) have to wait until I can get help. At 12:30 PM, CNA X and CNA C transferred R9 to her bed. CNA C reported that R9's routine is to be transferred to her broda chair prior to breakfast and transferred to her bed after lunch and incontinence care is provided prior to breakfast and after lunch CNA C reported that R9 required full feeding assistance and had to be sitting upright in her broda chair for all meals which was why she remained in her broda chair until after lunch. Review of the Dining Cart Order Schedule revealed breakfast on the Gilead Unit for residents that are assisted begins at 8:30 AM and lunch begins at approximately 12:30 PM with a 15-minute variable, resulting in R9 being in her broda chair for approximately 4-5 hours at a time. R9's bilateral lower extremities were contracted (inability to straighten legs due to shortening and tightening of the muscles) and her knees were rubbing together. R9 had mild redness between her knees and CNA C reported R9 should have a pressure relieving device in place to prevent a pressure injury. R9 was placed in her bed and incontinence was provided. R9's brief was saturated/heavy with urine and stool. R9 had a dressing on her right hip that did not have a date it was applied or the initials of the licensed nurse that completed the dressing change. CNA X reported that the area on R9's right hip was a new area of skin breakdown and CNA C agreed and stated that the skin breakdown was like a blister that popped. R9's sacral wound was uncovered/no dressing in place. CNA C completed pericare on R9 and covered R9's open sacral wound with skin protectant barrier cream. CNA C then placed a clean brief on R9 and repositioned her for comfort. CNA C and CNA X reported that R9 was to be repositioned at least every 2 hours to prevent skin breakdown. CNA C reported that because of the lack of facility staff, R9 would not receive timely incontinence care or repositioning because R9 required 2 staff assistance with hoyer transfers. CNA C reported that when the other CNAs were assisting other residents, there are no additional staff to assist her with transferring R9 to her bed. Review of R9's Progress Note Details from the contracted wound care agency dated 11/22/22 revealed, . Location: Sacrum .Date of Onset: Reported August 2022. Context: Pressure. Associated Signs and Symptoms: Increased pain noted .Nursing staff report patient developed a wound to her sacrum. Patient is dependent on staff for cares and repositioning .Wound Assessment .Sacral is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed .There is no change noted in the wound progression .Slightly larger SA (Surface Area) but wound clinically unchanged . Wound Orders .Cleanse wound with Normal Saline or Wound Cleanser. Wound Dressing: Apply hydrocolloid-change dressing 3 times per week; Change dressing as needed for soiling, saturation, or accidental removal. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Additional orders: Pressure Relief/Offloading .turn in bed at least once every 2 hours if able-check and change every 2 hours (and PRN) with repositioning . Coordination of Care .Education provided to LPN K on offloading, repositioning, and the importance of dressing remaining in place . Review of R9's November Treatment Administration Record (TAR) revealed, Hydrocolloid dressing right hip and coccyx for protection. change every 3 days and PRN when soiled. every 72 hours for protect right hip. R9's November TAR did not include the contracted wound care agency's wound care order for Cleanse wound with Normal Saline or Wound Cleanser. Review of R9's skin impairment Care Plan revealed, The resident is at risk for impaired skin r/t Disease process dementia, Immobility, Impaired nutritional status, incontinence. Stage 2 pressure ulcer of right coccyx Date Initiated: 08/07/2022 Revision on: 10/21/2022. R9's Care Plan was not revised to reflect R9's sacral Stage III pressure injury nor the pressure injury on her right hip. R9's Care Plan did not include interventions to relieve pressure between R9's knees. (Reference 8) Review of R9's Activities of Daily Living Care Plan revealed, .Check and Change (incontinence care) with AM/HS (morning and bedtime) care and before/after meals .Revision on: 11/03/2021. R9's Care Plan did not reflect the contracted wound care agency pressure relief orders. Review of R9's Skin Care Plan revealed, .Resident on an up and down schedule. Turn frequently, Float heels. Date Initiated: 08/07/2022. R9's Care Plan did not reflect the contracted wound care agency pressure relief orders. REFERENCES: 1.Review of the facility policy Skin Monitoring and Management-Pressure Ulcer dated 7/11/18 revealed, POLICY: It is the policy of this facility that: *A resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition or other factors demonstrate that a developed pressure ulcer was unavoidable; and *A resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new, unavoidable sores from developing. PURPOSE: The purpose of this policy is that the resident does not develop pressure ulcers unless clinically unavoidable, and that the facility provides care and services to: *Promote the prevention of pressure ulcer development; *Promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible); and *Prevent the development of additional, avoidable pressure ulcers . This policy acknowledges that, in certain circumstances, the development of pressure ulcers is an unavoidable occurrence. In accordance with the guidance issued by the National Pressure Ulcer Advisory Panel (March 2010), the facility recognizes that an unavoidable pressure ulcer is one which developed even though the provider evaluated the individual's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with individual needs goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. Facility nursing staff is expected to identify and document the resident's clinical condition and pressure ulcer risk factors related to the development of unavoidable pressure ulcers at the time of admission and thereafter as appropriate. