STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235719	A. Building B. Wing	08/19/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39918 Based on interview and record review, the facility failed to hold a care conference as scheduled for one sampled Resident (R901) of three reviewed for care planning, resulting in an unnecessary delay in continuing the collaborative care planning process. Findings include: A review of R901's medical record revealed that the resident was admitted into the facility on [DATE] with diagnoses that include Dementia, Psychotic Disorder and Hypertensive Heart Disease. A review of the Minimum Data Set (MDS) assessment dated [DATE] indicated that R901 was severely cognitively impaired. A review of R901's medical record revealed the following progress note written by Social Worker A on 8/12/22 at 10:03 AM: Coordinated meeting with [Ombudsman] and the IDT (interdisciplinary team), to facilitate transfer. Meeting will be held on 8/16/2022 at 1:30 PM . On 8/16/22 at 11:05 AM, the Ombudsman was interviewed via phone and explained that she would be attending a care conference today at the facility with R901, along with the IDT and R901's family member. On 8/16/22 at 12:46 PM, the Ombudsman informed this surveyor that the facility canceled the IDT meeting for R901 due to the survey, so she would not be on site as planned. The Ombudsman indicated that the meeting had been canceled by Social Worker A. On 8/16/22 at 12:49 PM, Social Worker A was interviewed and asked why she canceled the IDT meeting for R901. Social Worker A initially stated that, Everyone wasn't here today, and stumbled to give a clear explanation. Social Worker A then explained that she, Took the initiative to cancel the meeting because the state is here, and that she, Figured it was going to be hectic. Social Worker A stated that she contacted R901's family member, told her the team was busy and asked if the meeting could be rescheduled. On 8/16/22 at 3:08 PM, R901's family member, who was going to attend the scheduled IDT meeting for R901, was interviewed via phone and indicated that the facility gave her less than an hour's notice prior to canceling today's scheduled meeting. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/2022 at 11:43 AM, the Director of Nursing (DON) was interviewed and asked if a scheduled care planning meeting should ever be canceled by staff due to the State Agency being in the building. The DON stated, No, that should never be done. A review of the facility's policy/procedure titled, Resident/Family Participation - Assessment/Care Plans, revised 3/22/22, revealed, Each resident and his/her family members are encouraged to participate in the development of the resident's comprehensive assessment and care plan .1. The resident and his/her family, and/or the legal representative (sponsor), are invited to attend and participate in the resident's assessment and care planning conference .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This citation pertains to Intakes: M00127936 and MI00129425. Based on observation, interview and record review, the facility failed to operationalize policies and procedures to inform the resident's representative and physician of the elopement of one sampled Resident (R901) of one resident reviewed for notification, resulting in the resident's representative and physician not being informed of the resident's physical safety and psychosocial well-being. Findings include: A review of intake MI00127936 revealed the following, Complainant states the resident had alleged that [they] had gotten out of the building and was worried it would happen again. Complainant states the resident is demented and did not know the validity of what [they were] stating. Complainant states [they] spoke to staff members with the resident present who assured [them] that the resident had not ever gotten out and [they were] safe. Complainant stated while visiting in the resident's room another staff member (did not want to provide name in fear she would get in trouble) told [them] that the resident had actually eloped multiple times and it was not reported. Complainant states on Father's Day the resident eloped and was found by the administrator 3 miles away from the facility. Complainant states when the resident returned the staff were told not to report it. Complainant states [they were] never notified of any elopements . On 8/16/22 at 10:46 AM, R901 was observed in their room coloring with a 1:1 patient sitter (Patient Sitter D) in the room. The resident was pleasantly confused at this time. The 1:1 sitter was asked if she had been working with the resident long and indicated that this was her first time working with the resident and was not sure why R901 needed 1:1 supervision. A review of R901's medical record revealed that the resident was admitted into the facility on [DATE] with diagnoses that include, Dementia, Psychotic Disorder and Hypertensive Heart Disease. A review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 6/15 indicating a severe cognitive impairment. Further review of R901's medical record revealed that the resident was ambulatory, and review of their care plan revealed the following: [R901] is at risk of wandering and elopement; [R901] has dx (diagnosis) of dementia with bx (behavioral) disturbance, is on psych (psychotropic) med (medication) and is a new admission; has hx (history) of elopement from home and from another nursing facility. Approach date:12/29/2021: monitor when ambulating on the unit; keep near the nursing station. Approach date:12/29/2021 Redirect resident if [they] wanders toward any exit doors . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/22 at 9:06 AM, a phone interview was completed with hospice agency Certified Nursing Assistant (CNA) F regarding R901 eloping from the facility. CNA F explained that she was driving home between 6-7 PM, when she recognized R901 as a resident from the facility she provides hospice services at, walking down the street. CNA F was asked what street the resident was walking down and described a busy, high traffic street that is approximately 1 mile away from the facility. CNA F explained that R901 was walking in the street and she followed them in her car. CNA F explained she kept an eye on R901 so no would hit them, all while contacting the facility to notify them that she found one of their residents. CNA F explained that she eventually found a safe place to park her car in order to get to R901 and comfort them until the Director Of Nursing (DON) arrived. CNA F was asked R901's cognition at that time and explained that R901 appeared confused. A review of R901's statement revealed the following: Interviewer: Where were you going the other day? R901: I tried to go home because I heard my wife voice, I was going this way and that way because it was a big circle. Then someone said, 'hey I know you.' Interviewer: How did you get out? R901: Well, the door opens you just have to push it, the alarm will go off and they will have to reset it Interviewer: [R901] we want you safe and not to leave out. R901: I know I am sorry that I did that. I won't do it again. A review of the Facility Reported Incident investigative packet did not reveal an Incident/Accident report or any documentation that the resident's physician or resident's representative had been contacted following R901's elopement from the facility. A review of R901's progress notes did not reveal any documentation for the resident on the date that they eloped from the facility on 6/19/22. Upon further review, the last progress note before the elopement was dated for 6/17/22. Another progress note for R901 was not noted to be entered until 6/20/22, and did not reflect contact with the resident's physician or resident representative. On 8/18/22 at 11:44 AM, the DON was asked whether the resident's representative and physician had been contacted following F901's elopement. Upon review of R901's medical record, the DON was unable to locate documentation that the representative or physician had been contacted. No other explanation was provided at this time. A review of the facility's Elopements policy was reviewed and revealed the following, .3. When a departing (a definite elopement) individual returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Notify the Attending Physician; c. Notify the resident's legal representative (sponsor) of the incident; d. Complete and file Report of Incident/Accident; e. Document the event in the resident's medical record .

