STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235552	A. Building B. Wing	06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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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. 35102 Based on observation, interview, and record review, the facility failed to ensure a private and dignified environment for one Resident (#32) of one hospice (end-of life) resident reviewed. This deficient practice resulted in the potential for feelings of helplessness, sadness, and embarrassment. Findings include: During an observation/interview on 5/24/22 at 3:20 p.m., the Director of Nursing (DON) requested vital signs be taken on Resident #32 due to a change in condition. This Surveyor had been talking to Resident #32's roommate and soon stepped out of the room to afford privacy. At 3:28 p.m., Registered Nurse (RN) Z exited Resident #32's room and informed this Surveyor that Resident #32 was actively in the process of dying. RN Z confirmed Resident #32's code status was Do Not Resuscitate (DNR) and indicated oxygen was soon to be applied. During an interview on 5/25/22 at 3:30 p.m., the Nursing Home Administrator (NHA) confirmed unoccupied resident rooms were available on the same hall where Resident #32 currently resided. When asked why Resident #32 had not been provided a private room due to their deteriorating condition and eminent death which would allow Resident #32 to have private visitors, the NHA confirmed the facility had not thought about doing that. The NHA confirmed an understanding of a dignity concern since Resident #32, who now often had a family member at the bedside, was actively dying with an alert roommate with intact cognition. On 5/25/22 at 3:35 p.m., outside of Resident #32's room, Chaplain II said they came to visit with Resident #32. Once the door was opened, Resident #32's Family Member HH was observed at their bedside which was confirmed with by Resident Assistant (Staff) O. On 5/26/22 at 8:05 p.m., Certified Nurse Aide (CNA) S confirmed Resident #32 had passed away during the evening on 5/25/22. At 8:14 a.m., an observation of Resident #32's bed, located next to the door, showed it was stripped of linens, but flowers and some personal items remained on the nightstand. The same roommate resided in the room. Review of the facility's Hospice Services Facility Agreement revised 12/21, read in part, It is the policy to provide and/or arrange for hospice services in order to protect a resident's right to a dignified existence, self-determination, and communication with, and access to, persons and services .

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 40383 Based on observation, interview, and record review, the facility failed to follow through with the grievance process as expressed by eleven residents attending a confidential group meeting. This deficient practice resulted in the Resident's grievances not being addressed with reconciliation, and the potential for other grievances brought by cognitive Residents at the facility to continue to be unresolved resulting in frustration and continued complaints. Findings include: On 05/25/22 at 2:00 PM, eleven residents met in a confidential group meeting to express their concerns. During the confidential group meeting, the residents expressed they often brought concerns to management and during monthly Resident Council meetings but said no one seems to listen. The residents felt ignored. The minutes from past Resident Council meetings were reviewed with the eleven residents present. - The March minutes from the Resident Council of 3/9/22 had six issues listed under New Business. The issues were read to the group of residents, and they did not know the outcome or if any action had been taken. They felt the issues were unresolved. Two of the six issues had documentation of no action taken and one had no person responsible. The following Resident Council meeting of 4/13/22 had minutes in which the Old Business section with instructions: List follow-up from last months' minutes and identify staff person responsible was blank. No follow up from any previous Resident Council meetings was noted. - The April minutes indicated three issues. The residents felt one concern had been addressed, (a request for hamburgers), but the other two items were unresolved including: Nurses do not know how to answer call lights. The follow up on these issues in the May minutes in the Old Business section documented one comment: CNA's ignoring - in general. No other follow-up to any previous concerns was listed. During an interview on 5/25/22 at 3:50 PM, Activity Assistant (Staff FF) stated she sometimes assisted with the Resident Council meetings. She said when she heard of an issue (such as missing items), she just delivered the message to the person she felt who could solve the problem. She did not fill out a concern form. During an interview on 5/25/22 at 3:53 PM, the Activity Director (Staff B) said she was the person who generally filled out the Minutes form for the Resident Council. She also would follow up by sometimes filling out a CONCERN/COMPLAINT FORM but did not keep a copy of this form. She gave the form to the person who could take care of the problem or issue. The issue of concern resolution was discussed along with the lack of follow up documentation in the minutes. Staff B said there were no concern forms for these things, so they were not being tracked. Staff B said while she felt she was working on problems, she agreed there was not documentation which showed any progress or resolution to the issues brought up in the Resident Council meetings. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/25/22 at 4:14 PM, the Nursing Home Administrator (NHA) presented the file of completed concerns noting there were not many filed. The NHA said issues were not always recorded on the concern form per the policy and some issues were just discussed in interdisciplinary team meetings. The NHA said there was a breakdown in the process as concern forms were not always used. The facility policy titled: Resident and Family Grievances dated as revised 12/2020 read in part, .Prompt efforts to resolve include facility acknowledgement of a complaint/grievance and actively working toward resolution of that complaint/grievance . The staff member receiving the grievance will record the nature and specifics of the grievance on the designated resident assistance form or assist the resident or family member to complete the form .The Grievance Officer will take steps to resolve the grievance and record information about the grievance, and those actions, on the resident assistance form . In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Officer will issue a written decision on the grievance to the resident or representative the investigation (sic) upon request . Evidence demonstrating the results of all grievances will be maintained for a period of no less than 3 years from the issuance of the grievance decision.

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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. 35102 Intake# 127653 Based on interview and record review, the facility failed to inform the Emergency Contact/Family Member (FM) JJ of two, acute care hospital transfers for emergent medical needs for one Resident (#53) of three residents reviewed for changes in conditions. This deficient practice resulted in potential anxiety due to lack of knowledge regarding emergent medical transfers. Findings include: Review of Resident #53's Admission Record viewed 6/1/22, reflected the following major diagnoses: hemiplegia, depression, adjustment disorder, chronic obstructive pulmonary disease, chronic pain, and anemia. During a telephone interview on 5/23/22 at 11:24 a.m., Resident #53's FM JJ said the facility had not notified them of Resident #53's emergent hospital transfers and was completely shocked to get a call from the emergency room physician who was asking about what may have caused all the leg bruising found. FM JJ confirmed no verbal or written communication was provided by the facility of the hospital transfers at any time. FM JJ said Resident #53 after being discharged from the hospital was transferred to another nursing home where they currently reside. Review of Progress Notes on 3/19/22 and on 3/25/22, confirmed Resident #53 was transferred emergently to the local hospital for evaluation and treatment. An electronic transmission with the Nursing Home Administrator (NHA) on 6/1/22 at 4:01 p.m. read in part, There is no indication of family notification, and a recap of stay was not prepared as it was expected (Resident #53) would be returning to the facility . Review of the facility's Transfer and Discharge policy/procedure, 10/21, read in part, Emergency Transfers . b. Notify resident and/or resident representative.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observation and interview, the facility failed to provide a safe, clean and homelike environment as communicated by a confidential group of residents related to the storage of equipment and maintenance of common areas, including a day room and shower rooms, along with resident room maintenance affecting 18 (#'s 3, 8, 15, 17, 18, 19, 20, 28, 30, 32, 33, 40, 41, 43, 44, 45, 50, 51) of the 53 residents of the facility. This deficient practice has the potential to result in feelings of depression, anxiety and helplessness from residents experiencing these conditions. Findings include: On 5/24/22 between 8:00 AM and 5:00 PM and on 5/25/22 between 7:00 AM and 3:00 PM observations were made of the resident rooms and common use areas. The following observations validated the necessity of maintenance intervention: (These observations constitute examples of the deficient practice and are not considered comprehensive. Not all resident rooms were observed for these conditions due to access restrictions.) The faucet on the sink in the bathroom between resident rooms [ROOM NUMBERS] was leaking continuously. The hot water side of the faucet was inoperable. An interview with environmental services director (ESD) A was conducted on 5/25/22 at 9:45 AM and confirmed the facility was aware of the condition and was on a list of needed repairs. The ceramic tiled shower enclosure, located in the south end shower room had black mold in the juncture between the floor and wall on all three sides of the open enclosure. The juncture where the wall and floor met was not coved, or rounded, to facilitate proper drainage and cleaning as well as reduce pooling at this intersection. ESD A acknowledged the facility was aware of the condition . The concrete block wall on the opposite side of shower enclosure in the south shower room was missing an area of blocks measuring 21/2' x 31/2'. Adjacent blocks were observed to be cracked and broken, as if having been demolished by a [NAME] hammer. This exposed the hollowed areas of the cinder block, exposed dead end plumbing and was located directly next to a cart containing clean linens for residents' beds. ESD A acknowledged the facility was aware of this condition. The vinyl plank flooring in front of the shower enclosure in the south shower room was loose and not secured to the floor, allowing water to seep under and not completely dry, potentially leading to unrestrained mold and mildew growth. ESD A acknowledged the facility was aware of this condition. Vinyl bathroom flooring for rooms 104, 105, 108, 109, 110, and 111 were extensively stained around the commode and under the sinks appearing as there were commode overflows or sink fixture leakage. ESD A acknowledged the facility was aware of this condition. The plastic light fixtures above the sink in the bathrooms for 110/111 and 126/127 were cracked and broken. The sink in the bathroom for rooms 100/101 was not secured to the wall and hanging loosely from the wall bracket. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Carpeting in rooms [ROOM NUMBERS] was worn and unclean. The call light in the bathroom for rooms 106/107 was not provided with a pull cord. Night lights were inoperable in the bathrooms for rooms 108/109 and 110/111. An interview with ESD A was conducted on 5/25/22 at 9:45 AM in the ESD office. ESD A stated the facility was aware of many of the noted conditions and had put a list together of issues to be addressed. This was posted on a white board in the ESD office. ESD A stated the facility was trying to address the issues in a timely manner. 