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	PROCEDURE: RESIDENT ASSESSMENT The nurse responsible for assessing and evaluating the resident's condition on admission and readmission and is expected to take the following actions: A. Complete an admission assessment/evaluation and skin risk assessment to identify risk and to identify any alterations in skin integrity noted at that time . F. Assessment of wounds identified after admission: * A licensed nurse (which may be the facility Wound Nurse) must assess/evaluate a resident's skin at least weekly. All areas of breakdown, excoriation, or discoloration, or other unusual findings must be documented in the resident's clinical record. G. A licensed nurse (which can be the facility Wound Nurse) must assess/evaluate at least weekly each wound, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should include but not be limited to: *Measuring the wound *Staging the wound *Describing the nature of the wound (e.g., pressure, stasis, surgical wound) *Describing the location of the wound *Describing the characteristics of the wound *Describing the progress with healing, and any barriers to healing which may exist *Identifying any possible complications or signs/symptoms consistent with the possibility of infection. I. Once a wound has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's Order. *All wound or skin treatments should be documented in the resident's clinical record at the time they are administered. Stages/Description/Further Description . Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. o DOCUMENTATION- A. If the clinical assessment/evaluation indicates a change in condition or decline in the wound, the assessing/evaluating nurse will notify the physician and create a narrative nurse's note documenting that notification. B. Licensed Nurse should document skin evaluations in accordance with this policy in the resident's clinical record. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	o MONITORING- A. Daily via medication administration and treatment administration records *Ensure all orders have been implemented as ordered. B. Weekly via Weekly Skin Committee *Prepare and maintain Skin Committee review notes and recommendations in the resident's clinical record. *Document and implement recommended additions or changes to care plan in resident clinical record. C. Skin Inspection on Showering *On shower days, CNAs to observe resident skin. *Identify any areas of skin breakdown, discoloration, tears or redness. *Communicate findings to licensed nurse .*Licensed nurse to acknowledge findings, document pertinent information in resident's clinical record, and respond/obtain and implement treatment order as appropriate. D. Weekly skin check conducted by a facility licensed nurse *All residents will have a head to toe skin check performed at least weekly by a facility licensed nurse. *The licensed nurse should document the performance of the skin check in the resident's clinical record. *Any skin issues identified as a result of the weekly skin check should be documented and responded to as outlined above. F. Comprehensive skin review should occur on an as needed basis through the activity of the Interdisciplinary Team *The assessment/evaluation and recommendations of the IDT shall be documented in the resident's clinical record. o COMMUNICATION OF CHANGES A. Any changes in the condition of the resident's skin as identified daily, weekly, monthly, or otherwise, must be timely communicated to: *The resident's physician . o QUALITY ASSESSMENT AND ASSURANCE A. Incidences of skin breakdown which develop after a resident is admitted to the facility, whether the skin breakdown is avoidable or unavoidable, will be reviewed on a monthly basis, at a minimum, by the facility Quality Assurance Committee. B. Resident response to preventive measures and treatment designed to minimize skin breakdown or facilitate healing will be reviewed on a monthly basis, at a minimum, by the facility Quality Assurance Committee. C. The Quality Assurance Committee should, among other things, evaluate strategies to reduce the development and progression of pressure ulcers as well as monitoring the incidence and prevalence of skin breakdown in the facility. D. The activities and work product of the Quality Assurance Committee relative to the evaluation and assessment of skin breakdown, and the incidence and prevalence of skin breakdown in the facility, are protected from discovery or disclosure in accordance with the State Quality Assurance privilege. 2. Review of the National Pressure Injury Advisory Panel (NPIAP) Pressure Injury Stages revealed, .Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions) . Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. The National Pressure Injury Advisory Panel (NPIAP) is an independent not-for-profit professional organization dedicated to the prevention and management of pressure injuries (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3. Review of the National Pressure Injury Advisory Panel (NPIAP) National Quality Forum dated 8/23/19 revealed, .Stage 2 pressure injuries, as partial thickness wounds heal as a result of epidermal repair. Partial thickness wounds heal through resurfacing of the wound (epidermal proliferation and migration and the reestablishment of epidermal layers to restore the barrier function of the outer skin (epidermal) layers. Unlike full thickness pressure injuries, shallow Stage 2 pressure injuries often heal without long term consequences, loss of skin function or scar tissue formation. Healing occurs in a more predictable manner and depending on the underlying comorbidities, occurs in a shorter timeframe than full thickness wounds. The median time for healing in long term care facilities is 46 days, with longer healing times required for larger Stage 2 pressure injuries . 4. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Delegation and Collaboration-The skill of treating pressure injuries and wounds cannot be delegated to assistive personnel (AP). Instruct the AP to: o Report immediately to the nurse pain, fever, or any wound drainage. o Report immediately to the nurse any change in skin integrity. o Report any potential contamination to existing dressing, such as patient incontinence or dislodgement of the dressing. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1276). Elsevier Health Sciences. Kindle Edition. 5. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Continually assess a patient's skin for breakdown and color changes such as pallor or redness. Consistently use a standardized assessment tool such as the Braden Scale. The screening tool identifies patients with a high risk for impaired skin integrity or early changes in the condition of patients' skin. Early identification allows for early intervention. Observe the skin often during routine care (e.g., when the patient is

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #: MI00130971, MI00131278, MI00132243, MI00132497, MI00132931 and MI00132481 Based on observation, interview, and record review, the facility failed to provide sufficient staffing to 1.) prevent resident to resident abuse for 7 residents (Resident #9, #107, #32, #79, #24, #36, and #1), 2.) prevent the development/worsening of facility acquired pressure injuries for 2 residents (Resident #21 and #9), 3.) provide timely incontinence care for 2 residents (Resident #74 and #32), and 4.) provide adequate supervision for residents with known behavioral needs (wandering). This deficient practice places all residents residing in the facility at risk for unmet care needs and impaired physical, mental, and psychosocial well-being. Findings: On 11/28/2022, the current annual recertification survey and a review of several Facility Reported Incidents (FRI) and complaints commenced. It was identified during the onsite survey that the facility did not ensure there was adequate direct care staffing which resulted in the following deficiencies: 1. The facility failed to prevent resident to resident physical and sexual abuse, and protect residents from continued abuse, due to widespread system failures beginning with the failure to complete an annual facility assessment to determine direct care staffing needs, resident acuity, and staff competency and education requirements to meet the needs of residents with known behaviors and protect vulnerable residents. (Refer to noncompliance cited at F600-Abuse and F838-Facility Assessment). F600 Based on interview and record review, the facility . 3.) failed to identify increased behaviors and revise a care plan and 4.) failed to ensure there was sufficient staffing to supervise residents and prevent resident to resident abuse for 7 residents (Resident #9, #107, #32, #79, #24, #36, #1), resulting in a pattern of systemic neglect leading to resident to resident abuse and the decline in mental and psychosocial well-being. F838 Based on interview and record review, the facility failed to complete a comprehensive facility-wide assessment that included an assessment of the staffing needs, resident acuity, and staff training and education requirements, resulting in insufficient staffing to meet the needs of the residents, inadequate knowledge of the facility population and inadequate resources to care for residents and the potential for unmet care needs and physical and psychosocial harm for residents residing in the facility. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	2. The facility failed to provide an adequate number of staff to meet the basic needs of the residents related to pressure ulcer prevention/healing, (Refer to noncompliance cited at F686-Treatment and Services to Prevent/Heal Pressure Ulcers) F686 Based on observation, interview and record review, the facility failed to 1.) provide care following professional standards of practice and facility policy to prevent the development/worsening of avoidable pressure ulcers, 2.) assess, monitor, and provide ordered treatment for residents with new/worsening pressure ulcers, and 3.) promptly notify the physician of a change in condition for 2 residents (Resident #21 and #9), reviewed for alterations in skin integrity/pressure ulcers, resulting in unrecognized changes and the worsening of skin impairments, a delay in treatment and the potential for prolonged wound healing, infection, and overall deterioration in health status. Incontinence Care Resident #74 (R74) Review of an Admission Record revealed R74 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia. Review of a Minimum Data Set (MDS) assessment for R74, with a reference date of 10/14/22 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated R74 was severely cognitively impaired. During an observation on 11/28/22 at 09:59 AM, R74 was sitting in a chair in the common area of the Gilead Unit (locked dementia unit). R74 stood up from the chair and was visibly agitated and tearful. R74's pants and shirt were saturated with urine extending from her thighs to her midback with a strong odor of urine noted. At 10:02 AM, R74 sat back down sitting at the edge of the chair, appeared restless and shifting her weight back and forth (indicating discomfort). At 10:09 AM, R74 stood up from her chair and began pulling at her saturated pants with continued tearfulness and agitation. R74 began ambulating down the hallway towards the main dining/activity room and the chair she had been using was visibly wet with urine. During an observation on 11/28/22 at 10:14 AM, CNA Y brought R74 to her bathroom and assisted R74 with incontinence care. R74's brief was bulky and excessively saturated with urine. The entirety of R74's buttocks was erythemic (bright red) from prolonged exposure to urine in a heavily saturated brief. Resident #32 (R32) Review of an Admission Record revealed R32 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: alcohol use with alcohol-induced dementia, major depressive disorder, and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for R32, with a reference date of 11/3/22 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated R32 was severely cognitively impaired. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Review of R32's bladder Care Plan revealed, Resident has occasional bladder incontinence r/t (related to) Confusion, Dementia, Poor toileting habits Date Initiated: 05/11/2021 . Review of R32's Skilled Nursing note dated 11/17/22 revealed, Resident has been identified as having declines in dressing, toileting, and hygiene . During an observation on 11/29/22 at 08:40 AM, R32 was walking down the hall saturated with urine. Urine was observed on the buttock area of his pants and up to the lower back area of his shirt with a strong odor of urine noted. At 08:44 AM surveyor notified Licensed Practical Nurse (LPN) A that R32 was saturated with urine. LPN A walked R32 down to his room and had him sit in his cloth recliner on top of a thin blanket. LPN A then left the room without assisting R32 with incontinence care and a clothing change. LPN A returned to the medication cart to continue morning medication administration. During an observation on 11/29/22 at 08:44 AM-09:06 AM, R32 was left sitting in his recliner saturated with urine until Certified Nursing Assistant (CNA) W was finished providing care for another resident on the unit. During an interview on 11/29/22 at 09:07 AM, CNA W reported that there was not sufficient staff to meet the physical and behavioral needs of the residents. CNA W reported that 2nd shift is scheduled to have 3 CNAs on the floor and 1 support CNA to monitor residents in the main area. CNA W reported that there are times when 2nd shift only has 2 CNAs on the floor and that is not enough to control (R32) and (R24) specifically. CNA W reported that there are many residents on the Gilead Unit that wander and there is no way to manage behaviors, prevent resident to resident altercations, and/or wandering in and out of the rooms. CNA W reported that R32 and R24 have wandering tendencies that require frequent redirection. Resident Supervision During an observation and interview on 11/29/22 at 08:45 AM, a female resident in the Gilead Unit dining room ambulated down the hall to R32's room, entered his room, and used his bathroom. Shortly after the female resident entered R32's room/bathroom, LPN A and R32 entered his room so R32 could receive incontinence care. LPN A observed the female resident exit R32's bathroom and reported it was not uncommon for that female resident to wander into resident rooms to use the bathroom. LPN A stated, she gets lost, we redirect her. LPN A reported that the Gilead Unit had a lot of residents that have wandering behaviors which require supervision and a locked unit. During an observation on 11/29/2022 at 2:55 PM, R24 entered R32's room, opened R32's nightstand, removed an item of food from the nightstand and began eating it. A female resident then entered R32's room while R24 was still in there. While R24 and the female resident were in R32's room, a second female resident attempted to enter R32's room. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/29/2022 at 3:00 PM, LPN M reported that the Gilead Unit was staffed with 3 CNAs at that time and 1 CNA was pulled to another unit. LPN M reported that it was difficult to monitor residents that wander in and out of rooms, especially (R32) and (R24) and reported R32 and R24 were often involved in resident-to-resident altercations. LPN M reported that dinner time to bedtime was the most difficult time of the shift because the CNA's had to assist with feeding, changing, nighttime care, and getting residents to bed. LPN M reported the Gilead Unit needed additional staff to supervise residents that wander in and out of rooms and upset other residents. During an observation on 11/30/2022 at 12:01 PM, R24 was observed ambulating up and down the hallway. R24 walked past a resident in the hallway and was less than 6 inches away from the resident. There were no staff observed on the Gilead Unit at that time. R24 has been the aggressor in multiple recent FRI's regarding resident-to-resident abuse. During an observation on 11/30/2022 at 1:05 PM, R32 was ambulating up and down the hall, smiling and talking nonsensically, and stopped in front room [ROOM NUMBER] (female room). A female resident residing in room [ROOM NUMBER] observed R32 standing in her doorway facing into her room. The female resident ambulated down the hall appearing anxious and concerned that R32 would enter. The female resident (able to make needs known with a BIMS of 9/15) used hand motions (pointing and wrist flicking) to prompt/encourage R32 to step away from her doorway and then stood in her doorway to block R32 from entering her room. The female resident and R32 were within arm's reach with no staff observed on the Gilead Unit during the encounter (no physical or verbal aggression was noted during their interaction). R32's Electronic Health Record revealed documentation that R32 would become angry with redirection, agitated and combative with attempted assist, and combative with staff at times during encouragement placing residents that attempt to redirect R32 out of and/or away from their room at risk for physical/verbal abuse. R32's known behavior of wandering into resident rooms has resulted in recent FRI's regarding resident-to-resident physical and sexual abuse. During an observation on 11/30/2022 1:10 PM, R2 was in her wheelchair in the common area on the Gilead Unit. R2 reported she wanted to go to her room but was unable to self-propel herself in the wheelchair. R2 appeared agitated and frustrated, repeatedly attempted to stand, and demanded an ambulatory resident push her to her room. There were no staff observed on the Gilead Unit at that time. During an observation on 11/30/2022 at 1:24 PM, R32 walked closely past R74 in the common area on the Gilead Unit. R74 angrily shouted, get away from me you creep. Indicating residents on the Gilead Unit require close supervision to prevent resident to resident abuse. Resident and Staff Interviews During an interview on 11/28/22 from 10:31 AM-11:24 AM with R79 and R36, R36 reported that there are 2 residents that wander the units and like to go through people's rooms. R36 reported that the 2 residents that wander the halls and enter resident rooms are R32 and R24. R36 reported that both residents had recently entered his room without invitation (intake 132481). R36 reported that he raised my voice to get them to leave and R24 took a swing at me. R36 reported fear with 2 men trying to accost me. R36 reported that he pushed him away with my leg and then R32 came at me. R36 reported that he had to use his walker to protect himself and it took everything I could to get away from them. R36 reported that R24 and R32 are left unsupervised and they are dangerous together. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	R36 reported that residents that require supervision are not supervised. R36 reported that the facility had a couple other (residents) that were bad news. R36 reported that a few months ago R107 sexually assaulted a female resident (R36 was able to name R107 and R9-intake 132243). R36 stated the Gilead Unit is a vulnerable area. These women can't protect themselves from the residents with known behaviors. R79 reported that approximately 2 weeks prior she was in bed sound asleep and (R32) grabbed my boobs. I screamed! (intake 132931) R79 reported fear when she woke to a man standing over her and ongoing fear and anxiety that there have been no changes made to prevent another occurrence. R79 stated the facility needs to hire one person as a pair of eyes to watch the guys (R32 and R24). R79 reported that there were not enough staff to meet the needs of the residents and the staff can't keep up. R79 reported that there was recently a night shift where there was only 1 CNA for all of the residents on the Gilead Unit. R79 reported that there are 2 CNAs scheduled for 3rd shift and there's no way they can have 2 staff at night to watch those 2 guys (R24 and R32). It's not enough. They try hard but they can't do it (their jobs) with 2 guys that are extra trouble. R36 reported that they try to get R24 and R32 to stay out of other rooms by putting up stop signs (Velcro mesh across resident doorways) but R24 will remove the stop sign from the doors and enter the room. R36 reported that R32 recently went around peeing in garbage and sinks but not the toilet because of the lack of staff/supervision. R79 reported that she is fearful of R24 and if you say something (R24) doesn't like he (punching motion) and the nurses are scared of him. R79 stated, there's not enough staff to give care and attention to residents. If they could bring more staff