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39918 This citation pertains to intake MI00127847. Based on interview and record review the facility failed to ensure return to the facility and/or timely return to the facility for three sampled Residents (R910, R912, and R914), out of seven residents reviewed for admission/discharge concerns, resulting in the lack of, or delays in establishment and continuation of care. Findings include: Resident #910 (R910) A review of intake MI00127847 revealed: [R910] came from [facility]. Patients' legal guardian wanted her to return to that facility. Referral started in Allscripts (form of communication of hospital with facility) on 11/26 and patient was officially ready to discharge on 12/1. Case Manager has been reaching out to the facility every day, check in the morning for bed availability. They have provided timely responses of not being able to accommodate with room daily until today. Case Manager manager [from hospital] has emailed the [Corporate Employee R] without response on the status on 12/6. Patient has waited 5 days for a bed and now is requiring additional care and discharge will have to be held. Hospital is at a critical capacity and these additional delays causes significant capacity issues during these difficult times. The Allscripts correspondence between the facility and the hospital was provided for review from the complainant. The correspondence showed multiple lapses in communication from the facility to the hospital regarding R910's re-admission and multiple days where Corporate Employee R indicated to the hospital that the facility had no beds available for the resident's return. Review of R910's record revealed the resident was readmitted into the facility on [DATE] after being sent to the hospital on 11/25/21. On 8/17/22 at 10:59 AM, Corporate Employee S was interviewed via phone. When queried regarding the delayed re-admission for R910 in November/December 2021, Corporate Employee S indicated that she did not handle the re-admission and that the correspondence was between the hospital and Corporate Employee R. Corporate Employee S stated that the hospital initially told the facility the resident was ready for discharge on December 1st. On 8/17/22 at 3:41 PM, the Director of Nursing (DON) was queried regarding R910's delayed return to the facility after going to the hospital on 11/25/21. The DON was unable to provide much information other than she had just started working at the facility and didn't realize that the resident was ready to return from the hospital on 12/1. The DON stated that Corporate Employee R was handling the communication with the hospitals and case workers at that time. Resident #912 (R912) A review of intake MI00127847 revealed: (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[R912] admitted (to hospital) from [facility] and was cleared to return within 24 hours. [Facility] accepted patient but when it was time for discharge, they canceled the bed on 1/2/2022. The next morning 1/4/2022 they mentioned that they needed additional trach supplied (sic) which were obtained. Later in the day they mentioned they needed a part for their trach compressor. As of 1/7 (2022) - no communication from [facility] . This has caused an extensive delay in discharge at a time that the hospitals are full and need to transition our patients timely. The intake included an attachment that contained correspondence between the hospital and the facility [Corporate Employee R] regarding sending R912 back to the facility. No correspondence from Corporate Employee R was sent to the hospital after 1/4/22. A review of R912's facesheet revealed that the resident was admitted into the facility on [DATE] at 3:41 PM and discharged to the hospital on 12/31/2021 at 6:09 PM. The facesheet did not include the reason for discharge. The resident was marked as a Discharge - RE (Return Expected). Record review revealed that R912 did not come back to the facility. Further review of R912's record revealed a, Resident Transfer Form To Hospital/Other Care Facility form dated 12/31/2021 at 3:49 PM. The Primary Clinical Reason for Transfer: section of the form was left blank. No progress note related to the resident's transfer to the hospital was found. The resident's admission progress note indicated that the resident had a trach (tracheostomy). On 8/17/22 at 10:56 AM, Corporate Employee S was interviewed via phone. When queried as to why R912 did not come back to the facility, Corporate Employee S stated that the company's admission director at the time canceled the resident coming back to the facility (Corporate Employee S indicated that seemed odd to her) and it appeared that Corporate Employee R's reasoning for that was that the trach compressor was not operating at what it needed to be. Corporate Employee S was unable to provide further information and explained that Corporate Employee R was handling a lot of transfers for our company (at that time) .but we have moved to a different approach. On 8/17/22 at 3:41 PM, the Director of Nursing (DON) was queried regarding R912 and why she did not come back to the facility. The DON indicated that she did not know why R912 did not come back to the facility and that current staff were unable to access ECIN (Extended Care Information Network) to gather more information. Resident #914 (R914) A review of intake MI00127847 revealed: [R914] is a long-term resident from [facility]. They were advised that patient will need a BIPAP, and script sent on 3/18 (2022). On 3/19 they said the BIPAP will be delivered on Monday. On Monday and Tuesday there was no BIPAP machine delivered. On Wednesday 3/23 there still is not a BIPAP machine and we asked if the hospital could call and help expedite the equipment, but the facility refused to give any information. We are not able to discharge patient - currently a 5-day non-acute stay (on 3/23/2022). (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Allscripts correspondence between the facility and the hospital was provided for review from the complainant. The correspondence showed that R914 was medically stable for discharge on 3/18/22. The hospital sent BIPAP settings along with a prescription so the facility could order one for R914. Corporate Employee R indicated over multiple days that the BIPAP machine had not been delivered. The correspondence showed that the hospital attempted to get a number for the medical equipment company on 3/23/22 from Corporate Employee R but did not receive one. A review of R914's record revealed that the resident was sent to the hospital on 3/11/22 and discharged back to the facility on [DATE]. Further review revealed that the resident was treated at the hospital for Congestive Heart Failure and Acute Hypercapnic Respiratory Failure. On 8/17/22 at 11:21 AM, Corporate Employee S was interviewed via phone. When queried regarding R914's delayed re-admission into the facility in March 2022, Corporate Employee S indicated that Corporate Employee R handled that case. On 8/18/22 at 9:49 AM, the NHA was asked to provide: Transfers/Discharges/Admissions/Readmit policies/procedures. The facility only provided a policy/procedure related to discharge planning. On 8/19/22 at 10:58 AM, the Nursing Home Administrator (NHA) was interviewed regarding permitting residents to return to the facility/timely return. The NHA stated that someone else at a corporate level was handling admissions/re-admissions/discharges prior to her arrival and that she was unable to provide any information about them. The NHA was informed that any documentation/communication from the person who was handling admissions/re-admissions/transfers/discharges would be accepted for review prior to survey exit, however, none was provided.

