STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235561	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria Nursing and Rehab	707 Armstrong Lansing, MI 48911

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 27446 Based on observation, interview, and record review the facility failed to ensure the state Ombudsman and state agency contact information was accessible, for nine out of 13 confidential residents in a group meeting, who did not know where the contact information was located. Findings Included: On 4/03/2024 at 11:03 AM, during group interviews, nine residents stated they did not know who the state Ombudsman was, how to contact the Ombudsman, nor did the nine residents know where the information was posted. The nine residents also stated they did not know where the posting was located for the contact information for the state agency. Observation on 4/3/2024 at 12:10 PM, of the third and second floors common areas, that included both the east and west sides, all dinning and activities rooms, and the chapel, revealed no postings for the state agency or Ombudsman contact information. During the same observation, the first floor was observed to have a large glass display case on the wall in the lobby area. A poster for the Ombudsman's main contact number was on the posting. The state agency compliant hotline number was displayed on another posting however, the posting had the incorrect department listed for complaints. The postings were not readily accessible to residents who resided on the second or third floors. In an interview on 4/05/2024 at 11:11 AM, Administrator A was asked why the Ombudsman and stated agency contact posters were not posted on the second and third floor to be readily accessible to the residents who resided on the second and third floors. Administrator A stated that it had always just been that way, and he had never seen the postings on the second nor third floors before. Administrator A stated that the Ombudsman would make rounds to residents, so they knew who she was, and stated the state agency and Ombudsman contact information was discussed during resident council meetings. Review of the last six months, October, November, and December of 2023, and January, February, and March of 2024, of resident council meeting minutes revealed no discussions related to who the state Ombudsman was, where to locate the posting of the contact information for the state Ombudsman and state agency, nor their right as a resident to file a complaint with the state agency.

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on interview and record review, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments for two (Resident #23 and #68) of 19 reviewed. Findings include: Resident #23 (R23): Review of the medical record reflected R23 admitted to the facility 4/9/20 and readmitted [DATE], with diagnoses that included bipolar disorder and generalized anxiety disorder. The quarterly MDS, with an Assessment Reference Date (ARD) of 12/31/23, reflected R23 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R23's annual MDS, with an ARD of 4/17/23, was coded No for, A1500. Preadmission Screening and Resident Review (PASRR) .Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? A level II evaluation was noted in R23's medical record for 7/2022, reflecting a level II evaluation was needed again, by 7/20/23, if R23 remained in the nursing facility. During an interview on 04/04/24 at 12:54 PM, Social Work Director (SW) C reported R23's annual MDS for 4/17/23 should have been coded Yes for question A1500. Resident #68 (R68): Review of the medical record reflected R68 admitted to the facility on [DATE], with diagnoses that included diabetes and history of transient ischemic attack (TIA) and cerebral infarction. The quarterly MDS, with an ARD of 12/15/23, reflected coding for anticoagulant (blood thinner) use. R68's medical record reflected Enoxaparin Sodium (anticoagulant medication) was ordered with a start date of 9/9/23 and an end date of 10/9/23. There were no additional anticoagulant orders in R68's medical record. During an interview on 04/04/24 at 12:30 PM, MDS Coordinator F reported her guess was the anticoagulant was accidentally coded, as she did not see an anticoagulant order being in place during the look-back period of the quarterly MDS for 12/15/23.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 Based on observation, interview, and record review the facility failed to ensure for three out of 19 residents (Resident #41, 43 and 287) a complete comprehensive care plan was in place and/or implemented. Findings Included: Resident #41 (R41): Per the facility face sheet R41 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Diagnoses included stroke. In an observation and interview on 4/02/2024 at 2:54 PM, R41 was observed in bed, and no drinking water was observed in R41's room. A sign was observed on wall which revealed Pudding Thick Liquids .) During the same observation and interview R41 asked if she could get some water. A staff member was informed of R41's request. At 3:00 PM a Styrofoam cup with a lid was observed to have been placed on a bedside table that was in the bed one area. R41 resided in bed 2. The cup was way out of reach for R41, the straw was laying next to the cup, the water was not pudding thick and had ice in it. On 4/02/2024 at 3:05 PM, R41 was heard to be crying, and stated she wanted her water. On 4 /03/2024 at 2:40 PM, R41 was observed in her bed with door partial closed. An over the bed table that was out of reach for R41 was observed to have thickened water and juice in two small juice cups. Upon entering R41's room, R41 asked for a drink of water, and began to cry because she wanted a drink of water. On 4/04/2024 at 10:18 AM, R41 was observed in her bed crying, and stated she was thirsty. Pudding thick water and orange juice was observed to be on the over the bed table but out of reach for R41. Review of a nutritional evaluation dated 3/29/2024, revealed R41 required 1636 ml of water per day. In an interview on 4/04/2024 at 10:28 AM, CNA N stated R41 was to be checked on every 30 minutes, and said staff would give R41 a spoonful of water at that time. CNA N said she did not know how R41's fluid intake was monitored to assure she received her required 1636 ml of water per day. In an interview on 4/04/2024 at 10:40 AM, Registered Nurse (RN) W, who was also the Unit Manager, stated that the CNA's would document in R41's electronic medical record (EMR) that they gave R41 a drink,. RN W stated she was not sure how it was assured R41 received her daily water requirement of 1636 ml a day. Record review of R41's EMR revealed there was no CNA documentation of each drink of water they provided for R41. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R41's treatment administration record (TAR) for the month of March and April 2024 revealed no documentation of the drinks of water staff gave to R41. Review of R41's care plans revealed, I (R41) have an ADL (activities of daily living) self-care performance deficit r/t (related to) recent CVA (stroke) with dysphagia (difficulty swallowing), date initiated 11/29/2023, and revised on 1/10/2024. The care plan, under Interventions/Tasks revealed, EATING: I (R41) am totally dependent on (1) staff for PEG (feeding tube) tube management. dated 12/11/2023 and revised on 3/20/2024. The care plan did not include R41 required 1636 ml (milliliters) of water per day, did not include R41 was to receive drinks of water from staff when doing R41's 30 minute check, and did not include R41 was to be checked on every 30 minutes. Review of R41's Kardex (document Certified Nurse Aids [CNA] use to know how to provide care to a resident and reflects the resident's care plan) revealed in the EATING/NUTRITION section, .I (R41) need assistance of (1) staff for eating orally. The Kardex did not include R41 was to receive pudding thick liquids, nor did it include R41 was to be checked on every 30 minutes, and offered or given a drink of water with every 30 minute check. No other care plan was found in R41's EMR that addressed any of R41's above required needs. Resident #43 (R43): In an observation and interview on 4/02/2024 at 9:40 AM, R43 was observed in her bed, a Styrofoam cup of water was observed to be on the bedside table, that was not within reach from the bed, with a straw in it, but the paper the straw came in was still on the top part of the straw. R43 was asked if she could reach her water, R43 did not understand, and did not attempt to reach for water. The cup was full of water and was not dated. Another Styrofoam cup of water was observed on the bedside table, full to the top of water, had no ice, and no date to determine when it was fresh water. On 4/04/2024 at 10:56 AM, R43 was observed in bed, a full Styrofoam cup of water was observed on the over the bed table. R43 was asked if she knew where her water was located, but she did not respond to the question just mumbled. R43 was asked if she could reach her water, but did not respond. Review of a care plan in place revealed R43 had a care plan in place dated 5/8/2018 and revised on 12/30/23, that identified she had the potential for dehydration, and would drink independently. The interventions included, encourage fluids dated 5/8/2018 and revised on 5/11/2023, and ensure R43 had access to fluids. Review of a care plan dated 5/1/2018 and revised on 12/30/2023, that addressed R43's ADLs revealed R43 required staff assistance to walking, and transferring. 