35102 During an observation on 5/24/22 at 10:06 a.m., the South Hall Day Room was found to contain stored medical equipment and resident personal items. The left side of the room contained one electric powered wheelchair and one manual, high-back wheelchair. On the seat of the manual wheelchair were white socks with gray bottoms, a pair of black and blue sneakers, a pair of blue silver-striped shorts, and a blue mechanical lift pad. The right side of the room contained three scale battery packs, a battery charger, a soiled mouse pad all of which were placed on top of an end table. The end table was positioned between two upholstered chairs. Also, to the right side of the room nearest to the entry were a large upright scale (used to weigh residents in wheelchairs) and a regular floor scale. Certified Nurse Aide (CNA) L and CNA K entered the Day Room during this Surveyor's observation. Neither CNA L nor CNA K could identify who the wheelchairs belong to and confirmed neither wheelchair had a resident's name on it. When asked why scales were in the residents' Day Room, CNA K said the room was used to weigh residents. Both CNA L and CNA K confirmed the room was intended to be a common space for both residents and visitors. During an observation of the South Hall Day Room, on 5/26/22 at 8:27 a.m., the electric powered wheelchair was not found. The manual wheelchair and items remained in the same location as the previous observation on 5/24/22 at 10:06 a.m. Some additional items were now noted: two large, blue stuffed bags and a black jacket were found on an upholstered chair on the right side of the room. The two scales, multiple battery packs, battery charger, and mouse pad remained. During an observation on 5/26/22 at 8:57 a.m. two, loose piles of unfolded laundry lay directly on top of another upholster chair. The piles of clothing had the following colors: black, gray, Army green, red, blue, and a gray/pink print. A rose colored shirt laid directly on top of the end table positioned between the two upholstered chairs lying on one of the battery packs. 40383 On 05/25/22 at 2:00 PM, eleven residents met in a confidential group meeting to express their concerns. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the confidential group meeting, the residents brought up concerns with the South Day Room being crowded and cluttered. Resident C1 said she met with medical professionals in this room and feels bad because the others have to stop watching TV and leave. Resident C2 and C3 stated the room was messy with wheelchairs, boxes of stuff, a large scale, and there was not room to visit with guests or watch TV. Resident C5 said, They took some of the wheelchairs and stuff out (of the South Day Room) because I see that it is now (stored) in the corner over there. Resident C5 pointed to two high-backed wheelchairs with large boxes stacked on the seats of the chairs in the resident Activity Room we where we were meeting. Resident C2 said, The bad thing is the scale is in the (South) Day room. Residents C2, C4, C3, and C6 all expressed they did not like it when others were present (like watching TV) when they were weighed. The residents agreed they did not have a scale in their living rooms at home.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to provide personal hygiene for one Resident (#18) of one resident reviewed for activities of daily living (ADLs). This deficient practice resulted in feelings of frustration and embarrassment for Resident #18. Findings include: Review of Resident #18's Minimum Data Set (MDS) assessment revealed admission to the facility on [DATE], with diagnoses including heart failure, kidney disease, and depression. The assessment showed Resident #18 required one-person assistance with personal hygiene, and Resident #18 was able to be understood, and understand others. The Brief Interview for Mental Status (BIMS) assessment showed Resident #18 scored 4/15, which indicated severe cognitive impairment. Observations on 5/24/22 at approximately 10:00 a.m. and 10:20 a.m. revealed Resident #18 in his room seated in his wheelchair in bed, and then in the common area respectively, wearing a dirty shirt, with scrambled eggs down the front of the shirt. He was not shaven, and had long stubble on his entire face, from his mustache to under his chin. It appeared he had not been shaved at least a few days, with long hair stubbles evident. Resident #18 affirmed he liked and wanted to be shaved, and this was important to him. An observation on 5/24/22 at 10:54 a.m. revealed Resident #18 was seated in his wheelchair in the common area outside the nurses station, wearing the same shirt with scrambled eggs down the center, as several staff walked by and did not address his hygiene or shave him. An observation on 5/25/22 at approximately 10:00 a.m. and 11:00 a.m., revealed Resident #18 was seated in the common area outside the nurses station wearing a blue sweater, and was again not shaved. The stubble remained long on his face, and it appeared he needed to be shaved as he was growing a mustache and beard. Resident #18 was asked if he wanted to be shaved, and affirmed he was hoping to be shaved soon. An observation on 5/26/22 at 8:16 a.m. revealed Resident #18 was in bed, not shaven. Resident #18 was asked if he wanted to be shaved, and again affirmed he was hoping to be shaved today (5/26/22). Resident #18 was assisted to dress and transferred into his wheelchair by CNA V, who then left the room to start ADL cares with another resident, which they later confirmed. During an interview on 5/V/22 at approximately 8:27 a.m., Certified Nurse Aide (CNA) V confirmed Resident #18 did not appear shaved for at least 5 - 6 days. CNA V explained they had to prioritize adls with their residents and felt rushed, due to high resident caseload. CNA V reported Resident #18 should have been shaved, and confirmed he needed assistance with grooming and personal hygiene, and could not do himself, due to needing cues and set-up, and sometimes more assistance, even when using an electric razor. CNA V acknowledged the concern with resident choice not being honored, and they had been Resident #18's day shift aide for the past three days. During an interview on 5/26/22 at 9:15 a.m., the MDS nurse, Registered Nurse (RN) C, confirmed Resident #18 needed to be shaved, per his preference, after observing Resident #18 in his room unshaven. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #18's current Care Plan, accessed 6/01/22, showed Resident #18 required supervision assistance, set-up, and cueing with personal hygiene, which would include grooming/shaving. During an interview on 5/31/22 at 10:49 a.m., the Nursing Home Administrator (NHA) was asked about Resident #18 not being shaven until it was brought to the facility's attention last week (on 5/26/22). The NHA concurred Resident #18 should have been shaved, per his preference. The NHA confirmed via email on 6/02/22 there was no policy specific to ADL care provision.

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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. 35102 Based on observation, interview, and record review, the facility failed to prevent the development of multiple pressure ulcers for one Resident (# 6) of two residents reviewed for pressure ulcers. This deficient practice resulted in harm with the development of an unstageable coccyx wound and a Stage IV (four) right ankle wound which have the potential for delayed healing, infection, and deterioration of condition. Findings include: Review of Resident #6's Minimum Data Set (MDS) Assessment, dated 2/24/22, showed the following applicable diagnoses: stroke with hemiparesis/hemiplegia, diabetes, hypertension, and dementia. The Brief Interview for Mental Status (BIMS) score was 14/15 which reflected intact cognition. Resident #6 required two staff assistance for bed mobility, transfers, and toileting for both urine and bowel incontinence. The same MDS assessment identified pressure ulcer risk without any unhealed pressure ulcers at Stage I (one) or higher. On 5/26/22 beginning at 9:29 a.m., Resident #6's wound care was observed performed by Wound Care Nurse/ Licensed Practical Nurse (LPN) U and initially assisted by Certified Nurse Aide (CNA) M. Both performed hand washing in the bathroom and applied gloves. Resident #6 was lying on their back with their bilateral heels elevated on a blue foam pad. Resident #6's air mattress setting was dialed to 120 which indicated the softest setting. LPN U placed a paper towel on Resident #6's overbed table without first removing personal care items and cleaning and disinfecting the surface before placing down wound care supplies. Resident #6 personal items encompassed half of the overbed table. After dressing supplies were opened and prepped, LPN U removed their gloves and put on a new pair without the performance of hand hygiene. Resident #6's right ankle wound dressing was removed. The circular shaped wound was open, with surrounding redness outside of the wound edges. LPN U changed gloves before redressing the right ankle wound without the performance of hand hygiene. A left heel dressing was observed but not removed and assessed by LPN U who then changed gloves without performance of hand hygiene. CNA M turned Resident #6 on their left side (facing the direction of the door). The air mattress was not adjusted to a firmer setting to assist with repositioning. LPN U lowered the brief and folded it over into itself when a large amount of soft to liquid stool was found. LPN U removed the coccyx wound dressing and left it uncovered throughout the incontinence care which increased the opportunity for cross-contamination of stool to the wound. CNA M stood on the left side of the bed and repeatedly reached over Resident #6's body to dispose of the soiled, disposable incontinence wipes in a small garbage can located directly under the overbed table which contained the opened wound care supplies. LPN U removed gloves and washed hands in the bathroom while CNA M and now CNA S continued incontinence care on Resident #6 who was repeatedly turned from their right side to their back, and to their left side to cleanse stool. Resident #6's lift sheet was replaced by a bath blanket which was thicker and less smooth. When LPN U said that a top sheet was needed because of the air mattress, CNA S said the facility was completely out of them. CNA S handed soiled disposable wipes to CNA M who then placed them in the same trash can located under the wound care supplies. CNA M changed gloves without the performance of hand hygiene. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	LPN U with a new pair of gloves, redressed the coccyx wound. LPN U throughout the wound care observation touched the front of their mask which was ill-fitting, at times positioned under the nose, and which contained an exhalation valve. Hand hygiene was never performed after touching the mask. The air mattress was never adjusted to provide additional support to Resident #6's repositioning during wound and incontinence care. Resident #6 lower extremities appeared stiff and completely dependent for movement from staff. During a follow-up interview on 5/31/22 at 11:02 a.m., the Director of Nursing (DON) confirmed the following: 1) Staff were expected to clean and disinfect an overbed table prior to setting up wound care supplies and to place a larger sized barrier in place such as a blue disposable pad. 2) Staff were trained to either wash their hands or to use hand sanitizer with all glove changes. 3) Staff should not remove a dressing from an area before incontinence care was performed and/or to properly cover the wound to avoid cross-contamination. 4) Staff could have used a second waste bag to properly dispose of soiled incontinence supplies in their immediate proximity rather than reach over a resident to dispose of soiled items. When asked about Resident #6's facility-acquired wounds, the DON said she now had concerns with why the wounds were not improving after this Surveyor identified breeches in aseptic technique during Resident #6's wound care observation. When asked about the air mattress not being adjusted during the wound care and incontinence care, the DON confirmed the mattress should have been adjusted to a firmer setting to avoid causing potential injury to Resident #6. When asked about Resident #6's incontinence care with staff repeatedly turning from their left to right side, the DON said if frog positioning (by bending the knees and separating the legs), was used, Resident #6 would not have had to endure the repeated turning. Review of a facility provided untitled document sent via electronic transmission on 6/1/22 at 1:31 p.m. from the Nursing Home Administrator (NHA) showed Resident #6's pressure ulcer histories: A. Right ankle (malleolus) facility acquired pressure ulcer identified on 4/7/22 with the following measurements on 5/26/22 were 0.7 cm (centimeter) L (length) by 0.7 cm W (width) by 0.4 cm D (depth). Stage IV. B. Right lateral foot-facility acquired pressure ulcer identified on 4/4/22 Wound measurements and stage were not provided. Wound resolved 5/17/22. C. Left lateral facility acquired pressure ulcer identified on 4/4/22. Wound measurements and stage were not provided. Wound resolved 5/17/22. D. Coccyx-facility acquired pressure ulcer identified on 5/13/22 with the following measurements on 5/26/22 were 1.1 cm (L) by 1.1 cm (W) by 0.1 cm (D). Unstageable. (continued on next page)