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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** 40384 This citation pertains to Intake: MI00129425, MI00129142, and MI00127847. Based on observation, interview and record review the facility failed to ensure care needs were documented and met timely for three sampled Residents (R919, R920 and R905) of five reviewed for activities of daily living needs, resulting in a delay in care needs being met and the potential for unmet care needs. Findings include: Resident #919 (R919) On 8/18/22 at 7:59 AM, R919 was observed lying in bed on their back. They were asked how they were feeling, and R919 explained that they would like to get out of bed, had asked facility staff, and they had not gotten them up yet. R919 stated, It's difficult lying in bed like this. A review of R919's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included, Unspecified Fracture of Unspecified Thoracic Vertebra, Diabetes, and Stroke. R919 was cognitively intact and required extensive assistance for Activities of Daily Living (ADL). On 8/18/22 at 2:57 PM, an unidentified staff member from Therapy was asked about R919 attending therapy today. She stated that R919 is scheduled to go to physical therapy today, and is just waiting for facility staff to get R919 ready. On 8/18/22 at 3:18 PM, R919 was still observed in bed lying on their back. R919 explained that no one had gotten them up since asking this morning. On 8/18/22 at 3:23 PM, the unidentified Certified Nursing Assistant (CNA) assigned to R919 was asked why R919 had not gotten out of bed all day, and he explained that he was advised by physical therapy that they would be getting them up for the day after lunch. At this time, Nurse L interjected and further echoed the same explanation as R919's assigned CNA. Resident #920 (R920) On 8/19/22 at 12:41 PM, while walking down the hallway, this surveyor heard a resident yelling help. Upon arrival to R920's room, R920 explained that they had been waiting since 8:30 AM this morning for someone to change them, they had not been changed this morning, and was soaking wet. R920 also explained that their assigned nurse had yet to come in and look at their colostomy, as their skin was red and irritated. R920 further explained that they had spoken to their assigned CNA (Q) about it, and they stated they had let the nurse know. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/22 at 12:45 PM, R920 turned their call light on, and CNA Q entered the room. CNA Q was asked if they had notified the nurse of R920's request as they have reported asking to see them since this morning at 8:30 AM. CNA Q stated that they had told the nurse and was not sure what they were doing at that time. At this time, CNA Q walked out of the room followed by this surveyor who went to the nurses' station where R920's assigned nurse, Nurse L was sitting. CNA Q was observed whispering to Nurse L who at that time, grabbed her personal belongings and stated that she was going on her break. A review of R920's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Colon Cancer, Diabetes and Muscle Weakness. Further review of R920's medical record revealed that the resident was cognitively intact and required dependent assistance or 2 persons with toileting/incontinence care/ostomy care and management. Resident #905 (R905) On 8/16/22 at 8:37 AM, R905 was observed lying in bed, with their Foley catheter drainage bag lying flat on the floor. The resident was asked about their care and had no complaints aside from not receiving showers regularly. On 8/17/22 at 8:03 AM, R905 was observed in bed. Upon observation, both of the resident's hands were contracted, and their nails were observed to be elongated with a brown unknown substance underneath. On 8/18/22 at 8:20 AM, R905 was asked how they were doing today and stated, Better if I could get out of this bed. R905's fingernails were again observed as elongated with an unknown brown substance underneath them. A review of R905's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Stroke, Chronic Kidney Disease and Diabetes. A review of the resident's Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 6/15 indicating a severe cognitive impairment. R905 required extensive assistance of 1-2 persons for ADL's including toileting, transfers and hygiene. On 8/19/22 at 11:44 AM, the Director of Nursing (DON) was interviewed and asked about ADL care being provided to dependent residents. The DON explained that her expectation is for residents to be groomed, and up out of bed if they request it. A review of the facility's Activities of Daily Living policy was reviewed and revealed the following, .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on observation, interview and record review, the facility failed to provide and document recommended restorative services to maintain and/or improve activities of daily living for one sampled Resident (R905) of one resident reviewed for restorative services, resulting in a decrease in mobility, and the likelihood for a decrease in comfort and activities of daily living. Findings include: On 8/16/22 at 8:35 AM, R905 was observed lying in bed, with their Foley catheter drainage bag lying flat on the floor. The resident was asked about their care and had no complaints aside from not receiving showers regularly. A review of R905's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Stroke, Chronic Kidney Disease and Diabetes. A review of the resident's Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 6/15 indicating a severe cognitive impairment. R905 required extensive assistance of 1-2 persons for ADL's including toileting, transfers and hygiene. On 8/18/22 at 8:03 AM, R905 was observed in bed, with their Foley catheter drainage bag on the floor, and water at bedside, although R905 was not supposed to consume anything by mouth. Upon observation, both resident's hands were contracted, and their nails were observed to be elongated with a brown unknown substance underneath. There were no braces or splints observed on their arms/hands. On 8/19/22 at 8:20 AM, R905 was asked how they were doing today and stated, Better if I could get out of this bed. R905's fingernails were again observed as elongated with an unknown brown substance underneath them. R905's hands were observed as contracted and they were asked about their braces. R905 looked at their hands and stated, I used to have them. On 8/19/22 at 11:44 AM, the Director of Nursing (DON) was interviewed and asked about the facility's restorative program and explained that the program started in April. The DON was asked if the documentation of restorative services provided was located in the electronic medical record. The DON explained that the notes are handwritten and placed in a binder, which was for view by the surveyor. Upon review of the binder, there were no restorative notes for R905. At this time, the DON contacted the restorative aide, and he provided notes for the month of July. Upon review of the restorative notes, there were none for August, and the notes for July were only for the following dates: 7/7, 7/11, 7/13, 7/15, 7/18, 7/20, 7/22, 7/25, 7/27 and 7/29. The DON was asked about the missing dates and explained that residents do not necessarily obtain restorative services daily. A review of R905's physician orders dated for 6/14/22 revealed the following: Start Date: 06/14/2022. End Date: Open Ended. Order Description: Pt. (patient) referred to RNP/FMP (restorative/functional maintenance program) for ROM (range of motion) and splinting. PROM (passive range of motion) to BUE/LE's (bilateral upper extremities/lower extremities). PROM prior to donning Left WHO and Rt (right). c-splint/elbow extension splint for up to 6 hours without any changes with skin integrity and increased pain. Monitor skin/pain throughout wear time. Splints and splinting skin area/joints are to be clean and dry prior to donning splints .Repeat: Every Day. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Activities of Daily Living policy revealed the following, .2.The facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 40384 This citation pertains to Intakes: MI00127936, MI00128989, MI00129009, MI00129142, MI00129425, and MI00129451. Based on observation, interview and record review, the facility failed to provide adequate monitoring and supervision to prevent an elopement from the facility for one sampled Resident (R901), noted with severe cognitive impairment and known high risk elopement history resulting in, R901 exiting the facility through the North side door of the building unbeknownst to staff, located near a busy road, during the evening approximately one mile away by a non-facility staff member and after notification retrieved by the Director of Nursing (DON). This deficient practice resulted in an immediate jeopardy, with the likelihood of serious injury, harm, impairment, or death. Findings include: A review of Intake MI00129451 revealed the following, Incident Summary. The DON was notified by a staff member that a man resembling [R901] was walking down the street. She continued to keep her eyes on the person until hearing back from the DON. The DON had just left the facility, so she called and asked the charge nurse to complete a head count. During the headcount, it was noted that [R901] was not in [their] room. The DON went to the location and was able to redirect the resident and brought [them] back to the facility On 8/16/22 at 10:46 AM, R901 was observed in their room coloring with a 1:1 patient sitter (Patient Sitter D) in the room. The resident was pleasantly confused at this time. The 1:1 sitter was asked if she had been working with the resident long and indicated that this was her first time working with the resident and they were not sure why they needed 1:1 supervision. A review of R901's medical