46954 Resident #287 (R287) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission Record reflected R287 was admitted to the facility on [DATE] with diagnosis which included dependence on renal dialysis, end stage renal disease, heart failure, generalized anxiety disorder, type one diabetes mellitus, acquired absence of right leg below the knee, and muscle weakness. A Social Services Note dated 3/28/23 at 4:55 PM reflected R287's Brief Interview for Mental Status (BIMS) was scored 13 out of 15, indicating cognitively intact. R287's Care Plan indicated that he required supervision for assistance for most Activities of Daily Living. In an observation and interview on 04/02/24 at 9:42 AM, R287 was overheard speaking loudly to a staff member. R287 was very displeased with his breakfast and the staff member exited his room with the breakfast tray. After gaining permission to enter his room and talk, R287 was observed sitting on the side of his bed with the bedside table in front of him. R287 was nicely groomed and easily conversant. He reported that he was pissed because I get served garbage every single day. R287 was visibly frustrated and stated that the food has caused him to have severe gastrointestinal issues. He reported that his stomach pains were so severe that he canceled his Dialysis appointment the day prior. R287 went on to describe that the food taste is unacceptable, that the food is cold, his toast is soggy, and that the oatmeal was stiff and lumpy. R287 stated that he has learned to rely on the evening snack to meet his needs but the snack is insufficient. R287 stated that they will bring him a bag of chips and if he requests more, he is told that there are no more snacks available. He stated that even the staff agrees that the food is unappetizing. He continued to speak in an elevated voice stating again that the food here is bull*hit, and it pisses him off. R287 stated that he has not had a good meal since he was admitted and to make matters worse, for the Easter meal the residents were served a tuna fish sandwich or a hot dog. He stated that no one has came to speak with him about his concerns or gather food preferences. R287 acknowledged that he is a diabetic and a renal dialysis patient, so, nutrition is very important to him. He reported that he enjoys fruits and vegetables and likes to have a sandwich as an evening snack. In an observation and interview on 04/02/24 at 10:01 AM, Dietary Manager Q entered the room to speak with R287. Again, R287 elevated his voice and was visibly upset about the quality of the food. Dietary Manager Q apologized. When queried about the Easter Dinner, Dietary Manager Q acknowledged that she knew about the tuna fish sandwich being served as the Easter Dinner meal and stated that she had heard about it and [supply company] normally sends a holiday menu but unfortunately it did not happen this time. R287 reported to Dietary Manager Q that he loves fruit and salads and would rather consume a salad then whatever meal is being served. Dietary Manager Q stated that she would obtain a food preference form for R287. Dietary Manager Q returned with a plate of assorted fruits and cottage cheese. R287 was very thankful. On 04/02/24 at 10:14 AM, R287 was overheard audibly crying to a staff member about how terrible the food is at the facility and how he would rather go home. In an observation on 04/02/24 at 10:15 AM, the resident refrigerator was located. Inside the refrigerator contained two containers of yogurt, medication pass, and some resident food brought in from the outside. A tour of the unit revealed that there did not appear to be a pantry or a dry storage for snacks. In an interview on 04/02/24 at 10:29 AM, Certified Nursing Assistant T reported that dietary brings a bowl containing snacks in the evening, otherwise, food is not stored on the unit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nutrition Care Plan reflected an intervention initiated on 3/29/24 which stated honor food preferences as able. Review of a Nutrition Note from the hospitalization prior to admission to the facility dated 3/26/24 reflect that R287 was classified as underweight and had increased metabolic demands due to dialysis and chronic medical conditions but had weight gain as a desired goal and agreed to scheduled snacks. The Dietitian noted that R287 had good meal intake and enjoyed smoothies, cheese and crackers with his dinner. In an interview on 04/05/24 at 1:09 PM, Registered Dietician (RD) I reported that when a resident first comes in, RD I will talk with them about any intolerance's, allergies, and any religious requirements for food. RD I stated that she works side my side gathering food preferences and the dietary technician will gather information regarding food preferences from the resident. The food preferences are updated in the menu system and added to the tray ticket. When asked if she was able to view R287's tray ticket on her computer, she reported she was able. When asked if R287's tray ticket contained any information regarding food preferences, she reported that it did not.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review, the facility failed to timely investigate a fall and revise a fall Care Plan for one (Resident #287) of 19 reviewed for Care Plans, resulting in an inaccurate Care Plan, identifying the effectiveness of implemented interventions, and the potential for more falls. Resident #287 (R287) Review of the Admission Record reflected R287 was admitted to the facility on [DATE] with diagnosis which included dependence on renal dialysis, end stage renal disease, heart failure, generalized anxiety disorder, type one diabetes mellitus, acquired absence of right leg below the knee, and muscle weakness. A Social Services Note dated 3/28/23 at 4:55 PM reflected R287's Brief Interview for Mental Status (BIMS) was scored 13 out of 15, indicating cognitively intact. R287's Care Plan indicated that he required supervision for assistance for most Activities of Daily Living. In an observation and interview on 04/02/24 at 9:42 AM, R287 was seated on the side of the bed with his bedside table in front of him. R287 was groomed, easily conversant and had a right prosthetic limp R287 reported that he was admitted the week prior and used to be employed as a Certified Nursing Assistant before he was forced to medically retire. R287 expressed concerns regarding the food and briefly talked about his care needs. R287 replacement breakfast tray was delivered during the conversation, so we arranged a time to meet again the following day. In an observation and interview on 4/3/24 at 8:13 AM, R287 was not located in his room. A staff member reported that R287 had sustained a fall and was transferred to the emergency room . Review of a Clinical/Nursing Note dated 4/3/24 at 4:37 AM reflected This nurse answered residents call light at 0130 (AM). Resident asked nurse to check his sugar as he thought it could be low. While testing resident blood sugar resident states that before going to the bathroom he rolled out of the left side of his bed during his sleep. Resident reports that he then got himself off the floor, walked to the bathroom and back to the bed. Resident was dressed with RLE (right lower extremity) prosthesis on. Call light was within resident reach. Bed in appropriate position. This nurse educated resident onwaiting [sic] for help to arrive before transferring even more so after falling . R287 complained of pain to staff so he was transferred to the Emergency Department for evaluation. In an observation and interview on 4/4/24 at 12:17 PM, R287 was in his room, seated on the side of the bed with his call light in reach. R287 was dressed and groomed appropriately and in a pleasant mood. When asked about the fall, R287 stated that he had rolled out of bed while sleeping. He stated that he was so startled at he quickly jumped up off of the floor and got into bed. After laying in bed for a bit, R287 stated that he started to feel some rib pain and shortness of breath so he alerted staff. R287 stated that he would be interested in having a wider bed or a perimeter mattress to prevent him from falling out of bed again. He stated that he is not sleeping as soundly due to the fear of unintentionally rolling out of bed again. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan revealed R287 had an At Risk for Falls Focus Area initiated on 3/28/24 which reflected interventions such as having commonly used articles in place, reminding the resident to use his call light for assistance, and maintaining the bed in low position. As of 4/4/24, there were no added interventions for the fall R287 had sustained the day prior. Review of the Incident Report dated 4/3/24 at 1:30 AM revealed that R287 stated before going to the bathroom he rolled out of the left side of his bed while sleeping, then got himself off the floor, walked to the bathroom and back to bed. The Incident Report stated that the nurse educated the resident on waiting for help to arrive before transferring even more so after falling. The predisposing situation factor included ambulating without assistance. Review of the Progress Notes section revealed no Interdisciplinary Team (IDT) Meeting Note regarding an investigation, discussion, or proper intervention for the fall. Review of the Falls Care Plan revealed an added intervention on 4/9/24 to sit to standing slowly prior to ambulating. In an interview on 4/10/24 at 11:44 AM, Director of Nursing (DON) B stated that when a resident falls, staff should assess immediately and use the mechanical lift to get the resident up or leave the resident on the floor and call 911 if there are injuries. Falls are investigated which include gathering witness reports from staff. A fall intervention should be implemented immediately. The IDT team will then discuss the fall, review the incident report and staff statements, and revise or add interventions if necessary. The IDT team will review the added intervention for the next three days to assess effectiveness. When asked about the appropriateness of the intervention for R287 to sitting to standing slowly when he sustained a fall due to rolling out of bed mid sleep, DON B stated that she was unsure and would obtain the investigation for R287's fall and speak to the Assistant Director of Nursing. No other information was provided by survey exit. Review of the Falls Program reviewed on 1/24 revealed that if a fall occurs, the charge nurse will implement an immediate intervention. The IDT team will discuss the fall in a Risk Management meeting within 72 hours of the incident and discuss and determine the root cause of the fall. Additional interventions will be added to the Care Plan or Kardax if deemed necessary.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview, and record review the facility failed to provide prompt medical attention after a fall with multiple fractures for 1 of 3 sampled residents (R61) reviewed for falls, resulting in delay in treatment (21 hours wait prior to hospital transfer for right shoulder fractures), prolonged pain, and suffering. Findings include: Resident #61(R61) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R61 was a [AGE] year old female admitted to the facility on [DATE], with recent hospital readmission post facility fall resulting in two left humerus(upper arm) fractures. Additional diagnoses included cerebral vascular accident with left side weakness, hypertension (high blood pressure), peripheral vascular disease(decreased blood flow), anxiety disorder and depression. The MDS reflected R61 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact. During an observation and interview on 4/02/24 at 12:16 PM, R61's door was observed closed. Permission to enter was granted by R61. R61 was sitting on the edge of the bed eating meal independently with cast to left arm. R61 appeared calm and able to answer questions without difficulty. During observation and interview on 4/03/24 at 9:50 AM, R61 was observed in bed with full cast on left arm. R61 reported recent fall by bed after self transferring from the commode back to the bed. R61 reported landed on left side and yelled for help. R61 reported 10 out of 10 pain for 3 days before facility staff sent her to hospital. R61 reported the day she was sent to the hospital nurse arrived to shift and sent R61 to hospital related to increased uncontrolled pain. Review of R61 Progress Note, dated 3/18/2024 at 6:08 p.m., reflected, Resident heard calling for help from room. When this nurse entered, resident noted on floor next to bed. Resident states she got dizzy while trying to get to her commode from bed. Resident assessed and vitals taken. No bruising or injuries noted. Resident states pain to left shoulder, but no more than usual. Resident transferred from floor to wheelchair after assessment and helped into bed. Administrator, DON, Unit Manager, and Physician notified. Review of the Progress Note, dated 3/18/2024 at 7:00 p.m., reflected, The resident reported to the oncoming nurse that she thinks she broke her arm and she needed to go to hospital on call notified and ordered Stat X-Ray to left shoulder. Ultra.X said they won't be able to do it tonight it will be early in the morning. Pain medication given, will continue monitoring the resident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R61 on call Physician Progress note, dated 3/18/24 at 8:35 p.m., reflected, Date of Service: 03/18/2024 6:20 PM CT Details: Nurse Name : [named nurse working at time of fall Licensed Practical Nurse Z] .Primary Chief Complaint : Acute on Chronic Pain. History Present Illness : [AGE] year-old patient complaining of left shoulder pain. Patient had a fall earlier on during the day which was addressed by primary attending. Patient denied any pain following the fall but currently complaining of acute on chronic left shoulder pain. Patient has a known history of chronic left shoulder pain .Pain Level: 6 .MSK: Left shoulder pain with movement .Assessment/Plan .Pain in left shoulder(Primary) This is an acute new problem. The patient's condition is stable. Patient is complaining of acute on chronic left shoulder pain. Stat X-ray of the left shoulder. Call MD with results. Orders : Stat X-ray of the left shoulder. Call MD with results . Review of R61 Physician Progress note, dated 3/19/2024, reflected, Date of Service: 03/19/2024 .Chief Complaint / Nature of Presenting Problem: Follow-up left arm pain and radiology study .Staff notes patient suffered a fall likely mechanical. Staff notes patient complained of left arm pain on-call service ordered stat x-ray which revealed left humeral neck fracture, this is patient's affected side from previous CVA. Staff notes persistent pain complaints request for as needed pain medication .Pain Level: 9; 3/19/2024 1:59:18 PM . Diagnosis and Assessment Assessment .Closed fracture of neck of left humerus, initial encounter Secondary to a fall. Radiology reviewed. Significant edema. Will transfer to emergency department for further follow-up with orthopedic surgery. This is patient's affected hemiparetic arm. Continue to monitor awaiting transfer . Review of the Nursing Progress Note, dated 3/19/2024 at 4:00 PM, for R61, reflected, Neuros continued this shift and wnl for resident. Pain 9/10 to left shoulder,resident elevating arm on pillows. No new skin issues observed this shift. Review of R61 Progress Note, dated 3/19/2024 4:16 p.m., reflected, Resident with abnormal x-ray to left shoulder indicates Left Humoral head fracture. Per [named provider] NP send to ER for eval and tx. Resident aware and in agreement .Call placed to 911 for nonemergent transport at 1615. Awaiting transport at this time. Request for R61 Incident/Accident Reports along with complete investigation on 4/3/24 at 2:01 p.m. Review of the Incident Accident Report on 4/3/24 at 3:15 p.m., dated 3/18/24 at 5:01 pm, reflected alert and oriented R61 had unwitnessed fall during self transfer in room and found on the floor with complaints of left arm pain. The Report reflected R61 was transferred from the floor to the wheelchair. The report reflected no observed injuries at the time of the fall. The reported reflected no evidence of investigation including witness statements, interventions that were or were not in place(foot wear, level of bed, call light on or off, resident last observed, how resident was moved off floor, resident assessment .) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R61 Hospital Orthopaedic Consult, dated 3/19/24, reflected, [named R61] is a 60 y.o. female that presents with left shoulder and elbow pain after a ground level fall that she reports happened on Sunday 3/17/24, 2 nights ago. She has a history of CVA with left upper extremity hemiplegia. She notes pain in the left shoulder and elbow, but is unable to move either at baseline .Assessment: Left proximal humerus fracture, Left distal humerous fracture .Plan: Patient presenting with multiple left upper extremity fractures . maintain long arm splint ad sling to LUE. Elevate & ice to LUE. Pain control . Review of the hospital, Trauma Services Discharge Summary, dated 3/21/24, reflected R61 was admitted to the hospital on 3/19/24 at 4:58 p.m with discharge diagnoses that included, Traumatic closed displaced fracture of left shoulder with anterior dislocation. During an interview on 4/03/24 at 4:00 PM, Certified Nurse Aid(CNA) Y reported was working 3/18/24, when R61 fell in room. CNA Y reported nurse asked for her assistance around dinner time after R61 had been found on the floor. CNA Y entered R61 room and observed R61 on the floor complaining left arm, hurt really bad. CNA Y reported told the nurse and CNA Y she thought it was broke. CNA Y reported the nurse and CNA Y used a gait belt and staff on each side of R61 and lifted R61 under both arms and gait belt back to bed. CNA Y reported R61 call light was on when she entered the room. CNA Y reported R61 was independent in room prior to the fall according to the Kardex. CNA Y reported completed witness statement(not provided with investigation). Review of R61 Care Plan, dated 9/1/21, reflected intervention that included, TRANSFER: 1 person assistance. Remind me to turn towards my strong side when transferring and turning, and encourage me to use call light for assistance. I often self transfer and do not use call light to ask for assistance. During an interview on 4/3/24 at 5:40 p.m., Assistant Director of Nursing (ADON) K reported was not present when R61 fell on [DATE]. ADON K reported R61 was her own person and chooses to self ambulate, however, required one person assist prior to fall. ADON K reported educated R61 post fall about dangers of self transfer and verified R61 had additional fall 3/24/24. ADON K wound expect nurse to do complete assessment prior to transfer resident post fall and use hoyer to transfer. ADON K reported witness statements were part of investigation for R61 fall. During an interview 4/03/24 at 5:40 PM, Director of Nursing(DON) B reported did have witness statements from R61 fall on 3/18/24. DON B reported was unsure at that time what caused delay in x ray services and would expect STAT X-ray to be completed in fours hours. DON B reported R61 was own responsible person and frequently chose to self transfer and was care planned for one person assist with transfers. DON B verified R61 had additional fall on 3/24/24, after fall with fracture on 3/18/24. DON B reported wound expect nurse staff to complete assessment prior to transferring residents post fall and use hoyer to transfer off the floor. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview and record review on 4/05/24 at 4:06 PM, Unit Manager(UM) G reported nurse who was present for R61 fall on 3/18/24 at 5:01 p.m. entered the order for STAT X-ray on 3/18/24 at 7:32 p.m. After review of R61 EMR UM G reported the facility received R61 X ray results on 3/19/24 at 10:26 a.m. UM G reported would expect STAT X-rays to be completed within four hours and physician to be notified as soon as results are available of abnormal results including acute fractures. UM G verified R61 X-ray results included, Acute fracture of the left humeral neck. UM G was unable to answer why R61 was not transferred to the hospital until after 3/19/24 at 4:15 p.m. UM G reported nurses have access to Radiology reports and are expected to notify physicians immediately and was unable to determine when physician was notified of R61 acute fracture.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review facility failed to: 1) accurately assess, monitor, treat and prevent the development of pressure ulcers consistent with professional standards of practice to prevent avoidable pressure ulcers; and 2) implement care-planned and non-care-planned interventions for two Resident (R18 and R27) of three reviewed for pressure ulcers, resulting in facility acquired stage 3, and the increased likelihood for delayed wound healing and/or worsening of wounds and overall deterioration in health status. Findings include: Resident #27(R27) Review of the Face Sheet and Minimum Data Set (MDS) with ARD date 1/12/24, reflected R27 was a [AGE] year old male admitted to the facility on [DATE] related to mood disorder, left foot drop, osteoarthritis, anxiety, and depression. The MDS reflected R27 had a BIM (assessment tool) with score of 15 which reflected cognitively intact . Review of the facility Matrix, dated 4/02/24, reflected R27 had a facility acquired stage 3 pressure ulcer. During an observation and interview on 4/02/24 at 11:36 AM, R27 was in bed with legs exposed with dressing noted on bilateral lower legs. Left leg dressing was dated 3/31/24 and two right leg dressings were also dated 3/31/24. R27 reported dressings had not been changed for a couple days. R27 reported wounds were caused by lower leg braces and reported often crossed legs and caused open areas on skin. Review of the Electronic Medical Record, dated 3/1/24 through 3/21/24, reflected no evidence of weekly skin assessments until wounds were first identified on 3/21/24, according to Skin and Wound Evaluation completed on 3/21/24. The Skin and Wound Evaluation, dated 3/21/24, reflected R27 had, Stage 3: Full-thickness skin loss .Medical Device Related Pressure Injury. The Evaluation reflected the wound was identified on 3/21/24 and located on the right shin. Review of R27 Physician Orders, dated 3/4/24, reflected, Please apply Prafo boot to LLE while in bed to help reduce plantar contracture. May wear for up to 4 hours as tolerated with the goal of wearing through the night while in bed. Monitor skin when apply and remove. Notify doctor of any complications. Review of R27 Physician Orders, dated 3/21/24 through 4/4/24, reflected, Wound : right shin: cleanse with wound cleanser and pat dry. Apply xeroform cut to fit wound bed, apply a bordered foam dressing, cover with ace wrap over shin daily and as needed. every night shift. Review of R27 Physician Orders, dated 3/28/24, reflected Wound: left shin: cleanse with wound cleanser and pat dry. Apply xeroform cut to fit wound bed, apply a bordered foam dressing, daily and as needed. every night shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R27 Wound Care Plan, dated 3/22/24, reflected, Treatment as ordered by MD .Weekly skin assessments. Review of the Treatment Administration Record(TAR), dated 3/1/23 through 3/31/24, reflected R27 had order for, Weekly skin observation every Thursday PM shift. every night shift every Thu for skin monitoring. To document findings as per following criteria: 0-No skin breakdown, 1-Previously identified wound 2-Newly identified wound -Start Date- 11/03/2022. The TAR reflected, 0 on 3/7/24, 3/14/24, 3/21/24(wound identified), and 3/28/24(old wound and new wound according to other documentation). Review of R27 Provider note, dated 3/19/2024, reflected, Chief Complaint / Nature of Presenting Problem: Staff requested evaluation for left leg corrugation .staff notes patient was found to have excoriation on his left leg patient thinks secondary to brace .Diagnosis and Assessment Assessment: T14.8XXA: Excoriation Left lower extremity. No acute process on exam today. Will request wound care review continue local wound care. No indication for further diagnostics and/or treatment other than wound care . Review of R27 Wound Physician Note, dated 3/21/24, reflected, Chief Complaint / Nature of Presenting Problem: Initial wound care visit. History Of Present Illness: 70yr old male requested by facility for evaluation of wounds and follow up related to Left shin stage 3 pressure wound d/t use of medical device Wound #1 Wound Assessment: Wound- Left shin stage 3 pressure Measurements- 4.9 x 3.4 x 0.2cm .Wound Plan Of Care- xeroform/foam dressing daily and prn Wound Additional Orders- ACE wrap applied to LLE to protect tissue. Assess tissue underneath prafo boot q/shift while worn. Diagnosis and Assessment .Pressure injury of left leg, stage 3 . Review of the Activity Progress Notes, dated, 3/27/2024 at 12:56 pm, reflected, RN and UM observed open area to Right distal shin, open area to right superior shin, and fragile skin to left distal shin. Resident says I don't know. I do cross and rub my legs together. Wounds cleansed to right distal 7cm x 4cm x 0.1cm pink wound bed,no drainage. Right superior shin wound 6cm x 4cm x 0.1cm pink wound bed, no drainage cleansed with wound cleanser, patted dry, xeroform applied to wound bed, covered with border foam dressing. Fragile skin to left distal shin 4cm x 3cm, no drainage cleansed with wound cleanser, patted dry, and border foam dressing applied for protection. Treatment initiated daily and PRN for soiling/dislodgement. During an interview on 4/10/24 at 9:50 AM, Unit Manager(UM) G reported staff complete weekly skin assess and document in assessments and TAR. UM G verified R27's TAR reflected 0 on 3/21 and 3/28 and was unsure why and reported wound was identified on 3/21/24 and TAR should reflect that by use of number 1 or 2. During an interview on 4/10/24 at 10:20 AM, DON B reported skin assessments process changed about one month ago to using the TAR for skin assessments weekly indicated by numbers. DON B verified R27 TAR entry on 3/21/24 should reflect 2 not 0 for new wound and 1 and 2 on 3/28/24 and 4/4 instead of documented 0. During an interview on 4/10/24 at 12:12 PM, DON B reported nurses are expected to follow Physician orders and correctly date dressings when completed. DON B was unable to answer why R27 dressings were dated 3/31/24 when observed on 4/2/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	38383 Resident #18 (R18): Review of the medical record reflected R18 admitted to the facility on [DATE], with diagnoses that included spina bifida, dementia and major depressive disorder. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/22/24, reflected R18 scored 12 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 04/03/24 at 09:12 AM, a specialty air mattress was observed on R18's bed. A positioning wedge was observed in his room. R18 was observed seated in a geri chair recliner, in the dining room. On 04/03/24 at 09:30 AM, R18 was seated in a geri chair recliner, in his room. He stated he had no pressure ulcers that he was aware of, except a sore that he developed in 2/2023, which brought him to the facility. R18 reported he had a small and large wound on his bottom. R18's medical record reflected a stage four pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) of the sacrum, which was present on admission. The sacrum skin and wound evaluations for 2/1/24, 2/15/24, 2/22/24, 3/7/24 and 3/14/24 were not reflective of the size/measurements of the wound. R18's medical record reflected the presence of a facility-acquired pressure ulcer to the left gluteus (buttock), which was first identified on 12/14/24, as an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough (non-viable yellow, tan, gray, green or brown tissue) or eschar (dead or devitalized tissue; usually black, brown, or tan in color)). As of 1/25/24, the left gluteus pressure ulcer was documented as a stage three pressure ulcer (full-thickness loss of skin; subcutaneous fat may be visible in the ulcer). The left gluteus skin and wound evaluations for 2/22/24, 2/29/24, 3/7/24, 3/14/24 and 3/28/24 were not reflective of the size/measurements of the wound. The left gluteus skin and wound evaluation for 3/14/24 was not reflective of the appearance of the wound bed (type of tissue present). During an interview on 04/10/24 at 11:45 AM, Director of Nursing (DON) B reported a Nurse Practitioner and Registered Nurse visited the facility on Thursday's for wound evaluations. Her expectation was that pressure ulcers were assessed weekly, which was to include wound measurements and assessment of the wound bed. DON B reported R18's left gluteus wound should have been identified before it was unstageable.