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	235552	A. Building B. Wing	06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #6's right ankle wound culture (collected 5/12/22) showed a positive culture for staphylococcus aureus. (Bacterial infection most often spread by contaminated hands). Review of Resident #6's Braden Scale for Determining Pressure Ulcer Risk dated 5/26/22 placed them in a low-risk category for the development of pressure ulcers. As of the date this assessment was completed, Resident #6 had an unstageable pressure ulcer on the coccyx, a Stage IV pressure ulcer on the right ankle, and two previous facility aquired pressure ulcers to bilateral heels (healed as of 5/17/22) which would have caterorized them at a higher risk. Review of the facility's Wound Treatment Management and Documentation revised 7/21, read in part, Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to provide restorative nursing services for five Residents (#2, #6, #15, #21, and #35) of five residents reviewed for restorative therapy services. This deficient practice resulted in increased muscle stiffness and difficulty with transfers for Resident #2, plantar flexion (toes pointed) foot posture for Resident #21, and the potential for decreased range of motion/contractures and the potential for functional decline in mobility and adls (activities of daily living) for a total of twenty-five residents receiving restorative therapy services. Findings include: Resident #2 Review of Resident #2's Minimum Data Set (MDS) assessment, dated 2/08/22, revealed admission to the facility on [DATE], with diagnoses including multiple sclerosis, depression, and lung disease. Resident #2 required two-person assistance for bed mobility, dressing, and toileting, and total assistance for transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 10/15, which indicated Resident #2 had moderate cognitive impairment. During an observation on 5/26/22 at approximately 10:00 a.m., Resident #2 was observed to lift his arms with shaking, and demonstrated how he could not move his legs, which were strapped into a recline wheelchair with cushioned elevated footrests. Resident #2 explained he needed range of motion and restorative exercises for his legs to prevent stiffness. Resident #2 expressed frustration this was not being done regularly. During an interview on 5/26/22 at 10:11 a.m., Staff WW reported Resident #2 was declining functionally as he had no range of motion completed regularly for an extended period, and he wanted range of motion done especially for his legs, and had told Staff WW he needed range of motion to decrease the stiffness in his legs. Review of the Electronic Medical Record (EMR) revealed no completed logs for Resident #2 for a restorative program or range of motion. On 5/31/22 at 10:53 a.m., restorative logs were requested from the Director of Nursing (DON), who directed the request to Certified Nurse Aide (CNA) M, the restorative aide. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/31/22 at 12:07 p.m. with CNA M, and Physical Therapist Aide (PTA) W, CNA M explained they were getting reassigned to the floor (as a shift aide) about 70% of the time, due to staffing shortages or staff being mandated to work overtime. PTA W confirmed this was occurring. CNA M stated, [Resident #2's] knees are really tight .As his RNA [Resident Nurse Aide] every day [five times a week] [Resident #2] would not be as tight for dressing if I worked with him every day, and he would also have less pain for the [mechanical lift] . PTA W reported this lack of restorative therapy, especially range of motion exercises, could cause a decline in mobility and range of motion, contractures, pain, tightness, decline in transfers and ADLs such as brief changes, and place a resident at increased risk for pressure ulcers. CNA M reported they had only begun to document restorative services in the month of May (2022), and did not have any evidence of prior documentation, as the restorative nurse was no longer employed at the facility, and his supervisor was newly the DON. Documentation of participation in restorative therapy was requested for Resident #2, and a second facility resident, Resident #21. Review of Resident #2's Care Plan revealed an intervention dated 8/20/22 related to Restorative Services: I am participating in the Restorative Nursing Program r/t [related to] stillness and decreased ROM [range of motion], 3 - 7 times a week, or as tolerated. Date initiated: 3/10/2021. Revised 3/30/21 . Review of a resident log of residents receiving Restorative Therapy Services, received from CNA M on 5/31/22, revealed for Resident #2: PROM [passive range of motion] bilateral foot, ankle, knee, and hip for 15 minutes or as tolerated, 3-7 times per week. This log of residents receiving restorative therapy services did not include documentation of resident participation, which was second requested from the facility (the DON and CNA M). Review of Resident #2's weekly restorative note, received by CNA M, was not current, as it was dated 5/03/21. There were no more weekly summaries provided. Daily participation calendar logs (which showed all facility residents on a checklist) showed the following (for April and May, 2022): 5/22/22 to 5/28/22: Log is blank for Resident #2 for all days (7 days reflected per log). 5/15/22 to 5/21/22: Log is blank for Resident #2 for all days. 5/08/22 to 5/14/22: Log has one refusal on Wednesday; no other days are marked. 5/01/22 to 5/07/22: Log is blank for Resident #2 for all days. 4/24/22 to 4/30/22: Log is marked x 10 for Wednesday; no other days are marked. (No log for 4/17 to 4/23/22). There was no designation for type of exercise, only repetitions. 4/10/22 to 4/16/22: Log is marked x 15 for Thursday; no other days are marked. 4/03/22 to 4/09/22: Log is marked x 15 for Wednesday; no other days are marked. These logs showed minimal participation in the restorative program during April and May, 2022. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were two Follow up question reports provided additionally by CNA M regarding Resident #2's participation: 4/06/22: Amount of time spent range of motion (passive): 15 (minutes). 4/14/22: Amount of time spent providing range of motion (passive): 15 (minutes). Logs showed Resident #2's increased participation documented in both the EMR and on printed logs during March, 2022., however since that month documentation and participation in a restorative nursing program appeared to be minimal, which was corroborated by staff interviews. Resident #21 Review of Resident #21's MDS assessment dated [DATE] revealed Resident #21 was admitted to the facility on [DATE], with diagnoses including heart failure, kidney disease, anxiety, and depression. Resident #21 required extensive, two-person assistance with bed mobility and toileting, and did not complete transfers during the assessment period. The BIMS assessment revealed a score of 15/15, which showed Resident #21 was cognitively intact. Review of Resident #21's current Care Plan, accessed 5/25/22, revealed a restorative program related to muscle weakness, but not a plan itself which specified the services to be provided or types of exercise. During an interview on 5/25/22 at approximatley 3:53 p.m., Resident #21 confirmed they were not receiving range of motion services, and would be eager to receive range of motion therapy, as they were in bed much of day, and any assistance from restorative or therapy to increase her tolerance of sitting up in her wheelchair, as she reported a fear of falling. Resident #21 reported they had received this therapy in the past, but not recently. Review of Resident #21's current restorative log, accessed 6/02/22, in the Electronic Medical Record (EMR), which had a 30 day look-back period, revealed, Seated exercises in wheelchair or bed, 2# bilateral, 2 x 20 [reps], 2-3x week. This log was blank, with no dates marked for resident participation. Review of Resident #21's restorative services resident log revealed resident was to receive active range of motion to legs, seated exercises in chair or at edge of bed, 3 to 7 times a week. On 5/31/22 at 11:17 a.m. and 12:08 p.m., the Nursing Home Administrator (NHA) and DON were respectively made aware Resident #21's restorative program was not located in the EMR, neither were specific restorative interventions found in their Care Plan. The DON soon after (at 1:45 p.m.) acknowledged they did not have any additional documentation, as the staff were not consistently documenting refusals, and reported they did not have any additional documentation about a restorative program for Resident #21. The DON confirmed CNA M was getting pulled to the floor often to work shifts, and when this occurred the restorative programs were not being completed for facility residents. The DON reported this happened even more so during the past two months. The DON confirmed Resident #21 did have foot drop, and would benefit from range of motion exercises and/or other therapeutic interventions. (No earlier observation was made of Resident #21's foot drop as she was receiving cares.) (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of Resident #21 was made on 5/31/22 at 2:04 p.m. with Licensed Practical Nurse (LPN) Y, with Resident #21's permission. LPN Y draped Resident #21's legs for privacy, and observation of their feet revealed they were pointed down into plantar flexion posture (toes pointed down). LPN Y was able to range Resident #21's feet to near full dorsiflexion (weight bearing position), so there was no obvious contracture, but some stiffness and a modest range of motion variance was developing. During an interview on 5/31/22 at approximatley 2:15 p.m., PTA W was asked about Resident #21's restorative program. PTA W reported in the past Resident #21 had benefited from lower extremity range of motion exercises, and would benefit from sitting up in her wheelchair more often, and incrementally given Resident #21's anxiety. PTA W reported she meant to screen Resident #21 after their hospitalization but had forgotten to go back after Resident #21 initially refused. Daily participation calendar logs for Resident #21 showed: 5/22/22 to 5/28/22: Log had one refusal on Wednesday. 5/15/22 to 5/21/22: Log had no entries marked. 5/08/22 to 5/14/22: Log had no entries marked. 5/01/22 to 5/07/22: Log had two refusals marked. 4/24/22 to 4/30/22: Log had no entries marked. 4/10/22 to 4/16/22: Log had n/a marked. 4/03/22 to 4/09/22: Log had no entries marked. A weekly restorative summary note was provided dated 5/31/21, which was over a year old, but no other recent weekly summaries were received. Resident #15 During an observation on 5/31/22 at 3:09 p.m., Resident #15 was observed in the facility hallway. It was noted her lower extremities were crossed at the hip and knees, which appeared contractured, with her left hip/leg externally rotated over her right leg. During an interview on 5/31/22 at 3:54 p.m., Registered Nurse (RN) Z confirmed Resident #15 had lower extremity contractures of the hips and knees. Further staff interviews revealed they were present for an extended period of time. During an interview on 6/01/22 at 10:54 a.m., CNA M confirmed Resident #15 was in the restorative therapy program, however had missed some sessions due to staff shortages when he was pulled to work nursing aide shifts. CNA M reported range of motion exercises helped decrease tightness for Resident #15, which resulted in increased ability to participate in cares when they are provided regularly, especially personal hygiene and dressing tasks. Review of Resident #15's current Care Plan showed a focus of participating in a Restorative Care Plan 3 to 5 times a week, revised 3/05/21, with no specific interventions noted. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #15's restorative services resident log revealed Resident #21 was to receive active range of motion bilateral lower extremities and bilateral upper extremity general exercise as tolerated 3 - 5 x /week. Review of Resident #15's weekly restorative note showed only one entry on 5/13/22, which revealed Resident #21 refused but participated a few times a week, and had a small decline in their range of motion. There was no mention of a therapy referral. Review of Resident #15's logged restorative charting showed participation of one to two times a week during April and May, 2022, with no refusals marked, and one week participation three times a week. Resident #35 During initial facility tour on 5/24/22 at 9:49 a.m., Resident #35 was observed in their room seated in a manual wheelchair. The MDS assessment was marked for falls, however Resident #35 could not recall when they fell or how it occurred. During an interview on 6/01/22 at 11:00 a.m., CNA M confirmed Resident #35 was in the restorative therapy program, however had similarly missed some sessions due to staff shortages, which the DON earlier confirmed. CNA M reported Resident #35's restorative program was particularly important as it included sit to stand exercises, which would keep him mobile for progression to ambulation (per therapy services) once toe/foot wounds were further addressed. CNA M reported it concerned them when Resident #35 missed restorative sessions, as they did not want to see Resident #35 lose their ambulation ability, and Resident #35 was eager to participate as scheduled. Review of Resident #35's restorative services resident log revealed he was to participate in a functional maintenance program of ambulation with a front wheeled walker and contact guard assistance, wheelchair to follow 25 to 30 feet. If unable (such as currently) perform bilateral seated lower extremity exercises. Review of Resident #35's weekly restorative notes provided by CNA M were dated 4/25/21 and 5/15/21. There were no recent notes provided. Brief review of Resident #35's logged restorative charting showed participation only one time per week during April and May, 2022. It was noted the residents' restorative participation logs reviewed showed entries that indicated there was no restorative aide available as they were pulled to the floor (to work a shift in the facility). Review of the policy, Restorative Nursing Program, revised 12/20, provided by the NHA, revealed, It is a policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level .Nursing personnel are trained on basic, or maintenance, restorative nursing care that does not require the use of a qualified therapist or licensed nurse oversight . Resident will receive service from restorative aides when they are assessed to have the need for such services. These services may include: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Passive and active range of motion. B. Splint or brace assistance. C. Bed mobility training . D. Transfer training . E. Training and skill practice in dressing and/or grooming. F. Training and skill practice in eating and/or swallowing 35102 Review of Resident #6's MDS Assessment, dated 2/24/22, showed the following applicable diagnoses: stroke with hemiparesis/hemiplegia, diabetes, hypertension, and dementia. The Brief Interview for Mental Status (BIMS) score was 14/15 which reflected intact cognition. Resident #6 required two staff assistance for bed mobility, transfers, and toileting for both urine and bowel incontinence. The same MDS assessment identified pressure ulcer risk. On 5/24/22 at 2:49 p.m., Resident #6 was observed in bed. An unidentified CNA commented that Resident #6 preferred to remain in bed but indicated they would get out of bed to spend time with visitors in the Day Room. On 5/26/22 beginning at 9:29 a.m., Resident #6's wound and incontinence care were observed. Resident #6 was lying on their back with their bilateral heels elevated on a blue foam pad. Resident #6 lower extremities appeared stiff and completely dependent for movement from staff. Review of Resident #6's Care Plan, revision 3/5/21, read in part, I am participating in the Restorative Nursing Program r/t (related to) BLE (bilateral lower extremity) Weakness, 3-7 x (times)/ (per) week .I will improve my current level of function by participating in the restorative program, revised 3/5/21. The NHA was asked to provide the last three months of Resident #6's documentation of participation in the Restorative Program. The NHA provided the following passive range of motion treatment dates which were performed by CNA M who the NHA identified as the facility's Restorative Aide. A. March 2022 reflected the following dates 3/4, 3/9, 3/22, 3/29, and 3/31. B. April 2022 reflected the following dates 4/6, 4/12, and 4/13. C. May 2022 reflected the following dates 5/2, 5/5, 5/11, 5/13, 5/16, 5/17, 5/19, 5/25, and 5/26. Resident #6 had not received Restorative Care at least three to seven times per week for the last three months reviewed. During a telephone interview on 6/1/22 at 12:12 p.m., the NHA confirmed the facility was experiencing staffing concerns with covering the Restorative Program.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 This citation will have two deficient practice statements: A and B. A will address environmental safety deficiencies and B will address unsupervised wandering residents. A. Based on observation, interview and record review, the facility failed to ensure the resident environment was free from accident hazards as evidenced by elevated hot water temperature at the bathroom sinks for 8 resident rooms affecting 12 (#'s: 1, 6, 8, 16, 21, 36, 37, 38, 43, 44, 45, 51) of 53 total residents in the facility. The elevated water temperatures ranged from 121 F to 124 F in the affected resident bathrooms and had the potential to contribute to scalding injuries of the residents in the rooms utilizing the bathroom sinks. Additionally a missing end cap from a wall mounted hand rail exposed sharp metal edges potentially resulting in lacerations to ambulatory residents using the rails in that location. Findings include: On 5/24/22 between 8:00 AM and 8:45 AM temperature of hot water from sinks in residents' rooms was measured using a metal stem Thermapen thermometer. The following temperature measurements were made: room [ROOM NUMBER]/111: 124 F; room [ROOM NUMBER]/109 122 F; room [ROOM NUMBER]/119 122 F; room [ROOM NUMBER]/129 121 F. On 5/24/22 at 9:15 AM an interview was conducted with Environmental Services Director (ESD) A related to the elevated water temperatures. ESD A stated he had been monitoring water temperatures in resident areas and acknowledged that temperatures varied between 102 F and 124 F. Records of the facility monitoring were requested and it was learned the facility had not been keeping records of the water temperature monitoring since April of 2021. ESD A acknowledged he had not recorded the temperatures he had monitored. At this same time observations were made in the facility boiler room where the water heaters for the domestic hot water were located. The thermometer inserted into the water line directly downstream from the mixing valve was read as having an exit temperature of 124 F and verified by ESD A. ESD A stated he was unable to adjust the mixing valve to reduce the temperature of the water being circulated to the resident areas. On 5/24/22 at 7:35 AM and throughout the day until 4:45 PM, the end cap of the hand rail on the wall outside room [ROOM NUMBER] was observed off and exposing the sharp metal edges within the plastic outer construction. The end cap was observed propped up on the handrail. This was observed throughout the survey through 5/25/22 at 3:00 PM. 40330 DPS B has 2 parts: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The facility failed to provide safe entry and egress to shower stall entries in two of two facility shower rooms for one Resident (#21) of three residents reviewed for showers and personal safety, given thresholds in two of two facility community shower room stalls were 1/2 to 3/4 high. This deficient practice resulted in fearfulness and anxiety for Resident #21, which contributed to her requesting anxiety medication before taking showers, and may have contributed to Resident #21's report of rough treatment and an allegation of employee to resident abuse during showering (on 5/06/22). 2. The facility failed to provide adequate supervision of two Residents (#41 and #49) of two residents reviewed for wandering behaviors, which resulted in violation of facility residents' personal space, risk of injury to facility visitors, and risk of residents' elopement. Findings include: Review of Resident #21's Accident and Incident report titled, Allegation of Abuse, dated 5/16/22 at 12:30 p.m. , revealed to the Director of Nursing (DON) Resident #21 reported Certified Nurse Aide (CNA) L was rough with her during her shower on 5/06/22, and she had a bruise (described as 3 cm purple with green) on her abdomen. Resident #21 reported to the DON (and noted in the report) that the lip [threshold] on the shower room floor contributed to her fear of falling, and Resident #21 felt CNA L was rough with her. During an interview on 5/31/22 at 5:15 p.m. the Director of Nursing (DON) confirmed they only learned of the abuse allegation on 5/16/22, and believed the shower lip upon entry and egress to the shower staff on Resident #21's hall was too high. During an observation on 5/31/22 at approximately 5:30 p.m., the DON and Surveyor observed the shower room on Resident #21's hall and observed an elevated wooden threshold (lip) at the entry of the roll in shower, which the user (typically a CNA) would need to negotiate to push the shower chair castors over to roll the shower chair into the shower space to provide resident showers. A demonstration was done with two of the upright shower chairs with the blue mesh backing, and it was noted both bumped upon entry and exit of the shower stall, which was made even difficult when the chair held an occupant. It was noted the shower chair casters had to be lifted separately over the lip (which appeared higher) especially when coming out of the shower. The DON conveyed with Resident #21's anxiety and fear of falling this could contribute to her perception of rough treatment. The DON expressed concern a shower chair occupant could easily fall, become injured, or even be tipped forward out of the shower chair. Surveyor noted similar concerns during the observation. The DON confirmed only this one shower stall was being used by facility staff (in Resident #21's hallway). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/01/22 at 11:54 a.m., the Maintenance Director, Staff A observed Resident #21's facility hall shower room, and took measurements of the shower threshold (lip) for entry and egress into the shower stall. Staff A reported the lip was 1/2 to enter the roll in shower, and 3/4 to exit the roll-in shower. Staff A demonstrated negotiating rolling the shower chair in and out of the shower stall, in the two upright blue mesh backing shower chairs. Staff A concurred it was necessary to lift the chair castors over the shower entry threshold (lip) especially to exit the shower stall, which caused them to tip the chair a bit to the side or forward, which Surveyor also observed. A visual inspection was completed of the blue shower chair castors, which showed signs of wear and tear, likely from bumping over this threshold. This bumping over the threshold could also place residents at risk of fall or injury additionally if one or more of the castors fell off. There was also a green mesh reclined roll-in shower chair in the shower room. It was noted by Staff A and Surveyor this shower chair also had to be bumped over the threshold as well. Trials of 3/3 shower chairs yielded concerns with safe entry and egress in and out of the roll in showers, with Staff A concur with Surveyor and DON regarding risk of falls, injury, and other types of accidents. Staff A took measurements of the same threshold (lip) of the opposite hall facility shower room entry, which showed a threshold height of 1/2 both for entry and egress, which also had only one shower stall in use per Staff A. Staff A reported this height was also a concern for accidents, tipping chair, and/or fall risk, and demonstrated shower chair still needed to be bumped over entry; Surveyor observed same. During an interview on 6/01/22 at approximately 5:45 p.m , the Nursing Home Administrator (NHA) was asked about the safety/fall/accident environmental concerns related to the shower room thresholds, and Resident #21's expressed anxiety related to showers and entering and exiting the shower, and reports of rough treatment. The NHA acknowledged the concerns, and reported the facility was addressing the environmental concerns in the near future. Review of the policy, Environmental Conditions, received via email from the NHA on 6/02/22, per request of an environment/accident policy, revealed, [The facility] is designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for the residents, staff and visitors . There was nothing more specific to environmental safety/modifications and prevention of accidents. Resident #41 Review of Resident #41's Minimum Data Set (MDS) assessment, dated 4/19/22, revealed Resident #41 was admitted to the facility on [DATE], with diagnoses of Alzheimer's disease, dementia, Parkinson's disease, anxiety, and depression. The Brief Interview for Mental Status (BIMS) assessment was unable to be completed due to severe cognitive impairment. Resident #41 required extensive, one-person assistance for transfers, dressing, toileting, and hygiene and supervision for walking. During initial facility tour on 5/24/22 beginning at approximately 8:30 a.m., Resident #41 was observed to be wandering undirected in facility halls, in and out of a few resident rooms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/24/22 at 9:16 a.m., Activity Assistant , Staff , was asked about Resident #41's undirected wandering on the facility unit, and if Resident #41 had eloped from the facility. Staff responded, No, she goes from room to room [inside other