record revealed that R901 was admitted into the facility on [DATE] with diagnoses that include, Dementia, Psychotic Disorder and Hypertensive Heart Disease. A review of the Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 4/15 indicating severe cognitive impairment. Further review of R901's medical record revealed the resident was ambulatory, and review of the facility's care plan revealed the following: [R901] is at risk of wandering and elopement; [R901] has dx (diagnosis) of dementia with bx (behavioral) disturbance, is on psych (psychotropic) med (medication) and is a new admission; has hx (history) of elopement from home and from another nursing facility. Approach date:12/29/2021: monitor when ambulating on the unit; keep near the nursing station. Approach date:12/29/2021Redirect resident if [they] wanders toward any exit doors . On 8/16/22 at 11:05 AM, The State Ombudsman was interviewed via phone about concerns regarding the facility, and explained that R901 had eloped from the facility, and someone from the nursing home saw [R901], put [them] in the car and brought [them] back. The State Ombudsman further stated, [R901] got a good way away. I guess the door was propped open because they were bringing supplies in . The State Ombudsman further explained that the facility wants to ship [R901] out to any other location and are desperate to get rid of them because they are one of the residents who got out, however their spouse does not want them sent 3 hours away. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/16/22 at 12:12 PM, a phone call was attempted to Licensed Practical Nurse E, assigned nurse the date of R901's elopement to no avail. Review of their written statement revealed the following, Resident was with writer throughout the day at the nurses' station. [R901] was relaxed and calm throughout shift. After dinner between 4:45pm to 5pm I notified the Southside nurse and nursing aide that I will be going on break soon to see family for Father's Day and get an extra set of clothes. Resident was last observed eating snacks at nurse's station before going on break. Upon coming back from break north side nursing aide stated that [R901] has not been seen. We then began to search each room, bathroom, and notified all staff to search for resident. After 10-20 minutes there was a call to south side nurses station that resident was observed outside facility, DON was notified of resident's location and was then picked up and brought back to facility. A review of Nurse E's Human Resources file revealed a document titled Discipline Record Form noting that (Nurse E) were terminated on 6/30/2022. The document also revealed the following, On 6/19/22, [Nurse E] left his unit and residents for an extended period of time. He didn't give report to his coworkers. Did not do his elopement sheets for a resident under his care. [Nurse E] neglected his duties as a charge nurse, clocked in at 7:07AM and he clocked out at 8:37PM. He was clocked in at work when he was gone for a long time. His leaving the unit for an extended period of time without caring for his elopement risk resident was detrimental to the welfare of all the residents in the unit and to his fell ow employees and the company as a whole. On 8/16/22 at 2:24 PM, the Nursing Home Administrator (NHA) was interviewed and asked about R901 eloping from the facility and explained that she was not involved in the investigation as she was not the NHA at that time, however, she did hear that R901 was outside of the building, an aide saw them, and the [DON] brought them back in the building. The NHA was asked if they knew how far the resident had gotten and explained that she did not. The NHA was asked if she knew when the incident had occurred, and she explained that she thought it may have occurred during the afternoon on a Saturday. On 8/16/22 at 2:36 PM, the DON was interviewed and asked about the elopement of R901 and explained that she was in the building the date of the elopement and was driving away from the facility when she received a phone call about R901 being outside of the facility. She explained that she saw R901 and the Certified Nursing Assistant (CNA F). The DON was asked where the two were located and stated, Out by the North Hall door. The DON further explained that she parked her car, and redirected the resident back inside. The DON was asked for the name of the CNA, and initially indicated that she did not remember. She was asked if the CNA was employed at the facility and stated that they were contingent. The DON then revealed CNA F was not employed by the agency, but a CNA with a Hospice agency. A review of the statement by the DON revealed the following, At 6:55 (pm) got a call from staff who thinks resident is walking out the building; staff wasn't sure who it was but looked familiar. Receptionist called Code Pink, Checked, and found [R901] was not in [their] room. Receptionist stated she has been calling the nurse, but he is not answering his phone. Apparently, he left the building for lunch. DON driving out from facility parking lot and saw [R901] standing outside with another staff. They were talking. DON got [R901] and redirected back to facility . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/17/22 at 2:51 PM, a phone interview was completed with CNA G regarding the elopement of R901. CNA G explained that she was the only CNA assigned to the unit along with Nurse E who left the unit to go on a break. She explained that she saw R901 sitting at the nurses' station eating dinner when she entered another resident's room to assist them with their colostomy bag. She reported that she was having a difficult time with emptying the colostomy bag and did not have any help. CNA G was asked the amount of time she was in the room, and stated, About 30 minutes. CNA G reports that when she exited the room, she heard that they were looking for R901. A review of CNA G's written statement revealed the following, .Last time I saw [R901] was a few minutes after taking dinner tray. After that I got real busy. Also, nobody heard any alarm . On 8/18/22 at 9:06 AM, a phone interview was completed with the hospice agency CNA, CNA F regarding R901 eloping from the facility. CNA F explained that she was driving home between 6-7 PM, when she recognized R901 as a resident from the facility she provides hospice services at walking down the street. CNA F was asked what street the resident was walking down and described a busy, high traffic street that is approximately 1 mile away from the facility. CNA F explained that R901 was walking in the street, and she followed them in her car. CAN F explained she kept an eye on R901 so no one would hit them, all while contacting the facility to notify them that she found one of their residents. CNA F explained that she eventually found a safe place to park her car to get to R901 and comfort them until the DON arrived. CNA F was asked R901's cognition at that time and explained that R901 appeared confused. On 8/18/22 at 9:43 AM, a phone interview was completed with Nurse H regarding the elopement of R901. Nurse H explained that she was working on the Southside unit of the facility when Nurse E came over to the unit where she and another nurse, Nurse K were working. Nurse E stated that he was going on his break and had left his keys in his jacket at the nurses' station. Nurse H explained that Nurse K acknowledged him and said, Ok. Nurse H explained that hours later, R901's assigned CNA asked them if they had seen R901, which she reported she had not, and they began to look for them. Nurse H explained that R901's nurse had been gone for extended period of time and arrived back to the facility at approximately 7:15 PM with their basketball uniform on. Nurse H was asked if they had heard an alarm going off and stated, No, but the alarm on the door on the Northside of the building has not been working for a few weeks. On 8/18/22 at 10:02 AM, a phone call was attempted to Nurse K to no avail however, a review of her undated, unsigned statement revealed the following: I was at the nursing station with [Nurse H] when [Nurse E] came and told us (me and Nurse H) he was stepping out to go home and will be back. The keys are in his jacket pocket. This was around 4:30 to 5:00 I wasn't sure. I didn't realize anything until the Code Pink was called that was when we checked everyone and observed [R901] wasn't there. I didn't see Nurse E in between that because I was busy with my assignment. I only saw him at shift change again. But he didn't tell me to watch [R901]. Nothing like that. A review of R901's statement revealed the following: Interviewer: Where were you going the other day? R901: I tried to go home because