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 46954 This citation pertains to intake # MI00143255 Based on interview and record review the facility failed to investigate falls and implement effective interventions to prevent falls for one (Resident #86) of three residents reviewed, resulting in the potential for falls and injury. Findings include: Resident #86 (R86) Review of the Admission Record reflected R86 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis which included gastrostomy status (creation of an artificial external opening into the stomach for nutritional support), retention of urine, dementia with agitation and anxiety, need for assistance with personal care, delirium, and dysphagia (difficulty in swallowing food or liquid). The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/7/23, reflected R86's Brief Interview for Mental Status (BIMS) was scored 4 out of 15, indicating severe cognitive impairment. The Care plan reflected that R86 did not walk, required extensive assistance of two or more people for toileting and transferring, had an indwelling foley catheter due to retention of urine, and required assistance of one staff member for consuming meals and fluids. R86 no longer resided in the facility. Review of R86's Fall Care Plan revealed R86 had interventions for fall prevention initiated on 11/3/23 which included call light and remote to be clipped on UB (upper body) clothing, have commonly used articles within reach, maintain bed in low position, and reinforce the need to call for assistance. Review of a Social Services note dated 11/7/23 at 5:13 PM revealed that R86 was yelling out due to his call light being out of reach. The responding social worker clipped R86's call light to his gown. Review of a Health Status Note dated 11/22/23 at 12:53 AM reflected R86 had an unwitnessed fall around 1945pm (7:45 PM). Rolled out of his bed, resident stated I tried to get up I'm looking for my wife. Resident found on the floor, laying on his right side . placed floor mats on both side [sic]. Ordered to send out to hospital for further eval as resident is on Eliquis (blood thinning medication). R86 returned to the facility on [DATE] around 4:40 AM with no injuries noted. Review of a Health Status Note dated 11/22/23 at 9:55 AM reflected that the Interdisciplinary Team (IDT) reviewed R86's fall and added a new intervention to place floor mats on both sides of R86's bed. Review of R86's Care Plan revealed that fall mats on both sides of the bed was added as a fall intervention on 11/22/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Health Status Note dated 11/24/23 at 10:10 AM reflected IDT met to review previous fall. Resident observed on floor later in day [sic]. Resident said he was trying to get his remote. Call in bed control were clipped to edge of bed. Assisted back to bed . Make sure call light and bed controls are clipped to front of gown. Review of the Care Plan revealed that ensuring the call light and remote to be clipped on UB (upper body) clothing and have commonly used articles within reach were already initiated interventions to R86's Care Plan. Review of a Health Status Note dated 11/24/23 at 10:00 PM revealed patient (R86) was checked on during med (medication) pass and was found laying in bed. 10 minutes later patient screamed out for help and was found laying on floor mat on right side of bed. Resident was carried back to bed by RN (registered nurse) and CNA (certified nursing assistant). When asked what happened patient replied, take me home . Review of a Health Status Note dated 11/27/23 at 10:04 AM revealed IDT met to review resident recently observed on the floor. Resident continues with PT/OT (Physical and Occupational therapy) with safety goals in place .staff educated to be provided leave lights on during the day to help with delirium. Review of the Falls Care Plan revealed the intervention keep lights on during the day to help with orientation was initiated on 11/27/23. Review of a Health Status Note dated 11/27/2023 at 10:09 AM reflected IDT met to review recent fall. Resident alert and oriented to person per baseline for this resident . 30-minute checks continue as care planned lights to be on during the day to aid with delirium. Review of the Falls Care Plan revealed the intervention 30-minute checks was initiated on 11/27/23. On 4/4/24 at 1:04 PM, an email request was made for all Incident reports for R86. One Incident report dated 11/22/23 was provided. On 04/05/24 at 11:55 AM, the Nursing Home Administrator confirmed that there were no other Incident reports for R86. In an interview on 4/10/24 at 11:44 AM, Director of Nursing (DON) B stated that when a resident falls, staff should assess immediately and use the mechanical lift to get the resident up or leave the resident on the floor and call 911 if there are injuries. Falls are investigated which include gathering witness reports from staff. A fall intervention should be implemented immediately. The IDT team will then discuss the fall, review the incident report and staff statements, and revise or add interventions if necessary. The IDT team will review the added intervention for the next three days to assess effectiveness. When asked how many times R86 had experienced a fall, DON B was unsure. DON B reviewed the Health Status Notes regarding R86's other falls and confirmed that R86 had experienced several falls which should have generated an Incident Report and been investigated. A request for any additional information for the other falls went unfilled by survey exit.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 This citation pertains to intake # MI00143255 Based on observation, interview and record review, the facility failed to 1) ensure enteral feedings were provided as ordered to meet hydration and nutritional needs for one (Resident #86); 2) ensure fluids were freely accessible and provided to three (Resident #41, #43, and #86) and 3) prevent significant weight loss for one (Resident #68) of five reviewed for nutrition and hydration, resulting in weight loss, not receiving the ordered tube feeding formula, not receiving the total tube feeding volume ordered, feelings of distress, hospitalization , and the potential for unmet nutritional needs and continued weight loss. Findings Include: Resident #86 (R86) Review of the Admission Record reflected R86 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis which included gastrostomy status (creation of an artificial external opening into the stomach for nutritional support), retention of urine, dementia with agitation and anxiety, need for assistance with personal care, delirium, and dysphagia (difficulty in swallowing food or liquid). The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/7/23, reflected R86's Brief Interview for Mental Status (BIMS) was scored 4 out of 15, indicating severe cognitive impairment. The Care plan reflected that R86 did not walk, required extensive assistance of two or more people for toileting and transferring, had an indwelling foley catheter due to retention of urine, and required assistance of one staff member for consuming meals and fluids. R86 no longer resided in the facility. Review of the Nutrition Discharge paperwork from the Hospital dated 11/1/23 reflected that R86 had difficulty swallowing food and drink, however, was safe enough to consume his meals if the food was in a puree texture and the liquids were nectar thick. The Registered Dietician at the hospital also recommended elevating the head of the bed and offering small bites at a slow rate. Liquids should be administered via teaspoon. R86 was to receive medications and supplemental nutrition through his PEG tube (percutaneous endoscopic gastrostomy- a tube that delivers nutrition directly into your stomach) if he consumed less than 75% of his meal. Review of a Physician order dated 11/1/23 revealed Enteral Feeding order 4 times a day Isosource 1.5. This order was discontinued on 11/3/23. Review of a Dietary Note dated 11/3/23 at 2:13 PM revealed RD (Registered Dietician) made aware that resident is not tolerating current TF (tube feed) orders .Resident refused bolus via PEG tube, he started yelling and was combative hitting at nurse . His hospital discharge orders state that his goal is to use bolus feeds a supplemental if he consumes less than 75% of his meal orally. RD to change diet order to reflect this. Staff to encourage oral intake and use bolus feeds PRN (as needed) as residents allows. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the Care Plan revealed a Nutritional Focus area dated 11/3/23 which stated R86 had a nutritional problem or potential nutritional problem related to dysphagia, delirium, dementia, and gastrostomy. I am receiving supplemental enteral nutrition .I receive supplemental tube feed via PEG related to dysphagia, weight loss, PO (by mouth) intake and appetite . Interventions dated 11/3/23 included Diet as ordered: Regular Diet/Puree texture/NO liquids. Supplemental Enteral Nutrition if oral intake is less than 75% (Enteral nutrition (EN), also called tube feeding, is a way of providing nutrition directly into the gastrointestinal tract through an enteral access device (feeding tube). Enteral nutrition is a special liquid food mixture containing all of the nutrients required to meet nutrition needs, such as protein, carbohydrates, fats, vitamins, minerals, and other nutrients) and diet as ordered: NPO (nothing by mouth) initiated on 11/3/23 and revised on 12/19/23. Review of the Kardax (portion of the electronic medical record that informs Certified Nursing Assistants of care needs) reflected that R86 eating/nutrition section stated EATING: I am totally dependent on (1) staff for eating. Small bites, slow rate, upright during meals and 20-30 minutes after meals. The Care Plan or Kardax did not reflect that R86 could be offered fluids or to encourage oral intake and the diet orders reflected that R86 was unable to have liquids. Review of a General Diet Physician Order dated 11/1/23 at 5:13 PM revealed Puree texture (for food), nectar consistency (for liquids) for dysphagia. Supplement meal with one can of Isosource 1.5 (enteral nutrition for tube feeding) if meal intake less than 75%. Review of an Enteral Feed Order dated 11/1/23 reflected every shift flush feeding tube with 30 ml (milliliters) of water before and after medication administration flush feeding tube with 5 ml of water between each medication. Further review of the Physician Orders revealed no additional hydration sources for R86. Review of the Task documentation for R86's food intake for the dates of 11/3/23 until 11/10/23 reflected the following: On 11/4/23 at 8:00 AM, 100% of meal consumed. At 1:00 PM 75% of meal consumed. At 6:00 PM there was no documentation for the percent of meal consumed. Review of the Medication Administration Record revealed no ordered as needed supplemental meal was administered for the day. On 11/5/23 at 8:00 AM, 50% of the meal was consumed. At 1:00 PM 50% of the meal was consumed. At 6:00 PM 50% of the meal was consumed. Review of the Medication Administration Record revealed no ordered as needed supplemental meal was administered for the day. On 11/6/23 at 8:00 AM, 0% of the meal was consumed. At 1:00 PM, 25% of the meal was consumed. At 6:00 PM, 0% of the meal was consumed. Review of the Medication Administration Record revealed no ordered as needed supplemental meal was administered for the day. On 11/7/23 at 8:00 AM, 25% of the meal was consumed. At 1:00 PM, 25% of the meal was consumed. At 6:00 PM, there was no documentation for the percent of meal consumed. Review of the Medication Administration Record revealed no ordered as needed supplemental meal was administered for the day. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 11/8/23 at 8:00 AM, 0% of the meal was consumed and was marked as resident refused. At 1:00 PM, 25% of the meal was consumed. At 6:00 PM, 75% of the meal was consumed. The Medication Administration Record revealed that one supplemental as needed nutrition was administered at 10:23 PM. On 11/9/28 at 8:00 AM, 0% of the meal was consumed. At 1:00 PM, 0% of the meal was consumed. At 6:00 PM, 0% of the meal was consumed. The Medication Administration Record revealed that one supplemental as needed nutrition was administered at 8:23 PM. On 11/10/23 at 8:00 AM, 0% of the meal was consumed. Review of the Medication Administration Record revealed no ordered as needed supplemental meal was administered for the day. Review of a Behavior Note at 11/10/23 at 6:00 AM revealed Resident yelled out throughout the shift, frequent reminders given to use his call light. He only used the light several times and the rest continued to yell out for help. When writer or other staff answered his calls for help resident had no needs. One statement he shared with CNA's (Certified Nursing Assistant) was I don't want to die in this place. Resp (respirations)22, T(temperature):99.6 (Fahrenheit), damp cool cloth placed on his forehead. Portable air turned on d/t (due to) room very warm and stuffy . BP (blood pressure) 93/46, pulse 98 . writer rechecked b/p which 95/57. Writer to monitor and report to oncoming nurse. Review of a Health Status Note dated 11/10/2023 at 8:40 AM reflected Resident's B/P is 66/38 ((hypotensive: a blood pressure reading below the specified limit (90/60 millimeters of mercury (mmHg)). He appears non diaphoretic is arousable and communicated with writer that he does not want breakfast. On call provider called, and recommended monitoring vs (vital signs) every 15 minutes and encourage oral fluids. Will continue to monitor. R86's Vital Signs were as follows: 11/10/2023 08:40 AM 66 / 38 mmHg 11/10/2023 08:55 AM 72 / 41 mmHg 11/10/2023 09:34 AM 87 / 38 mmHg 11/10/2023 10:00 AM 70 / 30 mmHg Review of a Health Status note dated 11/10/2023 at 10:09 AM reflected Resident's blood pressure dropped to 70/30, became unresponsive and was only arousable by sternal rub. He started to have hematuria (blood in urine) in his foley catheter, order was given to send him to the ER (Emergency Department) . Review of the Hospital Paperwork dated 11/10/23 revealed that R86 presented to the emergency department with decreased responsiveness. Per report, [R86] was unresponsive and hypotensive. His blood pressure was 55/40 and 70/30 when Emergency Medical Services arrived. Upon presentation to the emergency room , [R86] required 4 liters of intravenous fluid to improve his blood pressure. Further review of the same Hospital Paperwork revealed that R86 had a serum sodium level of 144 milliequivalents per liter (mEq/L), which indicated that R86's serum sodium levels were on the higher range of the scale. Normal ranges are 135-145 mEq/l). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of a Nutrition Note during hospitalization dated 11/11/23 revealed R86 had inadequate energy intake related to decreased ability to consume adequate .as evidenced by documented intake from previous admission, patient reportedly sleeping most of the day, visible fat and muscle wasting and need for enteral nutrition via peg tube. The Dietician recommended scheduled tube feedings and scheduled water flushes to ensure R86 received the nutrition and hydration required. The document also reflected that R86 had thick oral secretions and weight loss as evidenced by the observation of muscle and fat wasting. Review of the Weights reflected on 11/1/23, R86 weighted 171 lbs (pounds) and upon readmission to the facility on [DATE], weighed 160.5 lbs which is a 6% weight loss in two weeks. In an interview on 04/05/24 at 1:43 PM, Registered Dietitian (RD) I reported that she did not have concerns for R86 as far as not meeting his nutrition and hydration needs because he received nutrition and fluids through his PEG tube. When asked if hydration needs were monitored such as reviewing intake and output or urine characteristics, RD I stated that she did not use intake and output or urine characteristic to ensure hydration needs were being met. When asked if there should be required documentation for someone with a nutrition and hydration risk, RD I reported that providing fluids was a standard of care and therefore, did not require additional documentation. After review of the meal consumption task and order for a PRN supplemental meal bolus, RD I acknowledged that R86 had missed several required feedings. In an interview on 04/10/24 at 11:44 AM, Director of Nursing B stated that she would expect that the Certified Nursing Assistants report to the nursing staff what the percentage of meal consumption was so that the nurses could administer the as needed supplemental feeding. 27446 Resident #41(R41): Per the facility face sheet R41 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Diagnoses included stroke. Review of R41's care plans revealed, I (R41) have an ADL (activities of daily living) self-care performance deficit r/t (related to) recent CVA (stroke) with dysphagia (difficulty swallowing), date initiated 11/29/2023, and revised on 1/10/2024. The care plan, under Interventions/Tasks revealed, R41 required staff assistance to walk and transfer. Review of R41's Kardex (document Certified Nurse Aids [CNA] use to know how to provide care to a resident) revealed in the EATING/NUTRITION section, .I (R41) need assistance of (1) staff for eating orally. In an observation and interview on 4/02/2024 at 2:54 PM, R41 was observed in bed, and no drinking water was observed in R41's room. A sign was observed on wall which revealed Pudding Thick Liquids .) During the same observation and interview R41 asked if she could get some water. A staff member was informed of R41's request. At 3:00 PM a Styrofoam cup with a lid was observed to have been placed on a bedside table that was in the bed one area. R41 resided in bed 2. The cup was way out of reach for R41, the straw was laying next to the cup, the water was not pudding thick and had ice in it. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 4/02/2024 at 3:05 PM, R41 was heard to be crying, and stated she wanted her water. On 4 /03/2024 at 2:40 PM, R41 was observed in her bed with door partial closed. An over the bed table that was out of reach for R41 was observed to have thickened water and juice in two small juice cups. Upon entering R41's room, R41 asked for a drink of water, and began to cry because she wanted a drink of water. On 4/04/2024 at 10:18 AM, R41 was observed in her bed crying, and stated she was thirsty. Pudding thick water and orange juice was observed to be on the over the bed table but out of reach for R41. Review of a physician's order dated 3/29/2024 revealed, that after each meal if R41 ate less than 50% of the meal she was to receive a tube feeding bolus (one time not continuous), which included a total of 180 ml (milliliters) of water. Review of a nutritional evaluation dated 3/29/2024, revealed R41 required 1636 ml of water per day. In an interview on 4/04/2024 at 10:28 AM, CNA N stated R41 was to be checked on every 30 minutes, and said staff would give R41 a spoonful of water at that time. CNA N said she did not know how R41's fluid intake was monitored to assure she received her required 1636 ml of water per day. In an interview on 4/04/2024 at 10:40 AM, Registered Nurse (RN) W, who was also the Unit Manager, stated that the CNA's would document in R41's electronic medical record (EMR) that they gave R41 a drink,. RN W stated she was not sure how it was assured R41 received her daily water requirement of 1636 ml a day. Record review of R41's EMR revealed there was no CNA documentation of each drink of water they provided for R41. Review of R41's treatment administration record (TAR) for the month of March and April 2024 revealed no documentation of the drinks of water staff gave to R41. Resident #43 (R43): In an observation and interview on 4/02/2024 at 9:40 AM, R43 was observed in her bed, a Styrofoam cup of water was observed to be on the bedside table, that was not within reach from the bed, with a straw in it, but the paper the straw came in was still on the top part of the straw. R43 was asked if she could reach her water, R43 did not understand, and did not attempt to reach for water. The cup was full of water and was not dated. Another Styrofoam cup of water was observed on the bedside table, full to the top of water, had no ice, and no date to determine when it was fresh water. On 4/04/2024 at 10:56 AM, R43 was observed in bed, a full Styrofoam cup of water was observed on the over the bed table. R43 was asked if she knew where her water was located, but she did not respond to the question just mumbled. R43 was asked if she could reach her water, but did not respond. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of a care plan in place revealed R43 had a care plan in place dated 5/8/2018 and revised on 12/30/23, that identified she had the potential for dehydration, and would drink independently. The interventions included, encourage fluids dated 5/8/2018 and revised on 5/11/2023, and ensure R43 had access to fluids. Review of a care plan dated 5/1/2018 and revised on 12/30/2023, that addressed R43's ADLs revealed R43 required staff assistance to walking, and transferring. In an interview on 4/05/2024 at 1:28 PM, Registered Dietician (RD) I stated that it was her expectation that the staff were giving or offering drinks through out the day and with meals, and every two hours if the resident could not take a drink themselves. RD I said she would only get a resident's fluid intake from talking to UM W, and said fluid intake was not documented anywhere, not even for residents who could not take their own drink and depend on staff. 38383 Resident #68 (R68): Review of the medical record reflected R68 admitted to the facility on [DATE], with diagnoses that included diabetes, dysphagia (difficulty swallowing) and history of transient ischemic attack (TIA) and cerebral infarction. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/16/24, reflected R68 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 04/02/24 at 11:57 AM, R68 was seated on the edge of his bed. He reported the facility's food was terrible, and he could not eat it. R68 reported he had lost weight since his admission to the facility, and he was tired of going hungry. When asked what made the food terrible, R68 reported he did not have any teeth, and the facility was aware of that. On 04/03/24 at 08:35 AM, R68 was observed in bed. R68 stated he did not have any teeth and was working on getting new dentures before admitting to the facility. R68 reported he had seen the dentist at the facility. He reported difficulty eating due to not having any teeth or dentures. A dental consult note for 9/28/23 reflected, .Edentulous [no teeth] .does not have dentures, unhappy with his chewing ability; oral mucosa appears pink and shiny . A dental consult note for 10/20/23 reflected, .Patient has no dental concerns .Patient has had dentures made in the past but they didn't fit and could not be worn. He is having trouble chewing and would like to have new ones made. This will benefit his nutrition and general health . Took preliminary upper and lower impressions for complete dentures . During an interview on 04/05/24 at 11:13 AM, UM G reported she had contacted the facility's dental group, and was informed they had not started R68's dentures. UM G was told the process for new dentures was started through someone else, and the facility's dental provider could not start a new process for dentures until the old one was discontinued. UM G stated the facility's dental provider reported they would be looking into how to get the old group to discontinue that process so they could start it. UM G reported the facility's dental provider group had never conveyed to the facility that R68 was in the process of getting dentures with another dental group. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	According to the medical record, on 09/11/2023, R68 weighed 204.7 pounds (lbs). On 03/07/2024, R68 weighed 183.1 pounds, which is a -10.55 percent weight loss. On 4/3/24, R68 weighted 182.2 pounds. A Nutrition Evaluation for 9/12/24 reflected, .Resident not satiated by facilities meal serving sizes. Reports he is still hungry . A Nutrition Evaluation for 12/13/24 reflected, .Resident has expressed in the past that he either does not like the facility's food or does not receive enough food. He currently receives double portions with all meals and occasionally forgets that he ate d/t [due to] his mentation. Staff is encouraged to offer additional food if this happens . R68's weight history since admission reflected the following: 9/11/2023: 204.7 Lbs 9/18/2023: 205.3 Lbs 9/25/2023: 206.0 Lbs 10/1/2023: 203.2 Lbs 11/28/2023: 200.4 Lbs 12/4/2023: 201.3 Lbs 1/2/2024: 193.8 Lbs 1/29/2024: 187.0 Lbs 2/6/2024: 189.2 Lbs 3/7/2024: 183.1 Lbs 4/3/2024: 182.2 Lbs Physician's Orders, dated 2/11/24, reflected R68 was to receive a no sugar added mighty shake two times a day with breakfast and lunch and a magic cup daily with dinner. A Physician Order with a start date of 9/12/23 and revision date of 3/7/24 reflected R68 was to have a consistent carbohydrate (CCD) diet, mechanical soft texture, double portions, ground meat, pureed fruit and extra sauce/gravy with ground meats. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 04/05/24 at 09:29 AM, R68 was observed lying in bed. He reported he had already eaten breakfast, and his tray had already been taken. He reported having scrambled eggs, two cartons of milk, two chocolate shakes and rice krispies cereal. R68 reported consuming all of his eggs and cereal and consuming both of his shakes. R68 reported he did not get a double portion of eggs on his breakfast plate. R68 stated he did not get full from breakfast that morning. Additionally, R68 stated he was not always getting his double portions at meals. A breakfast tray ticket was observed on his over-bed table and reflected double portions were to be provided. During an observation and interview on 04/05/24 at 12:44 PM, Registered Dietitian (RD) I reported R68 was one of the residents that was never satisfied with the food. He would say he did not receive things, and they would find them in his drawer. RD I removed R68's plate cover. The plate consisted of ground chicken parmesan with marinara sauce and noodles, cauliflower and one piece of toasted bread that had been cut in half. A bowl of peaches, appearing half full, was also observed. RD I reported the meal was a double portion. When asked if R68's meal had extra sauce, as noted on his tray ticket, RD I stated, I would not say that is extra sauce by any means. The tray ticked also reflected that R68 was to have a no sugar added mighty shake on his tray. RD I confirmed that the shake had not been provided with the meal. The tray ticket reflected tomato soup was to be provided with lunch, which was not observed to be served with R68's meal. During an interview on 04/05/24 at 01:50 PM, RD I reported R68 had a history of saying he did not eat when he did or saying he did not receive certain foods that would be found in his drawer. RD I reported R68's weight loss over six months was significant because it was an 11% loss. Anything over a 10% weight loss over six months was considered significant. She reported that after assessing his six month weight loss, R68 would be placed on weekly weights for four weeks, which would continue until his weight was stabilized. RD I reported that as of 3/7/24, R68 was considered to have significant weight loss of 10.6% in six months. She reported R68 should have been placed on weekly weights around 3/7/24. RD I stated she had heard R68 say he did not receive double portions at meals, and she sent an email to the Dietary Manager, reminding that he needed double portions.