residents' rooms] and likes to explore. Staff was asked about Resident #41's activity interests, and participation in facility activities. Staff reported they are only able to engage Resident #41 in drinking hot cocoa, and briefly sitting with them in the activity room. No sensory or other attempts at meaningful activities were identified. Surveyor asked for clarification on Resident #41 entering other resident rooms. Staff added, [Resident #41] does not normally take things; she pats residents on their heads, and rubs their shoulder; most of them accept it; a couple don't have the patience . An observation on 5/24/22 at 11:00 a.m. revealed Resident #2 seated in their manual wheelchair outside the doorway to their room in the facility hall. Resident #41 walked into another resident's room, peeked her head in, and then came up to Resident #2 quickly and touched Resident #2's chest. Resident #2 verbally redirected Resident #41 away, and swatted his hand towards hers to move her hand away. No staff were in the hallway or nearby, thus Surveyor had to intervene by providing verbal redirection to Resident #41, which caused her to leave Resident #2. Resident #2 reported this caused him feelings of frustration, and does occur on occasion. Additional observations of Resident #41 on 5/25/22 and 5/26/22 revealed her in the facility common areas, with occasional brief touch to other residents. Resident #41 was not observed with the activities staff during these observations, or otherwise during the survey. The nursing staff redirected Resident #41, as well as other facility residents when she approached them. Resident #41 was observed once with a Kleenex box she picked up herself from her room, and once with a stuffed animal, but otherwise was not observed with any sensory interventions that could have promoted decreased wandering behaviors and calming, such as hand massage by staff, or other safe, guided sensory interventions. Additional observations of Resident #2 touching other facility residents included: 5/31/22 at 10:40 a.m., Resident #41 grabbed Resident #40's right arm, which was in a sling, three times, with Resident #40 needing to attempt to redirect Resident #41 himself, before staff intervened. Resident #40 was in the common area at the nurses station. This could have resulted in injury to Resident #40's right arm. 5/31/22 at 3:06 p.m., Resident #41 touched and held Resident #14's hand at the nurses station, requiring staff redirection. Resident #41 was a frail, unweight resident at risk for falls. 6/01/22 at 2:15 p.m.: Resident #41 approached Resident #15, who was wheeling her wheelchair up the hallway into the common area outside the nurses station, touching her shoulder. Resident #15 yelled loudly, NO, and Resident #15 removed her hand. Resident #15 was asked if this bothered her, and she responded, Yes, I don't like her touching me. This resulted in psychosocial distress for Resident #15. Review of Resident #41's Behavioral logs, retrieved 6/02/22, with a 30-day look-back period, showed monitoring for Behavior: Wandering/Exit seeking: Entering other resident rooms: Offer companion or stuffed animal or other activity when resident restless. Did the resident exhibit wandering/exit seeking behaviors during the time-frame?. This log monitored resident behaviors each shift, three times daily. Over the 30 day look-back period, Resident #41 displayed wandering behaviors a total of 13 times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #41's current Care Plan, revealed a focus on elopement risk, not for wandering behaviors, per se. There was only one intervention which could be related to wandering behaviors, Distract me by holding my hand, taking a walk with me. I snack on many different things such as candies and cookies . Review of the facility policy, Elopements and Wandering Residents, revised 07/21, received via email from the Nursing Home Administrator (NHA) on 6/02/22, revealed, The facility ensure that residents who exhibit wandering behaviors and/or at risk for elopement receive adequate supervision to prevent accidents and receive care and services in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk .Wandering is random or repetitive locomotion that may be goal directed 9e.g the person appears to be searching for something, such as an exit, or non-goal directed or aimless .The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering .6. Monitoring and Managing Residents at risk for Elopement or Unsafe Wandering .d. Adequate supervision will be provided to help prevent accidents or elopements . 35102 Resident #49 Review of Resident #49's MDS Assessment, dated 4/28/22, showed the following diagnoses: Alzheimer's disease and dementia. The facility did not attempt the BIMS since Resident #49 rarely made self understand or rarely had the ability to understand others. Resident #49 required two staff assistance for bed mobility, transfers, and toilet use. One staff assistance was needed for locomotion. During an observation on 5/24/22 at 2:23 p.m., Resident #49 (seated in wheelchair holding a doll) had been stroked, several times, across the face by Resident #41. Resident #49 appeared confused and did not react to the touching. Resident #41 attempted to push Resident #49's wheelchair but was unsuccessful since Resident #41 held the feet to the ground. CNA M approached and redirected Resident #41 away from Resident #49. Resident #49 left and entered another resident's room (119) which was not their room. Resident Assistant (Staff) O retrieved Resident #49 from the room shortly afterwards. During an observation on 5/24/22 at 2:30 p.m., Resident #49 quickly self-propelled using their feet (in wheelchair) down South Hall to the exit door located at the very end of the hall. An alarm sounded. An unidentified CNA responded and redirected Resident #49 by turning the wheelchair around and left the hall. Resident #49 immediately turned the wheelchair around and headed backwards the entire length of South Hall to the nurse's desk. This Surveyor had to jump out of the way to avoid a collision. On 5/25/22 at 3:45 p.m., Resident #49 was self-propelling down South Hall and slammed into Surveyor. Resident #49 made no verbal response and continued down the hallway. During an observation on 5/25/22 at 3:55 p.m., Resident #49 had set-off the elopement alarm at the end of South Hall. The following staff were talking together in the hallway (CNA DD, Staff O, and Physical Therapist (Staff) KK) but did not address the alarm nor redirected Resident #49 away from the door. A male visitor exited the last room on the right and pulled Resident #49 backwards away from the alarming door until the alarm stopped sounding. Resident #49 turned the wheelchair around and proceeded towards the nurses' desk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately following the observation, the Nursing Home Administrator (NHA) was sought for a for an interview but was out of the building. On 5/25/22 at 4:01 p.m., Registered Nurse (RN) C was briefed on the observation which just occurred involving Resident #49 and the male visitor. RN C said that Resident #49 does not like to be pulled backwards and should have been redirected by staff and not the visitor. During an observation on 5/25/22 at 4:21 p.m., Resident #49 was in the Activity Room without any staff presence. The elopement alarm sounded but no staff responded. Resident #49 exited the Activity Room which ended the alarm sounding. On 5/31/22 at 1:05 p.m., Confidential Resident #1 and Confidential Resident #7 said that Resident #49 often comes into their room(s) and disturbs items. When asked if a door barrier had ever been offered to deter Resident #49 from coming into the room, both Confidential Residents responded no. When asked what they have been doing to handle Resident #49 from coming into the room(s), both responded they needed to keep their door(s) closed at all times. When asked how it made them feel, both indicated they were concerned for Resident #49's safety. Both Confidential Resident #1 and #7 said they did not like having residents who came into their rooms (who were not invited).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 40383 Based on observation, interview, and record review, the facility: 1) failed to provide sufficient staffing to respond to call lights in a timely manner as expressed by residents in a confidential group meeting, and as expressed by Resident # 4 and #152 of 28 residents reviewed for staffing needs and 2) failed to provide sufficient staffing to ensure resident participation in a restorative program for five Residents (#2, #6, #15, #21, #35), of five reviewed for restorative needs. This deficient practice resulted in actual unmet care needs including residents soiling themselves when staff were untimely in response and actual unmet restorative needs including missed restorative sessions and the potential for decreased range of motion/contractures, and a decline in functional mobility and/or Activity of Daily Living (ADL) decline. Findings include: On 05/25/22 at 2:00 PM, eleven residents met in a confidential group meeting to express their concerns. During the confidential group meeting, the consensus of the group was the staff were trying hard, but there were just not enough staff, and the residents all had to wait too long to be helped. Resident C2 said there was a long wait for assistance to use the bathroom. She stated, Some aides don't seem to care, and you usually have to wait over 30 minutes after using the call light. Eight of the eleven residents in the group agreed they usually had to wait at least 30 minutes for help after the call light was pressed. Resident C1 stated, I have had accidents, and had to go in my brief because I had to wait so long. Resident C1 recalled a specific time she pressed the call light and fell asleep while waiting. She said when she woke up two hours later the call light was still on. Resident C3 said it was frustrating having to wait so long. Resident C4 said, They just can't get to everyone, and it does seem like they are ignoring you. Resident C5 stated, I have been in the bathroom and took my cell phone because no one will come with the call light. I have had to call the front desk twice to have them come assist me from the toilet. Resident C5 said it was frustrating when staff were not prompt. During an interview on 5/25/22 at 4:40 PM, Certified Nurse Aide (CNA) DD said she would like to spend more one-on-one time with the Residents. CNA DD stated, It is hard to get all of the call lights when you have 15-16 residents alone. It is very hard to get to everyone. CNA DD said she understood the resident's frustration and explained, I was just giving a shower, so my hall partner had to answer the lights. There are not enough staff when all of the lights are going off. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/25/22 on 4:48 PM, a Confidential Management Staff Member (Staff BB) was asked about expectations for call lights to be answered. Staff BB said call lights should be answered as fast as possible and there had been education for all staff to answer call lights. Staff BB explained staffing had been a challenge. She stated, When there are two aides in the room, it will take them longer to get to a call light. especially at night when there is very minimal staff. Staff BB said, the facility just did not have staff, and this answer was not to be interpreted as an excuse but as a systemic problem. Staff BB discussed incentives and bonuses and trying to avoid staff burn out. Staff BB stated, We definitely need more help. People cannot even get vacations. We have many call offs as they are tired. Staff BB felt staffing was a huge problem. The policy titled: Call Lights System dated 12/2020, read in part, all staff members who see or hear an activated call light are responsible for responding . During an interview on 5/25/22 at 4:57 PM, Resident Assistant (Staff O) stated Sometimes we don't get to eat or get a break. We are busting our butts and can't get to everything. Staff O said she did not always get all her work done including her documentation. Staff O gave an example, I am feeding people and 7 lights are on and someone is always upset because you can't get to them all (residents). Staff O said many of her residents needed two person assists and accidents do happen (residents soiling themselves), when we can't get everyone to the bathroom on time. Staff O stated, We start putting people to bed at 6:30 (PM) and they do not want to go to bed but we have to start then to get it done. Staff O said the staff was working many hours and some weekends had to work 16 hours back-to-back (16 hours on one day and return to work 16 hours the following day.) During an interview on 5/26/22 at 7:56 AM, CNA S stated, You come out of a room and their (residents) lights are all on. You can't get to them all. CNA S said the facility needed more CNAs as the CNAs were being mandated to stay and work overtime (OT). When