I heard my wife voice, I was going this way and that way because it was a big circle. Then someone said, 'hey I know you.' (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviewer: How did you get out? R901: Well, the door opens you just have to push it, the alarm will go off and they will have to reset it Interviewer: [R901] we want you safe and not to leave out. R901: I know I am sorry that I did that. I won't do it again. On 8/18/22 at 4:01 PM, an interview was completed with the Regional Director of Operations (RDO) who was serving as the Administrator the date of the elopement. She explained that she received a phone call and was told that the resident was outside on the street part of the facility campus, and that the DON was on her way home when she turned back around and escorted the resident back into the building. The RDO explained that they submitted the Facility Reported Incident, and the DON completed interviews with staff. A review of the facility's Elopements policy did not reflect monitoring and supervising residents at risk of elopement. The Administrator was notified of Immediate Jeopardy on 8/18/2022 at 12:16 PM and a plan of correction was requested to remove the immediacy that began on 6/19/2022. The facility provided the following removal plan. Immediate Jeopardy was removed on 8/19/2022 and validated by the team on 8/19/2022. Removal Plan: The following steps were implemented immediately as listed: - 6/19/22-Resident back in room and facility safely - 6/19/22-Full body assessment completed, no signs of swelling, redness, bruises, or cuts noted. Pain assessed- resident denies pain. ROM negative for pain. No adverse effects noted. - 6/19/22-hourly safety checks in place; one on one sitter with resident - 6/19/22---Elopement policy and Incidents and Accident Reporting Policy reviewed with nurses and certified nurse aides on the unit. Policy understood and verbal understanding confirmed. - 06/19/22-hourly Elopement checks and hourly exit door check audits in place - 6/21/22-Elopement Assessments for all residents completed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 06/23/22-Education for all Staff on Elopement Policy and Incidents and Accident Reporting Policy completed - 06/23/22-Elopement Drill completed - From 6/24/22 to current date-all new admits reviewed for elopement risks and zero triggers noted. Other residents found at risk (2) placed on 1 hour safety monitoring. A QA meeting was held with the IDT in attendance to review action steps and results to assure compliance. The facility alleges abatement on June 19, 2022. Although the immediacy was removed on 8/19/22, the facility remained out of compliance at pattern with actual harm that is not Immediate Jeopardy as sustained compliance could not be verified by the state agency.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39918 This citation pertains in part to intake MI00127847. Based on observation, interview, and record review, the facility failed to assess for removal of a urinary catheter following admission to the facility for one sampled Resident (R907) of three residents reviewed for catheters, resulting in a urinary tract infection (UTI), pain, and resident frustration. Findings include: On 8/16/22 at 8:37 AM, during an initial tour of the facility, R907 was observed sitting in bed. The resident's Foley catheter drainage bag was observed to be lying flat on the floor. When queried regarding the catheter, R907 confirmed that she has an indwelling Foley urinary catheter and that she wishes it would get taken out. R907 was asked why she has the catheter to which she responded, I was having problems peeing .I wish they'd get rid of the catheter because it burns. On 8/16/22 at 9:30 AM, R907 remained in bed and the Foley/catheter drainage bag remained lying on the floor. R907 was calling out from her room asking for help to get up out of bed. Two unidentified staff members in maroon scrubs passed by the resident's room but did not acknowledge R907. A review of R907's Brief Interview for Mental Status (BIMS) assessment dated [DATE] indicated that the resident was cognitively intact (BIMS of 13/15). Further review of the resident's record revealed that R907 was admitted into the facility on [DATE] with diagnoses that included Anemia, Generalized anxiety disorder, Gastrointestinal hemorrhage, Type 2 diabetes mellitus without complications, Mood disorder due to known physiological condition, Essential (primary) hypertension, Acute myocardial infarction, Gastro-esophageal reflux disease without esophagitis, Chronic or unspecified gastric ulcer with hemorrhage, Chronic kidney disease, stage 3, Obstructive and reflux uropathy, unspecified, Chronic total occlusion of coronary artery, and Neuromuscular dysfunction of bladder, unspecified. A review of R907's (Facility's Corporate Name) Admission Nursing Comprehensive Evaluation (admission comprehensive evaluation) document, completed by Nurse I and dated 07/23/2022 at 12:16 AM under the Observations tab in the resident's electronic medical record (EMR) revealed an indwelling catheter evaluation that included the following: .-Does the resident have a terminal illness or sever (sic) impairment, which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain? No -Does the resident have a Stage III IV pressure ulcer (full thickness skin loss) in an area affected by incontinence? No -Is there a documented Post Void Residual volumes in range over 200 cc? No -Inability to manage the retention/incontinence with intermittent catheterization? No -Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction? No (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	-Summary: All questions are checked no and there is no appropriate diagnosis. No additional information related to R907's catheter was found on the Admission assessment and no additional catheter assessments were found upon reviewing the resident's medical record. Further review of R907's medical record included two hospital documents from R907's admission, one titled, Printable Discharge Form, and the other titled, Patient Discharge Summary. Both documents indicated that R907 was discharged from the hospital after being treated for a gastrointestinal bleed and anemia. The resident's medical history on the Patient Discharge Form, included diagnoses of DM type II, Hypothyroidism, Anemia, Hyperlipidemia, Anxiety disorder, Mood disorder, Essential hypertension, Myocardial infarction, Atherosclerotic heart disease, Gastroesophageal reflux disease, Chronic gastric ulcers with hemorrhage, and Chronic kidney disease (CKD), stage III. Documentation supporting diagnoses of Obstructive and reflux uropathy and Neuromuscular dysfunction of bladder were not found. A review of R907's History and Physical completed by Physician (MD) J and dated 07/26/2022 revealed no indication for continuing R907's urinary catheter and did not make mention of the diagnoses of Obstructive and reflux uropathy or Neuromuscular dysfunction of bladder. R907's CKD was addressed but did not indicate use of a catheter. MD J signed a physician order on 7/27/22 for R907's catheter (despite admitted [DATE]) which read, Foley Catheter 16fr (size of catheter) for Obstructive and reflux Uropathy ATC (around the clock). A review of R907's progress notes revealed: -08/01/2022 7:38 AM, resident c/o (complains of) pain when urgency to urinate. writer asked resident to notify nurse next time she feels pain if it persists. Foley bag had been emptied, writer was unable to see if there was any discoloration or odor to urine. Oncoming nurse made aware. -08/02/2022 10:30 AM, written by Nurse Practitioner (NP) C, .Following for anemia, dysuria and generalized pain .Also reports of burning on urination however much improved after Pyridium. No fever chills .GU (genitourinary): Incontinent of bladder .ASSESSMENT/PLANS: .#Dysuria likely UTI (urinary tract infection). UA CS (urinalysis, culture & sensitivity) .start Pyridium (used to relieve symptoms caused by irritation of the urinary tract such as pain, burning, and the feeling of needing to urinate urgently or frequently) 200 3 times daily x 2 days . A progress note from Physician (MD) B dated 08/03/2022 [Recorded as Late Entry on 08/08/2022 07:47 AM] was reviewed and revealed that the resident's name was spelled incorrectly, indicated there were no new concerns per nursing staff, and indicated that the resident was incontinent of bladder, under the genitourinary assessment with no mention of a urinary catheter. The Assessment/Plans, section included the following: #Anemia #Atherosclerotic heart disease #History of myocardial infarction #Constipation (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	#DM (Diabetes mellitus) #GERD (Gastroesophageal reflux disease) #Essential hypertension #HLD (Hyperlipidemia) #CKD (Chronic Kidney Disease) #Debility and muscle weakness +Continue current medical management +will Continue to follow labs +24/7 Coordinated care +Fall precaution +continue to maintain comfort +PT/OT (Physical Therapy/Occupational Therapy) +Skin integrity checks and precautions +monitor diet/ dietitian on consult +Social worker involved +DVT (blood clot) prophylaxis +GI (gastrointestinal) prophylaxis. Discussed this plan with nursing staff. Inform our team of any acute changes or complaints. -08/04/2022 11:40 AM, written by Nurse Practitioner (NP) C, .Following for positive urinalysis. No signs and symptoms of infection at this time, no lethargy weakness, fever chills, dysuria is resolved, denies any pain . 