on it would be perfect. During an interview on 11/30/2022 at 12:40 PM, CNA X reported that residents were not receiving the care they required because of the lack of staff. CNA X reported that there were many residents on the Gilead Unit that required extensive assist or 2 assist with cares and the staff were expected to monitor and supervise (R32) and (R24). CNA X reported that when a resident that requires 2 persons assist for care is being helped, it takes 2 CNAs off the floor which results in even less supervision for R32 and R24. CNA X reported that because of the lack of staff available on the Gilead Unit she has seen an increase in resident falls and resident to resident altercations. CNA X reported that if there is a call off on another unit, they pull from the Gilead Unit. CNA X reported that second shift is the most difficult because they are expected to monitor R32 and R24 while also providing care to all the residents (incontinence care, toileting, repositioning), assisting with dinner (passing trays, feeding, picking up trays), monitoring residents that are sundowning (increased behaviors that occur in the evening), and putting the residents to bed. CNA X reported that there were many residents that required 2-person assistance to get to bed because of their use of a hoyer lift. CNA X reported that it was not reasonable to expect that ADL care and supervision can be completed with the number of staff available. During an interview on 12/01/2022 at 12:45 PM, DON reported that only she and LPN K were part of the nursing management team. DON reported that LPN K was working as the Unit Manager as well as the Wound Care Program nurse. DON reported that the Infection Preventionist/Assistant Director of Nursing had abruptly quit on 11/30/22 at 7:30 PM.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to complete a comprehensive facility-wide assessment that included an assessment of the staffing needs, resident acuity, and staff training and education requirements, resulting in insufficient staffing to meet the needs of the residents, inadequate knowledge of the facility population and inadequate resources to care for residents and the potential for unmet care needs and physical and psychosocial harm for residents residing in the facility. Findings: Review of the facility policy Facility assessment dated [DATE] revealed, It is the policy of this facility to conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies .The facility will use the facility assessment to assist with the following: Understand the nature of its resident population and the resources (human, physical, contractual and electronic, among others) that it will need to care for those residents competently during day to day emergency operations. This will include how those resources will be managed (e.g. staffing assignments, oversight of third party contracts, etc.) .2. Determine the number, competencies and skill sets of nursing staff needed to provide high quality care to its residents. 3. Determine the number, competencies and skill sets of its behavioral health staff needed to provide high quality care to its residents . 7. Determining what clinical services, the facility is capable of providing (e.g. specialized Alzheimer's care, dialysis care, ventilator care, etc.). 8. Determine what policies and procedures are needed in order to best implement the resources and services identified in the facility assessment .12. Determine the content, type and frequency of training for staff, independent contractors and volunteers, including, but not limited to, training for CNAs and training in behavioral health services . Review of the Facility Assessment received on 11/28/22 revealed an assessment date of 10/4/22. The Facility Assessment revealed no evaluation of diseases, conditions, physical, functional or cognitive status, acuity of the resident population, or behavioral needs. The Facility Assessment revealed no evaluation of the facility's training program to ensure training needs were met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The Facility Assessment revealed no comprehensive evaluation of policies and procedures that may be required to provide care to the residents consistent with professional standards. No additional information was included in the facility assessment to describe how these policies and procedures are maintained and evaluated to ensure compliance with current professional standards of practice. During an interview on 11/30/2022 at 4:44 PM NHA was asked to provide clarification on the general staffing plan and the resident acuity levels in the Facility Assessment. On 12/1/22 at 8:54 AM an updated Facility Assessment was received from the NHA. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Facility Assessment updated on 12/1/2022 revealed a section for Resident Acuity (this section was not on the previous Facility Assessment.) This section contained a comprehensive assessment of all residents by unit and acuity levels and an ideal staffing pattern based on resident acuity for each unit and each shift. The updated Facility Assessment revealed no evaluation of the facility's training program to ensure training needs were met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The updated Facility Assessment revealed no comprehensive evaluation of policies and procedures that may be required to provide care to the residents consistent with professional standards. No additional information was included in the facility assessment to describe how these policies and procedures are maintained and evaluated to ensure compliance with current professional standards of practice. The updated Facility Assessment revealed no evaluation of the facility's training program to ensure training needs were met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. Review of personnel files revealed that several nurse aides had not completed required 12 hours of annual training. During an interview on 11/30/22 at 9:42 AM, the Administrator acknowledged that (a) there was a lapse in required staff training due to a temporary agency person being utilized in the Human Resource position, and (b) that several nurse aides had not received required annual training, including dementia and abuse training. During an interview on 12/05/22 at 01:01 PM, regarding the QAPI program (Quality Assurance and Performance Improvement), NHA reported that the Facility Assessment had been reviewed during an ad hoc QAPI meeting pertaining to concerns identified during the current/ongoing survey. NHA reported that they have identified a better method for evaluating acuity. NHA reported they are also incorporating a look back of incident trends on the units including days of week, staff, time of day etc. that incidents occur. NHA reported that they have received feedback from the CNAs on staffing needs for each unit. NHA reported that staffing competencies are also being reviewed to ensure requirements are being met. NHA reported that even if there is sufficient staffing on the unit the education and competencies are necessary to ensure they are able to manage behaviors and meet the needs of the residents. NHA reported that they are reviewing the Facility Assessment to ensure all requirements are met.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31771 Based on observation, interview and record review the facility failed to ensure an accurate and complete medical record for one resident (Resident #82 (R82) who had, and was using, a rescue inhaler without documentation that a self-administration assessment had been completed and that the facility provided repeated refills of the inhaler without documentation of its use resulting in the Resident not assessed for self-administration of the medication, inaccurate medication documentation, and the potential for self-administered medication abuse and the potential for all facility residents to have inaccurate medical records. Findings: R82 was originally admitted to the facility 4/14/21 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Emphysema (a condition in which the air sacs of the lungs are damaged and enlarged), and Anxiety. During an interview conducted 11/28/22 at 9:47 AM in his room R82 was observed holding a Proventil multi dose inhaler in his hand. R82 reported he lets staff know when he needs a refill. Review of the Electronic Medical Record (EMR) of R82 reflected a Doctors Order written 6/25/21 for a Proventil HFA Aerosol Solution multidose inhaler with instructions for use and that the Resident May keep at bedside. Must notify nursing when administered. The policy provided by the facility titled Self-Administration of Medications dated 7/11/2018 was reviewed. The facility policy reflected the purpose of the policy was to determine if a resident was able to participate in self administration and to maintain safety and accuracy of medication administration. The policy reflected that the resident will be evaluated. The policy reflected, 4. If the resident is a candidate for self-administration of medications, this will be indicated in the chart (EMR). And 5. Resident will be instructed regarding proper administration of medication by the nurse. And 6. Nursing will be responsible for recording self-administration doses in the resident's medication administration record (MAR). Review of the EMR for R82 did not reveal that an assessment for self-administration of a Proventil inhaler had been completed for R82. In an interview conducted 11/30/22 at 11:36 AM the Director of Nursing (DON) reported that an assessment of self-administration for the Proventil inhaler had not been completed for R82. Review of pharmacy invoices provided by the facility from March 2022 to November 2022 reflected R82 had been provided eight refills of the Proventil inhaler. In a telephone interview conducted 12/1/22 at 1:26 PM Pharmacist Nreported that eight Proventil inhalers have been dispensed to the facility for R82 since March 2022. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Proventil HFA Aerosol Solution package insert reflected one inhaler contains two hundred actuations (doses) of the medication. The facility policy on self-administration of medications and the Doctor's Order of 6/25/21 both reflect nursing is to document when R82 administers the medication. Review of the MARs for R82 from April to November 2022 reflected nursing had documented one administration of the Proventil inhaler on July 30, 2022. No other doses of medication administration were documented by nursing on the MARs from April to November 2022 despite R82 receiving eight refills (1600 actuation) of the Proventil inhaler. No further information was provided by the facility prior to survey exit.