asked how many times in the past month CNA S had been mandated to stay the reply they had most recently been mandated 3 days in a row this past weekend. CNA S said it was not too bad as usually the CNAs are mandated and have to work the next shift or 16 hours straight. CNA S stated, This weekend I worked 16, 12, 12, (hours on Friday, Saturday, and Sunday). It was a lot. I do get burned out. CNA S said the facility just could not get more help as no one wants to work in Long Term Care. The Payroll Summary time sheet report for CNA S confirmed they had worked: 5/20/22 - one 8-hour shift followed by a Union Mandated OT of 7.77 hours 5/21/22 - one 8-hour shift followed by a Union Mandated OT of 4.03 hours 5/22/22 - one 8-hour shift followed by a Union Mandated OT of 3.94 hours During an interview on 5/26/22 at 8:00 AM, CNA N said the facility needed more staff as the CNAs were mandated sometimes 2 or 3 times per week and had to work either 12 hour or 16-hour shifts. CNA N said, Call ins are bad. She felt the staff could not do quality work. CNA N said she was mandated the previous weekend twice. She stated, I had it good and only had to work 2 -12s. I got off easy as others had 16s and had to do 3 mandated days in a row. The Payroll Summary time sheet report for CNA N confirmed they had worked: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5/20/22 - one 8-hour shift followed by a Union Mandated OT of 4.20 hours 5/21/22 - one 8-hour shift followed by a Union Mandated OT of 4.03 hours During an interview on 5/26/22 at 8:07 AM, Licensed Practical Nurse (LPN AA) stated the licensed nurses also were mandated to stay at times. During an interview on 05/26/22 at 8:57 AM, the Director of Nursing (DON) verified the staffing list noting of the 22 CNAs listed on the staff roster, two were no longer at the facility and four were prn (part time or as needed or had other duties such as facility transport driver). The total number of facility CNAs was 16 listed with one additional resident assistant. The Facility assessment dated [DATE] was reviewed and did not list a planned CNA or nursing pattern for scheduling and read in part, The facility determines staffing levels upon review of acuity and availability and will adjust staff as needed . Provide Person-Centered/Directed Care . Build relationships with resident/get to know them; engage residents in conversation Find out what residents' preferences and routines are; what makes a good day for the resident . Staff type: . Staffing is maintained at a level to meet the needs of the resident population. 35102 Call Light Concerns for Resident #152 and Resident #4 During an observation on 5/26/22 at 8:33 a.m., Registered Nurse (RN) P told Certified Nurse Aide (CNA) N that Resident #152 needed assistance. At the same time, the light above the door was lit and alarming, when Resident #152's roommate came out into the hall and spoke to RN P and said (Resident #152) needed help. RN P responded, ok but then did not enter the room to ascertain why Resident #152 had used the call light. During an observation on 5/26/22 at 8:35 a.m., Resident #4 came out of the room, in a wheelchair, and asked this Surveyor for a toothbrush and toothpaste. RN P was standing at the medication cart directly behind Resident #4 and said, without facing Resident #4 directly, responded that they could get the items. Resident #4 said, You told me earlier, the CNAs will help me. RN P entered Resident #4's room and prepared the oral care supplies in the bathroom. During an interview and observation on 5/26/22 at 8:47 a.m., Resident #152 was observed sitting at the bedside in a wheelchair with a sling to left arm. The arm was not supported and the left hand was slightly swollen and purple. Resident #152 said they needed to use the bathroom and that (CNA N) told them she would be coming back. This Surveyor asked Resident #152 to use the call light (was able without assistance from Surveyor). Resident #152 repeated that she thought CNA N was coming back to help her. During an observation on 5/26/22 at 8:58 a.m., Resident #152's call light signal above the door was flashing and sounding. RN P was in the same hall but continued walking away towards the nurse's desk without adressing the alarm. At 9:02 a.m., RN P responded to Resident #152's call light and assisted to the bathroom for toileting needs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 9:06 a.m. while Resident #152 was still in the bathroom, CNA N told CNA S they were leaving the floor for a break. During an interview on 5/31/22 at 11:02 a.m., the Director of Nursing (DON) acknowleged the facility had staffing concerns. The DON confirmed staff were working double shifts and multiple consecutive shifts. The DON agreed their current staffing levels were not meeting all the needs of residents. Restorative Concerns Review of Resident #6's MDS Assessment, dated 2/24/22, showed the following applicable diagnoses: stroke with hemiparesis/hemiplegia, diabetes, hypertension, and dementia. The Brief Interview for Mental Status (BIMS) score was 14/15 which reflected intact cognition. Resident #6 required two staff assistance for bed mobility, transfers, and toileting for both urine and bowel incontinence. The same MDS assessment identified pressure ulcer risk. On 5/26/22 beginning at 9:29 a.m., Resident #6's wound and incontinence care were observed. Resident #6 was lying on their back with their bilateral heels elevated on a blue foam pad. Resident #6 lower extremities appeared stiff and completely dependent for movement from staff. Review of Resident #6's Care Plan, revision 3/5/21, read in part, I am participating in the Restorative Nursing Program r/t (related to) BLE (bilateral lower extremity) Weakness, 3-7 x (times)/ (per) week .I will improve my current level of function by participating in the restorative program, revised 3/5/21. The NHA was asked to provide the last three months of Resident #6's documentation of participation in the Restorative Program. The NHA provided the following passive range of motion treatment dates which were performed by CNA M who the NHA identified as the facility's Restorative Aide. A. March 2022 reflected the following dates 3/4, 3/9, 3/22, 3/29, and 3/31. B. April 2022 reflected the following dates 4/6, 4/12, and 4/13. C. May 2022 reflected the following dates 5/2, 5/5, 5/11, 5/13, 5/16, 5/17, 5/19, 5/25, and 5/26. Resident #6 had not received Restorative Care at least three to seven times per week for the last three months reviewed. During a telephone interview on 6/1/22 at 12:12 p.m., the NHA confirmed the facility was experiencing staffing concerns with covering the Restorative Program. 40330 Resident #2 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #2's Minimum Data Set (MDS) assessment, dated 2/08/22, revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis, depression, and lung disease. Resident #2 required two-person assistance for bed mobility, dressing, and toileting, and total assistance for transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 10/15, which indicated Resident #2 had moderate cognitive impairment. During an observation on 5/26/22 at approximately 10:00 a.m., Resident #2 was observed to lift his arms with shaking, and reported and showed surveyor he could not move his legs, which were strapped into a recline wheelchair with cushioned elevated footrests. Resident #2 explained he needed range of motion and restorative exercises for his legs to prevent stiffness. Resident #2 expressed frustration this was not being done regularly. During an interview on 5/26/22 at 10:11 a.m., Staff WW reported Resident #2 was declining functionally as he had no range of motion completed regularly for an extended period, and he wanted range of motion done especially for his legs, and had told Staff WW he needed range of motion to decrease the stiffness in his legs. Review of the Electronic Medical Record (EMR) revealed no logs for Resident #2 for a restorative program or range of motion being completed. During an interview on 5/31/22 at 12:07 p.m. with CNA M, and Physical Therapist Aide (PTA) W, CNA M explained they were getting reassigned to the floor (as a shift aide) about 70% of the time, due to staffing shortages or staff being mandated to work over (overtime). PTA W confirmed this was occurring. Review of Resident #2's Care Plan revealed an intervention dated 8/20/22 related to Restorative Services: I am participating in the Restorative Nursing Program r/t [related to] stillness and decreased ROM [range of motion], 3 - 7 times a week, or as tolerated. Date initiated: 3/10/2021. Revised 3/30/21 . Review of a resident log of residents receiving Restorative Therapy Services, received from CNA M on 5/31/22, revealed for Resident #2: PROM [passive range of motion] bilateral foot, ankle, knee, and hip for 15 minutes or as tolerated, 3-7 times per week. Resident #21 Review of Resident #21's MDS assessment dated [DATE] revealed Resident #21 was admitted to the facility on [DATE], with diagnoses including heart failure, kidney disease, anxiety, and depression. Resident #21 required extensive, two-person assistance with bed mobility and toileting, and did not complete transfers during the assessment period. The BIMS assessment revealed a score of 15/15, which showed Resident #21 was cognitively intact. Review of Resident #21's current Care Plan, accessed 5/25/22, revealed a restorative program related to muscle weakness, but not a plan itself which specified the services to be provided or types of exercise. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/25/22 at approximatley 3:53 p.m., Resident #21 confirmed they were not receiving range of motion services, and would be eager to receive range of motion therapy, as they were in bed much of day, and any assistance from restorative or therapy to increase her tolerance of sitting up in her wheelchair, as she reported a fear of falling. Resident #21 reported they had received this therapy in the past, but not recently. Review of Resident #21's current restorative log, accessed 6/02/22, in the Electronic Medical Record (EMR), which had a 30 day look-back period, revealed, Seated exercises in wheelchair or bed, 2# bilateral, 2 x 20 [reps], 2-3x week. This log was blank, with no dates marked for resident participation. Review of Resident #21's restorative services resident log revealed resident was to receive active range of motion to legs, seated exercises in chair or at edge of bed, 3 to 7 times a week. On 5/31/22 at 11:17 a.m. and 12:08 p.m., the NHA and DON were interviewed. The DON confirmed CNA M was getting pulled to the floor often to work shifts, and when this occurred especially recently the restorative programs (for facility residents) were not being completed. The DON reported this happened even more so during the past two months. Resident #15 During an observation on 5/31/22 at 3:09 p.m., Resident #15 was observed in the facility hallway. It was noted her lower extremities were crossed at the hip and knees, which appeared contractured, with her left hip/leg externally rotated over her right leg. During an interview on 5/31/22 at 3:54 p.m., Registered Nurse (RN) Z confirmed Resident #15 had lower extremity contractures of the hips and knees. Further staff interviews revealed they were present for an extended time period. During an interview on 6/01/22 at 10:54 a.m., CNA M confirmed Resident #15 was in the restorative therapy program, however had missed some sessions due to staff shortages when he was pulled to work nursing aide shifts, which the DON earlier confirmed. CNA M reported range of motion exercises helped decrease tightness for Resident #15, which resulted in increased ability to participate in cares when they are provided regularly, especially personal hygiene and dressing tasks. Resident #35 During initial facility tour on 5/24/22 at 9:49 a.m., Resident #35 was observed in their room seated in a manual wheelchair. The MDS assessment was marked for falls, however Resident #35 could not recall when they fell or how it occurred. During an interview on 6/01/22 at 11:00 a.m., CNA M confirmed Resident #35 was in the restorative therapy program, however had similarly missed some sessions due to staff shortages, which the DON earlier confirmed. CNA M reported Resident #35's restorative program was particularly important as it included sit to stand exercises, which would keep him mobile for progression to ambulation (per therapy services) once toe/foot wounds were further addressed. CNA M reported it concerned them when Resident #35 missed restorative sessions, as they did not want to see Resident #35 lose their functional mobility (ambulation), and Resident #35 was eager to participate as scheduled. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	It was noted the residents' restorative participation logs reviewed showed entries that indicated there was no restorative aide available as they were pulled to the floor (to work a shift in the facility).