8/2: More than 100,000 CFU/mL E. coli .ASSESSMENT/PLANS: #Positive urinalysis. Awaiting urine sensitivity, will defer ABT (antibiotic therapy), no signs or symptoms of infection at this time . -08/04/2022 6:36 PM, NP reviewed recent UA results and ordered Macrobid (antibiotic) 100 mg Q12H (every 12 hours) x 7 days. R907's progress notes continued to mention the resident taking oral antibiotics to treat a UTI but did not include further assessment for continuation of the urinary catheter. Continued review of R907's progress notes revealed: (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	-08/17/2022 7:11 PM, Resident continues to yell out help, threatening to throw herself on the floor. Resident observed ambulating down hall with foley in hand, stated it came. I don't know what happened. 16 French foley reinserted. Med size BM (bowel movement) noted . -08/18/2022 6:49 AM, Resident is alert and able to make needs known. Requires a 1PA (one person assist) with transfers. Resident yelled all night for help .Resident also wanted to pull her foley out because she said it did not belong. Resident also educated about the importance of her foley . On 8/18/22 at 8:00 AM, R907 was observed lying in bed. The resident's Foley catheter drainage bag was observed lying on the floor. On 8/18/22 at 8:32 AM, R907 remained in bed and the Foley catheter drainage bag remained lying on the floor. R907's assigned nurse, Licensed Practical Nurse (LPN) L was interviewed and queried regarding R907's catheter. LPN L explained that she didn't think R907's catheter was re-assessed for use and was not sure why the resident came into the facility with it. When queried regarding R907's catheter getting pulled out the previous day, LPN L stated that she did not receive report of that incident. When queried regarding her knowledge of how R907 felt about her catheter, LPN L stated she wasn't sure and that R907 has behaviors. On 8/18/22 at 8:50 AM, the Minimum Data Set (MDS)/LPN M, who had initiated the care plan for R907's catheter, was interviewed. LPN M was asked where the information was located in R907's record to support the continuation of the urinary catheter after admission. LPN M indicated that she gathered information from the patient, patient's family, and hospital documentation but was unable to provide a specific document or information. On 8/18/22 at 10:04 AM, the Director of Nursing (DON) was asked to provide information regarding R907's catheter which included an assessment for need and if the facility had conducted any voiding trials. On 8/18/22 at 11:26 AM, the DON had not yet provided the requested information regarding R907's catheter. The Nursing Home Administrator (NHA) was asked for the following: Voiding trials/PVRs (post-void residuals) for [R907], or assessments indicating need for continuing indwelling urinary catheter. On 8/18/22 at 11:42 AM, the DON was interviewed and claimed that she spoke with NP C who stated the resident was supposed to have a catheter because of obstructive uropathy (this was not noted to be documented in any of NP C's progress notes). The DON stated there were no voiding trials conducted. The DON then reviewed R907's admission documentation including hospital records as well as called LPN M during the interview. The DON was not able to locate and/or show where the supporting diagnoses were found for R907's catheter upon admission to the facility. The DON stated that LPN M was Looking for the discharge paperwork from the hospital .I think what they uploaded is not the whole packet. The DON was asked if the whole packet - i.e. all information necessary for R907's admission into the facility - should be uploaded and available in the resident's medical record to which she responded, Yes, it should be. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 8/18/22 at 2:37 PM, the DON emailed a copy of the 7/23/22 admission bladder assessment completed by Nurse I (dated 07/23/2022 and noted above) along with a form titled TENA/SCA Bladder Observation. This bladder observation assessment was filled out by hand, contradicted the electronic assessment completed by Nurse I, was dated 7/23/22 (date also handwritten), was not signed, and was not noted to be available in the resident's medical record during the survey. This form was only provided after multiple inquiries regarding R907's supporting catheter documentation. All other assessments for R907 were noted to have been completed electronically however this one was not. Final review of R907's progress notes revealed: -08/18/2022 07:01 PM, Resident observed having increased behaviors. Increased agitation and screaming throughout the day .[NP C] D/C'd (discontinued) indwelling foley catheter AND ordered to Straight cath Q6H (every 6 hours), if residual greater than 350 mL to contact NP . The facility provided two policies/procedures related to catheters, however upon review they were not noted to address assessing for removal/continuation of indwelling urinary catheters. A review of the facility's policy/procedure titled, Catheter Care, Urinary, revised 3/15/22, revealed, Infection Control .Be sure the catheter tubing and drainage bag are kept off the floor .

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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** 40384 This citation pertains to Intakes: MI00127847, MI00127936, MI00128989, MI00129009, MI00129142, MI00129425, and MI00129451. Based on observation, interview and record review the facility failed to ensure that there was adequate staff to meet the needs of two sampled Residents (R901 and R902) of four residents reviewed for staffing, resulting in a lack of staff to monitor and provide for residents' safety. Findings include: Resident #901 (R901) On 8/16/22 at 11:05 AM, the State Ombudsman was interviewed via phone about concerns regarding the facility, and explained that R901 had eloped from the facility, and someone from the nursing home saw [R901], put [them] in the car and brought [them] back. The State Ombudsman further stated, [R901] got a good way away. I guess the door was propped open because they were bringing supplies in . On 8/16/22 at 12:12 PM, a phone call was attempted to Licensed Practical Nurse (LPN) E, assigned nurse the date of R901's elopement to no avail however. A review of their written statement revealed the following, Resident was with writer throughout the day at the nurses' station. [R901] was relaxed and calm throughout shift. After dinner between 4:45pm to 5pm I notified the Southside nurse and nursing aide that I will be going on break soon to see family for Father's Day and get an extra set of clothes. Resident was last observed eating snacks at nurse's station before going on break. Upon coming back from break north side nursing aide stated that [R901] has not been seen. We then began to search each room, bathroom, and notified all staff to search for resident. After 10-20 minutes there was a call to south side nurses station that resident was observed outside facility, DON (Director of Nursing) was notified of resident's location and was then picked up and brought back to facility. A review of Nurse E's Human Resources file revealed a document titled Discipline Record Form noting that they (Nurse E) were terminated on 6/30/2022. The document also revealed the following, On 6/19/22, [Nurse E] left his unit and residents for an extended period of time. He didn't give report to his coworkers. Did not do his elopement sheets for a resident under his care. [Nurse E] neglected his duties as a charge nurse, clocked in at 7:07AM and he clocked out at 8:37PM. He was clocked in at work when he was gone for a long time. His leaving the unit for an extended period of time without caring for his elopement risk resident was detrimental to the welfare of all the residents in the unit and to his fell ow employees and the company as a whole. On 8/17/22 at 2:51 PM, a phone interview was completed with CNA G regarding the elopement of R901. CNA G explained that she was the only CNA assigned to the unit along with Nurse E who left the unit to go on a break. She explained that she saw R901 sitting at the nurses' station eating dinner when she entered another resident's room to assist them with their colostomy bag. She reported that she was having a difficult time with emptying the colostomy bag and did not have any help. CNA G was asked the amount of time she was in the room, and stated, About 30 minutes. CNA G reports that when she exited the room, she heard that they were looking for R901. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's time punches for 6/19/22 revealed that facility nursing staffing for the day shift consisted of one CNA and three nurses, one which was terminated for, . leaving the unit for an extended period of time without caring for his elopement risk resident was detrimental to the welfare of all the residents in the unit and to his fell ow employees and the company as a whole. Resident #902 (R902) A review of R902's medical record revealed that they were admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included Dementia, Mood Disorder and Epilepsy. Further review of the medical record revealed that the resident was severely cognitively impaired and required supervision for Activities of Daily Living. On 8/16/22 at 2:05 PM, all incident and accident reports for R902 were requested from the facility. Upon review there were no reports for 6/6/22. Further review of R902's medical record revealed the following progress notes: 06/06/2022 7:18 AM. At start of shift writer and CNA observed resident wandering in and out of rooms. Writer asked resident what [they] were looking for, resident stated 'I'm looking for the bathroom.' Resident was easily redirected yet continued to wander until [they] went to sleep. DON notified. 06/06/2022 5:58 PM. Writer received resident resting in bed .Resident rested throughout shift and monitored hourly for elopement. Resident safety maintained and monitored throughout shift. 06/06/2022 4:25 AM. Ax2 (alert and oriented to person and place) Resident appeared anxious, confused on am/pm settings, and expressed the need to run a few errands. Nurse was able to redirect resident. Received scheduled meds, treatment and PRN (as needed) medications for exit seeking behavior . A review of police records from the local police department revealed the following incident that occurred on 06/06/2022 after being contacted by facility staff via 911: 06/06/2022 : 21:50:44 (9:50pm) Narrative: PATIENT MISSING FOR 30IN 06/06/2022 : 21:50:49 Narrative: 30MIN 06/06/2022 : 21:51:16 (9:51)Narrative: [R902] WEARING CREAM HOODED SWEATER WITH HOODED SPECKS OVER IT, BLU JEANS 06/06/2022 : 21:51:35 Narrative: SHORT GRY HAIR, BEARD AND MUSTACHE 06/06/2022 : 21:51:37 Narrative: IS CONFUSED 06/06/2022 : 21:51:45 Narrative: CAN BE COMBATIVE AT TIMES, IS ON MEDS 06/06/2022 : 21:52:20 (9:52pm) Narrative: FRONT DOOR ALARM WENT OFF 30MIN AGO, THINKS [R902] MAY HAVE GONE OUT 06/06/2022 : 21:52:43 Narrative: HAS DEMENTIA, SOME MENTAL DISORDERS (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	06/06/2022 : 21:54:46 (9:54pm) Narrative: ADVISING LAKESIDE MALL 06/06/2022 : 21:56:33 (9:56pm) Narrative: THEY WILL BE CHECKING THE AREA 06/06/2022 : 21:57:28 (9:57pm)Narrative: MALE WAS FOUND IN ANOTHER RESD (resident) ROOM 21:57:50 Narrative: CAN CANCEL. On 8/17/22 at 11:51 AM, the Assistant Director of Nursing (ADON) was asked if he was aware of an incident in which the local police were called related to a missing resident who was later located in another resident's room. The ADON explained that he had not been made aware of an incident like this. The ADON was asked if the expectation would be for an Incident and Accident report to be completed, and he explained that his expectation would be for this type of incident to be documented and that he and the DON be notified. On 8/17/22 at 12:06 PM, the Director of Nursing (DON) and Nursing Home Administrator were asked if they were aware of the police being contacted related to R902 being considered missing and then located in another resident's room. They both denied knowing about this incident. The DON explained that her expectation would be to be notified of an incident such as that. A review of the facility's Staffing policy revealed the following, Policy Statement The facility provides adequate staffing to meet needed care and services for our resident population. Policy Interpretation and Implementation 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39918 Based on observation, interview, and record review, the facility failed to ensure medication and/or treatment carts were locked and secured while unused and unsupervised by authorized personnel, potentially affecting all 47 residents in the facility, and resulting in the potential for unauthorized access to medications, treatments, and the potential for injury. Findings include: On 8/16/22 at 8:26 AM, during an initial tour of the facility, a medication cart was noted to be unlocked and unsupervised outside of room S211 (South Hall). All drawers to the cart with resident medications and various supplies were accessible with the exception of the locked narcotic drawer. On 8/18/22 at 10:26 AM, a medication cart was noted to be unlocked and unsupervised near the South nurses' station. No staff were present in the area. All drawers to the cart with resident medications and various supplies were accessible with the exception of the locked narcotic drawer. A used COVID+ rapid test was observed sitting on the edge of the cart. On 8/19/22 at 8:16 AM, a treatment cart was noted to be unlocked across from the South nurses' station. No staff were present in the area. All drawers in the cart were accessible. Scissors were present in top drawer, along with a pink bottle of perfume stored among wound care supplies. On 8/19/22 at 8:17 AM, a medication cart was noted to be unlocked and unsupervised outside of room S213 (South Hall). All drawers to the cart with resident medications and various supplies were accessible with the exception of the locked narcotic drawer. On 8/19/22 at 9:55 AM and 10:07 AM, the treatment cart was noted again to be unlocked and unsupervised across from the South nurses' station. On 8/19/22 11:43 AM, the Director of Nursing (DON) was interviewed and asked if medication/treatment carts should be locked and secured when staff are not using them and not in the immediate vicinity to which the DON responded, Of course, all the time. A review of the facility's policy/procedure titled, Storage of Medications, revised 3/17/22, revealed, . Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals will be locked when not in use, and trays or carts used to transport such items will not be left unattended if open or otherwise potentially available to others .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39918 This citation pertains in part to intakes MI00128989 and MI00129756. Based on observation, interview, and record review, the facility failed to serve food per resident preference for two sampled Residents (R910 and R916) of three reviewed for dietary needs/preferences, resulting in the resident being served food that they disliked and resident frustration. Findings include: On 8/16/22 at 11:05 AM, the Ombudsman was interviewed and explained that she had been at the facility yesterday for the resident council meeting. The Ombudsman stated that a complaint the resident council has is that food portions at the facility are small, and the residents are not allowed to get seconds. On 8/16/22 at 12:00 PM, R910 was interviewed in their room as they were receiving their lunch tray. R910 was asked if they felt like they get enough food to eat at the facility to which they replied, No. The portions are too small. R910 lifted the cover off of their lunch plate to reveal a small portion of spaghetti with tomato sauce and a small piece of garlic bread. R910 stated, I can't eat it. R910's meal ticket was reviewed and revealed: 8/16/2022 Tuesday Lunch, DISLIKE .No tomato or tomato products . R910 was asked if they often receive foods on their dislike list to which they replied, Yes. R910's Brief Interview for Mental Status (BIMS) assessment dated [DATE] was reviewed and revealed a score of 14/15 indicating an intact cognition. On 8/16/22 at 2:00 PM, during an interview, R916 appeared frustrated and explained that the facility asks them what they want to eat, what they like and don't like to eat, but then serves them the food they don't like anyway. R916's Minimum Data Set (MDS) assessment dated [DATE] was reviewed and revealed that the resident has an intact cognition. On 8/19/22 11:43 AM, the Director of Nursing (DON) was interviewed and queried regarding serving food at the facility per resident preference. The DON stated that residents should not be getting served food that is on their dislike list. A review of the facility's policy/procedure titled, Resident Food Preferences, revised 3/17/22, revealed, The Dietitian will discuss resident food preferences with the resident when such preferences conflict with a prescribed diet. The resident has the right not to comply with prescribed diet or dietary restrictions .The resident's clinical record (orders, care plan, or other appropriate locations) will document the resident's likes and dislikes and special dietary instructions or limitations such as altered food consistency and caloric restrictions .