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 40383 Based on observation, interview, and record review, the facility failed to post actual nursing hours worked, this has the potential to affect all residents within the facility. This deficient practice resulted in necessary staffing information not being available to residents and visitors. The Nursing Department Daily Staffing forms were observed and several days were missing. During an interview on 5/26/22 at 8:24 AM, the Admissions Coordinator (Staff EE) said she completed the daily staffing sheets when she was working. Staff EE stated, I don't know who does them when I am off. Together we reviewed the notebook where daily staffing sheets were filed. Daily staffing sheets for 5/4, 5/5, 5/10, 5/11, 5/12, 5/16, 5/19, 5/20, 5/26 were in the file, however the other dates did not have staffing sheets and appeared to be missing. Staff EE said she was off for some of the missing days and stated, It looks like no one did them when I was off. During an interview on 5/26/22 at 8:35 AM, the Director of Nursing (DON) stated she did not do this task. During an interview on 5/26/22 at 8:37 AM, the Nursing Home Administrator did not know where the missing staffing sheets were and suggested Maybe the DON's box. The DON responded she did not receive them. The NHA said this is a system they will work on.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 13791 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety as evidenced by: 1. Failing to monitor and ensure the mechanical dish machine was properly sanitizing food contact surfaces. 2. Failing to provide a cleanable wall surface behind the mechanical dish machine. This deficient practice has the potential to result in food borne illness among any or all 53 residents in the facility. Findings include: On 05/24/22 at 11:36 AM Dietary Staff (DS) G was observed conducting dish washing duties at the low temperature dish machine. (DS) G was asked to demonstrate the method of ensuring proper levels of the hypochlorite sanitizer was present during the sanitizing cycle of the machine. (DS) G retrieved a proper test strip and at the proper time dipped the strip into the solution within the chemical mixing reservoir. When the strip was retracted from the solution, (DS) G read the strip as having less than 25 ppm. (parts per million) (DS) G stated Oh that's not right. When asked what the proper concentration of sanitizer was to be, (DS) G stated 100 ppm. A review of the Low Temp Dish Machine Log, located in a notebook in the kitchen, was conducted. The log organized into columns with three entries for each day and each meal to record the concentration of sanitizer. The morning meal of 5/24/2022 was blank, as well as the entire previous day's entries and another 17 blank entries since the first day of the month (May). On 5/24/22 at 12:29 PM the dish machine was observed along with Dietary Manager (DM) E, who tested the solution again and found the concentration to be less than 25 ppm. An interview with the Dietary Manager (DM) E was conducted on 5/25/22 at 9:45 AM regarding the documentation for the sanitizing concentration in the dish machine. When asked if there was a policy which required testing of the dish machine, DM E stated Not really. When asked if the log, in of itself, indicated a requirement to test the machine for each meal, DM E stated I guess so. On 5/25/22 at 10:45 AM, an interview with Registered Dietician (RD) J was conducted and confirmed the expectation was that staff would test the dish machine for each meal's dish washing procedures. On 5/24/22 at 7:45 AM, during the initial tour, all other observations in the kitchen, the wall behind the soiled end of the dish machine was observed to have missing ceramic tiles, exposing the backing board to high levels of splash. This created a surface which was no longer easily cleanable. Additionally, the drainboards were not sealed to the wall allowing water spray to drip behind and down the wall to the floor. The FDA Food Code 2013 states: 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under S7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA registered label use instructions, and shall be used as follows: (A) A chlorine solution shall have a minimum temperature based on the concentration and PH of the solution 50-99 PPM when the water has a pH of 10 or less and minimum temperature of 100 F. and 6-101.11 Surface Characteristics. (A) Except as specified in (B) of this section, materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be: (1) SMOOTH, durable, and EASILY CLEANABLE for areas where FOOD ESTABLISHMENT operations are conducted; (2) Closely woven and EASILY CLEANABLE carpet for carpeted areas; and (3) Nonabsorbent for areas subject to moisture such as FOOD preparation areas, walk-in refrigerators, WAREWASHING areas, toilet rooms, mobile FOOD ESTABLISHMENT SERVICING AREAS, and areas subject to flushing or spray cleaning methods

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. 35102 Intake #127653 This citation will have two deficient practice statements: A and B. A. Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices for: 1.) proper linen storage; 2.) performance of hand hygiene during wound and incontinence care; 3.) adherence to mask use for COVID-19 precautions; and 4.) awareness of Transmission-Based Precautions for a multi-drug resistant organism. These deficient practices had the potential to result in cross-contamination of infectious organisms. Findings include: LINENS During an observation on 5/24/22 at 9:58 a.m., the South Hall shower room was observed. A concrete, block wall on the opposite side of the shower, had multiple missing blocks of concrete which left exposed plumbing several feet high from the floor up the wall. The gray, vinyl baseboard trim was pulled away from the same area. The exposed area contained a great accumulation of dust/debris resting on the broken/jagged concrete blocks and floor. A stocked, uncovered linen cart was positioned directly next to the exposed opened wall. A second uncovered linen cart was stored directly across from the one next to the opened wall. Directly in front of the exposed wall, and linen cart, two gray floor tiles were missing, and the surrounding tiles were loose which exposed a soiled concrete floor and partially soiled laminate, tan-marbled flooring. During an observation on 5/25/22 at 4:45 p.m., the laundry department was observed. Two clothes lines were strung across the room which contained individual clothes pins securing 20 wash cloths, one transfer lift, and 18 oblong shaped cleaning pads. Three large laundry bins were overfilled (approximately one foot above the top of the rim) and covered with bath blankets. The bin furthest to the left, contained a pop bottle with an exposed red cap tucked inside the corner. During an interview on 5/25/22 at 5:00 p.m., Staff Q when asked about the laundry bins said the laundry had not been processed due to staffing shortages. When asked about the broken dryer(s), Staff Q said Certified Nurse Aide (CNA) M had repaired one about a month and a half after it had broken in December 2021. When asked why a CNA had made the repair and not maintenance staff, Staff Q said the facility did not have one at the time. Staff Q said CNA M had taken parts from another dryer to make the repair on the broken dryer. When asked how the linens were transported to the local laundromat for drying, Staff Q said the facility van was used during the week, but staff were made to use their personal vehicles on the weekends when the transporter was not working. Staff Q confirmed transporting wet linens posed a risk of cross-contamination with using personal vehicles. During an interview on 5/31/22 at 11:02 a.m., the DON confirmed all linen carts needed to be kept covered when exposed to dust/debris or moved to a different location to avoid posing risk to immunocompromised residents. Hand Hygiene (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/26/22 beginning at 9:29 a.m., Resident #6's wound care was observed performed by Wound Care Nurse/ Licensed Practical Nurse (LPN) U and initially assisted by Certified Nurse Aide (CNA) M. Both performed hand washing in the bathroom and applied gloves. After dressing supplies were opened and prepped, LPN U removed their gloves and put on a new pair without the performance of hand hygiene. Resident #6's right ankle wound dressing was removed. LPN U changed gloves before redressing the right ankle wound without the performance of hand hygiene. A left heel dressing was observed but not removed and assessed by LPN U who then changed gloves without performance of hand hygiene. CNA M turned Resident #6 on their left side (facing the direction of the door). LPN U lowered the brief and folded it over into itself when a large amount of soft to liquid stool was found. LPN U removed the coccyx wound dressing and left it uncovered throughout the incontinence care which increased the opportunity for cross-contamination of stool to the wound. CNA M stood on the left side of the bed and repeatedly reached over Resident #6's body to dispose of the soiled, disposable incontinence wipes in a small garbage can located directly under the overbed table which contained the opened wound care supplies. LPN U removed gloves and washed hands in the bathroom while CNA M and now CNA S continued incontinence care on Resident #6. CNA S handed soiled disposable wipes to CNA M who then placed them in the same trash can located under the prepped wound care supplies. CNA M changed gloves without the performance of hand hygiene. Mask Use During the facility's Entrance Conference, on 5/24/22 at 8:13 a.m., the Director of Nursing (DON) was asked to replace their surgical mask immediately after it was pulled down under the chin. Throughout Resident #6's wound and incontinence care observation on 5/26/22 at 9:29 a.m. and with Resident #50's wound care on 5/26/22 at 10:10 a.m. LPN U repeatedly touched the front of their mask which was ill-fitting, at times positioned under the nose, and which contained an exhalation valve. Hand hygiene was never performed after touching the mask. During an observation and interview on 5/25/22 at approximately 11:00 a.m., LPN U's high filtration facemask with an exhalation valve was loosely secured and under the nose. When asked about the apparent soiling, LPN U suggested it may be due to make-up. LPN U confirmed they were unvaccinated (COVID-19) and had a medical exemption. No hand hygiene was performed after LPN U replaced the mask above the nose. During an interview on 5/31/22 at 11:02 a.m., the DON said they were unaware of LPN U's use of a high filtration mask which contained an exhalation valve. The DON said it was not approved for use. The DON confirmed all masks needed to be secured to the face and covering the nose and mouth. During an observation on 5/31/22 at 3:56 p.m., CNA T surgical mask was under their nose (blue color facing out). CNA T had just left Resident #50's room and walked to the hall computer and began using it. Transmission-Based Precautions (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the Entrance Conference on 5/24/22 at 8:13 a.m., the DON said Resident #50 was in transmission-based precautions (TBP) for MRSA (Methicillin-resistant Staphylococcus aureus-gram positive bacteria which is very difficult to treat due to antibiotic resistance) which was currently being treated in a foot wound. The DON said Resident #50 had a roommate that was not being treated for the same organism. During an observation and interview on 5/26/22 at 10:10 a.m., Resident #50's wound care was observed. LPN U, CNA N, and CNA S put on Personal Protective Equipment (PPE) which consisted of yellow, disposable gowns and gloves (face masks were already being worn) without the performance of hand hygiene. The isolation cart did not contain a bottle of hand sanitizer. The closest location for the sanitizer was wall-mounted across the hall. LPN U was asked to discuss the right diabetic foot wound. LPN U said Resident #50 had MRSA in a wound under the breast but said the isolation could now be discontinued since there's no longer a wound. When told about the DON informing the Surveyor during Entrance Conference that Resident #50 had MRSA cultured from right foot, LPN U responded, I didn't know that. Upon entering the Residents' room, Resident #50's overbed table was located on roommate's side of room (closest to the door). LPN U pulled the table back over towards Resident #50's bed next to the window. Wound care supplies were placed directly on top of the table without first cleaning and disinfecting the table. A bottle of saline spray fell off the table and rolled a few times on the floor. LPN U removed both gown and gloves and left the room. A few minutes later, LPN U returned with a new gown and washed hands in bathroom and put on a new pair of gloves. CNA N removed Resident #50's right leg medical boot and compression wraps to bil legs. CNA N washed hands in the bathroom and changed gloves and assisted CNA S with a total lift for Resident #50's roommate. The same gown was still being worn. LPN U removed Resident #50's right yellow anti-slip sock. A dressing was noted on the sole towards the toes and then removed. LPN U touched the overbed table and mask with soiled gloves. The opened wound had macerated edges. A blue dressing was noted inside wound. LPN U changed gloves and performed hand hygiene prior to the placement of the new dressing. LPN U, CNA N, and CNA S were observed touching many environmental surfaces between Resident #50's area and the roommate and continuing cares with both residents simultaneously. The curtain dividing the Residents contained a large brown stain noted towards the end of the curtain on Resident #50's side. CNA S had not changed gloves during the course of the whole observation. CNA N changed gloves one time. Gross hand contamination by all staff within room occurred by repeatedly touching curtains, medical equipment, furniture, personal items, and both Residents when wound care was performed. During an interview on 5/31/22 at 11:02 a.m., Resident #50's wound care observation was discussed with the DON who said the number of staff in the room during wound care should have been limited. Resident #50's wound care should have been performed separately from when the roommate was receiving cares and transferred with a mechanical lift which would reduce the risk of cross-contamination. When asked about Resident #50's positive wound culture for MRSA, the DON was surprised and said LPN U should have been aware. Review of the facility's Infection Prevention and Control Program revised 12/20, read in part, a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed .c. All staff shall use .PPE according to established facility policy governing the use of PPE. Linens .d. Linen shall be stored . on covered carts . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	13791 B. Based on observation and interview, the facility failed to handle resident linens in a sanitary manner as evidenced by the months long continuing use of a local laundromat facility where proper infection control measures could not be established. This deficient practice has the potential to affect all 53 residents. Findings include: On 5/24/22 at approximately 9:15 AM, observations of the laundry department were conducted with Maintenance Director (MD) F. At this time it was learned that both (two of two) natural gas laundry dryers were no longer functioning. It was explained the dryers were less than a year old and the vendor refused to conduct warranty work on the machines. When asked how linens were being cared for, it was learned staff were required to take them down to a local laundromat and use the dryers there. When asked how long this condition had been going on, MD F stated that one of the dryers had been non-functional since January and the second since late in March 2022. When asked what other options were available, a local commercial laundry service vendor was identified within 15 miles. When asked why the facility had not contracted with the vendor, stated I'm not sure. No one has signed the contract. When asked if it was felt this was a sanitary way of handling linens for the residents, MD F stated, probably not. On 5/24/22 at approximately 9:25 AM, an interview was conducted with the nursing home administrator (NHA) concerning the practices being followed for resident linen cleaning. The NHA acknowledged the dryers had been inoperable for a long period of time and a laundry vendor had not been contracted but had been in negotiations since March 5, 2022. The NHA confirmed there was a local vendor who had been contacted in March of 2022 but had not pursued signing a contract to eliminate the need to use the laundromat on a daily basis. On 5/24/22 at approximately 10-:25 AM an interview was conducted with environmental staff H who stated it was impossible to handle the laundry in a hygienic manner having to transport wet linens to the laundromat and return dry linens back to the facility. Staff H stated, Who knows what happens in that place down there, referring to the laundromat.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35730 Based on observation, interview and record review, the facility failed to ensure the safe function of dryers in the laundry service area, the safe wiring in two of eleven rooms reviewed for safety (rooms 128-B and 109-B), and a potentially dangerous floor cleaning machine was properly stored when not in use. This deficient practice resulted in the potential for fire, electrocution, and/or other hazards for all 46 vulnerable residents, the staff and the public. Findings include: On 7/12/22 at 10:50 a.m., the laundry area was observed with Staff B. Both commercial dryers in the room were out of service, according to Staff B. There were two residential electric dryers in use in front of large windows. Both dryers were plugged into 220v (volt) electrical outlets. One of the dryers was plugged in via an extension cord with no safety inspection/approval tags on the cord. The extension cord appeared to be homemade. Both dryers had exhaust ducts flowing from the rear of the units uphill and out the open windows above the dryers. The exhaust ducts were flexible plastic with spiral collapsable frames and not connected, secured or attached to any support at the window end. Both windows remained open and allowed for pest entry. Both windows were covered in lint. There was a commercial floor drying fan sitting up on the counter below the windows, operating and blowing toward the windows. Staff B pointed to the set up and stated, How healthy is that? On 7/12/22 at 11:30 a.m., room [ROOM NUMBER]-B was observed to have metal conduit behind the Resident's bed holding wiring. The conduit was falling off the wall for the length of the conduit behind the bed, with the wiring exposed and hanging freely out of the conduit. The sharp screws were out of the wall and hanging freely from the conduit. Resident #6-1 was in the bed for the duration of the survey. On 7/12/22 at 1:25 p.m., Environmental Services Director, (Staff) L observed the laundry area and residential dryers with this Surveyor and was asked about the set up. Staff L said the commercial dryers were still out of service and the facility was having trouble getting parts. Staff L was asked if any attempts were made to obtain contracted services for laundry, and responded the only vendor available required a three year commitment and corporate wouldn't approve the contract. Staff L provided an email from the corporate office that revealed, .[name of vendor] is not able to do a contract on a month to month basis. They want at least a year commitment. During a follow up interview on 7/13/22 at 7:23 a.m., Staff L confirmed the 220v electric extension cord on the residential dryer was homemade by himself. On 7/13/22 at 8:55 a.m., Staff L accompanied this Surveyor to rooms 109-B, where the electrical wiring behind the bed was falling out of its conduit and off the wall, and to room [ROOM NUMBER]-B, and agreed the hanging exposed wires with sharp hanging screws, was not a safe environment. Staff L said his environmental rounds looked at specific things, but he would have to expand those rounds to be all encompassing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235552	A. Building B. Wing	06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/13/22, from 1:00 p.m. till 4:15 p.m., an electric carpet/floor cleaner was observed in the common area just across from the nursing station. The electric cord swirled haphazardly on the floor in front of the area where residents regularly congregated. When the Director of Nursing (DON) was asked about the unattended machine left in the common area for hours, the DON agreed it was not safe as some of the female residents like to vacuum and could try to plug in and use the machine mistakenly, with a high risk of injury. The DON also agreed the haphazardly strewn cord was a trip hazard in the heavily frequented resident area. The International Mechanical Code revealed the following: 504.6 Domestic clothes dryer ducts. Exhaust ducts for domestic clothes dryers shall be constructed of (rigid) metal and shall have a smooth interior finish. The exhaust duct shall be a minimum nominal size of 4 inches (102mm (millimeter)) in diameter. The entire exhaust system shall be supported and secured in place. The male end of the duct at overlapped duct joints shall extend in the direction of airflow. Clothes dryer transition ducts used to connect the appliance to the exhaust duct system shall be limited to single lengths not to exceed 8 feet (2438 mm) and shall be listed and labeled for the application. Transition ducts shall not be concealed within construction. The National Electrical Code: NFPA 70 prohibited the use of 220v extension cords and homemade extension cords. 400.8 (temporary wiring) 590.3(D)(B) (extension cord use)