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39918 Based on observation, interview, and record review, the facility failed to maintain an indwelling urinary catheter drainage bag in a sanitary manner, and ensure personal protective equipment (PPE) was donned appropriately for source control, affecting two sampled Residents (R907 and R905) and potentially affecting all residents and/or staff in the facility, resulting in the potential for infection. Findings include: Resident #907 (R907) On 8/16/22 at 8:20 AM, upon entering the facility, Staff O was observed to not be wearing a face mask. A sign on the door indicated that masks were required in the building. When queried if staff were required to wear a mask while in the facility, Staff O indicated that they should be. On 8/16/22 at 8:37 AM, during an initial tour of the facility, R907 was observed sitting in bed. The resident's Foley catheter drainage bag was observed to be lying flat on the floor. On 8/16/22 at 9:30 AM, R907 remained in bed and their Foley catheter drainage bag remained lying on the floor. On 8/18/22 at 8:00 AM, R907 was observed lying in bed. The resident's Foley catheter drainage bag was observed lying on the floor. On 8/18/22 at 8:32 AM, R907 remained in bed and their Foley catheter drainage bag remained lying on the floor. On 8/18/22 at 4:04 PM, Staff P was observed walking down the main hallway with their mask pulled down under chin, not covering the mouth or nose. On 8/19/22 at 9:47 AM, Staff P was observed in the main hallway amongst other staff members with their mask covering their mouth but not their nose. On 8/19/22 at 11:43 AM, the Director of Nursing (DON) was interviewed and asked if staff were required to wear masks while in the building. The DON indicated that staff should be wearing masks all the time in the building in common areas, even in the front lobby (with the exception of being in one's own office). The DON stated, We do education on that all the time. When queried if indwelling Foley catheter drainage bag should be lying on the floor, the DON responded, No. A review of the facility's policy/procedure titled, Catheter Care, Urinary, revised 3/15/22, revealed, Infection Control .Be sure the catheter tubing and drainage bag are kept off the floor . A review of the facility's policy titled, COVID-19 Preparation and Prevention, dated 12/9/20, read in part: . Source Control - Use of a cloth face covering or face mask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing . Resident #905 (R905) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/16/22 at 8:35 AM, R905 was observed lying in bed, with their Foley catheter drainage bag lying flat on the floor. On 8/18/22 at 8:03 AM, R905 was observed in bed, with their Foley catheter drainage bag on the floor, and water at bedside, although R905 was not supposed to consume anything by mouth. A review of R905's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Stroke, Chronic Kidney Disease and Diabetes. A review of the resident's Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 6/15 indicating a severe cognitive impairment. R905 required extensive assistance of 1-2 persons for Activities of Daily Living, including toileting, transfers and hygiene.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39918 This citation is related to intake MI00129142 and M00127847. Based on observation, interview, and record review, the facility failed to ensure a resident's call light was in working condition for one sampled Resident (R907) out of a total sample of 22, resulting in the resident's inability to directly call for staff assistance and unmet care needs. Findings include: On 8/16/22 at 9:30 AM, R907 was observed lying in bed. R907 was calling out from her room asking for help to get up out of bed. Two unidentified staff members in maroon scrubs passed by the resident's room but did not acknowledge R907. On 8/19/2022 at 8:23 AM, R907 was observed lying in bed. R907 was hitting her call light (above her bed) repeatedly and stating she needs help with her breakfast tray. The call light was observed to not activate inside the room nor outside of the room. R907 stated that she hits her call light but no one comes. When informed that it looked like it wasn't working, R907 stated, No wonder I can't get anybody. On 8/19/22 at 9:48 AM, R907 was observed sitting on the edge of her bed. When asked about her call light, the resident stated, I use it but it don't work. When asked how long it seemed that her call light wasn't working, R907 responded, It's been like that a couple days, at least three days. The Nursing Home Administrator (NHA) was asked for R907's call light logs at this time via email, but responded, We don't have that system here. R907 stated she had no clothes to wear and asked if That lady (referring to Certified Nursing Assistant (CNA) Q) was coming back down yet? R907 was calm and cooperative but repeatedly asking the surveyors if we were able to help her get dressed. R907 stated she needed her brief changed again because it Has poop in it. On 8/19/22 at 9:53 AM, CNA Q was observed sitting down at the nurses' station. When queried if she was planning to go back to help R907, CNA Q stated that she already helped the resident go to the bathroom and that the resident didn't tell her she wanted to get dressed. On 8/19/22 at 9:56 AM, Staff N was asked to check R907's call light above her bed. Staff N tested the light and indicated that it was not working. Staff N unplugged the call light cord and plugged it back in. The call light was now observed to activate when Staff N tested it. The call light was shut off and tested on ce more, and was again observed to not be working. Staff N said that it was loose and needed to be adjusted. On 8/19/21 at 11:43 AM, the Director of Nursing (DON) was interviewed and asked if call lights were expected to be in working condition to which she responded, Yes, definitely. When queried if R907's call light was in working condition, the DON responded that she was aware there was an issue with it a day or two ago. When asked if a work order was submitted for R907's call light, the DON stated, No, I just made sure they fixed it after I saw that right away. When informed that the call light was observed to not be working today, the DON responded, I guess something is definitely happening. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R907's progress notes revealed: -08/17/2022 4:23 AM .Resident is alert and able to make needs known. Resident yelled once during the night for Tylenol and something for anxiety . -08/17/2022 2:42 PM .Resident repeatedly yelling/screaming out . -08/17/2022 7:11 PM .Resident continues to yell out help, threatening to throw herself on the floor . A review of R907's Brief Interview for Mental Status (BIMS) assessment dated [DATE] indicated that the resident was cognitively intact (BIMS of 13/15). Further review of the resident's record revealed that R907 was admitted into the facility on [DATE] with diagnoses including but not limited to Anemia, Generalized anxiety disorder, Gastrointestinal hemorrhage, Type 2 diabetes mellitus without complications, Mood disorder due to known physiological condition, and Essential (primary) hypertension. A review of the facility's policy/procedure titled, Nurse Call #018, dated 3/11/22, revealed, 1. All residents will have access to a nurse call device while in their room. The device will be operable by the resident with consideration for any physical disabilities or limitations s/he may have. 2. The nurse call device will communicate with the nurse station. 3. All staff members have responsibility to respond to nurse call alerts . 6. Should staff identify that call light cords are missing, inoperable, or otherwise non-functional in resident rooms or bathrooms, then the Charge Nurse, Director of Nursing and Facility Manager must be informed immediately.