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 27446 Based on observation, interview, and record review the facility failed to ensure there was sufficient staffing, call lights were within reach, and call lights were answered promptly for 10 out of 13 confidential group interviews, and for two out of four residents (Resident #41 and 43). Findings Included: During a confidential group meeting on 4/03/2024 at 10:21 AM, one resident stated that staffing was so bad there were several times she would not receive staff assistant getting up out of bed and would miss the activities. The same confidential resident stated that about 4-5 times she did not receive staff assistance getting out of bed to attend activities and resident council, which resulted in her missing the activities and resident council meetings entirely. The resident stated it was due to not having enough staff. Another confidential resident stated he was told by staff they did not have enough time and were too busy to assist him to get up out of bed. Ten of the 13 confidential residents agreed that the call light wait times were 45 to 60 minutes. The residents said that staff would turn off their call light and say they would be right back but would never come back. The 10 residents all stated and agreed that the staff would be on their cell phones all the time and would wear headphones. The residents stated that the staff would talk on their phones while they were providing their caring and said the staff would enter their rooms talking on their phones with headphones on which made them not know if the staff member was talking to them or not. The 10 residents further stated that early in the morning staff would have their phones in their pockets with music playing, and it would wake them up. Review of the monthly resident council meeting minutes revealed that in October and December of 2023, and February and March of 2024 it was documented that residents had complained about call light answer times, concerns with receiving staff assistance, and/or staff on their phones while providing care. March of 2024 meeting minutes revealed, Call-light response time-still and issue . Resident #41 (R41): Review of R41's care plans revealed, I (R41) have an ADL (activities of daily living) self-care performance deficit r/t (related to) recent CVA (stroke) with dysphagia (difficulty swallowing), date initiated 11/29/2023, and revised on 1/10/2024. The care plan, under Interventions/Tasks revealed, R41 required staff assistance to walk and transfer. In an observation on 4/03/2024 at 2:40 PM, R41 was observed in bed with the room door partially closed. R41's call light was observed to be wrapped around the room divider curtain and out of R41's reach. In an observation on 4/03/2024 at 2:55 PM, a staff member was observed to enter R41's room to provide care and upon exiting R41's room, it was observed that R41's call light remained tied around the divider curtain, and out of R41's reach. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 4/04/2024 at 10:18 AM, R41 was observed in her bed crying, the call light was attached to side of R41's bed sheet. R41 was asked if she knew where her call light was located, in which she stated over there and pointed at the wall. R41 was asked if she could reach her call light, and R41 said no. R41, per request and observation, and did not know her call light was attached to side of her bed, and upon asking R 41 was not able to reach her call light. In an observation on 4/3/2024 around 3:00 PM, a call light for room [ROOM NUMBER] was observed blinking and alarming. A staff member was observed to walk by the alarming call light but did not stop to answer the light and address the resident's need. In an observation on 4/04/2024 at 10:49 AM, room [ROOM NUMBER] was observed to have the call light on, which was noted by a blinking light and an alarm sound. A nurse pushing a medication cart was observed to stop at the room next door, room [ROOM NUMBER], speak to a resident in room [ROOM NUMBER], and then leave the hall without responding to the resident's needs in room [ROOM NUMBER]'s, leaving the call light blinking and alarming. In an interview on 4/04/2024 at 10:24 AM, Licensed Practical Nurse (LPN) O stated R41 was able to use her call light. In an interview on 4/04/2024 at 10:40 AM, Registered Nurse (RN) W, who was also the Unit Manager, stated that she has seen R41's call light on, so she said R41 would have used her call light and turned it on. In an observation on 4/4/2024 at 10:56 AM, R43 was observed in her bed. R43 was asked if she knew where her call light was located, however did not respond. Observation of R43's call light revealed it was located underneath R43's bed and out of reach. Review of R43's care plans revealed, urinary incontinence . initiated on 5/1/2019, and revised on 12/30/2023. The care plan interventions included, I (R43) do not consistently use my call light .keep call light within reach when in room and encourage to use.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview, and record review the facility failed to insure that two residents (R56 and R63) were free from significant medications errors out of two residents reviewed for significant medication errors resulting in the potential for adverse physical reactions/outcomes to residents. Findings Included: Resident #56(R56) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R56 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included alcoholism, hypertension (high blood pressure), peripheral vascular disease, osteomyelitis bilateral ankles, orthopedic amputations bilateral feet related to recent gangrene infection(septicemia), and current smoker . The MDS reflected R56 a BIM (assessment tool) score of 15 which indicated his ability to make daily decisions was cognitively intact. The MDS reflected R56 had no behaviors including rejection of care. During an observation and interview on 04/02/24 at 10:20 AM, R56 was in the hall self propelling in wheelchair with boot on right leg and platform shoe left. R56 reported wound had wound clinic and infection appointment that day. R56 reported recent infection in both feet with recent amputations and current antibiotic treatment. R56 appeared well groomed and pleasant and able to answer questions without difficulty. Review of R56 Physician Progress Note, dated 2/21/2024, reflected, Date of Service: 02/21/2024 . Chief Complaint / Nature of Presenting Problem: Follow-up hospitalization History Of Present Illness: [AGE] year-old male with known chronic medical conditions including hypertension PAD alcohol use disorder history of VTE patient was recently admitted to the hospital for sepsis secondary to gangrene patient was started on IV antibiotics by infectious disease ultimately transition to oral Levaquin and Augmentin culture demonstrated Proteus in wound and blood culture 6 weeks course of antibiotic therapy. Patient underwent angioplasty by vascular surgery was determined to have adequate blood flow to heal any surgical intervention podiatry was consulted for concern for osteomyelitis patient underwent left foot metatarsal bone resection 1 through 5. Patient also went right foot tendo Achilles lengthening with right foot Lisfranc amputation and washout with delayed closure and application right foot wound VAC patient discharged subacute rehab with wound VAC and wound care orders patient weight bearing left heel in cam boot for transfers nonweightbearing right foot first and surgical shoe patient went through alcohol withdrawal at the hospital was weaned off benzodiazepines patient had AKI which improved with fluid resuscitation had postoperative anemia requiring PRBCs 1 unit was discharged to this facility for subacute rehab staff notes patient is overall stable staff denies significant respiratory or GI complaint . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria Nursing and Rehab	707 Armstrong Lansing, MI 48911

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R56 Infectious Disease Progress Note, dated 2/18/24, reflected, Assessment: 1. Extensive bilateral necrotizing infection involving the bone in a patient with peripheral vascular disease and diabetes with proteus mirabilis bacteremia and proteus vulgaris from wound culture .s/p proximal transmetatarsal amputation of the left and complete metatarsal removal on the right. Recommendation .Start Augmentin 875 TID and Levoquin 750 mg .Will likely need 6 weeks of antibiotics given the left transmetatarsal amputation was not complete. Follow up with ID outpatient in 1-2 weeks . Review of R56 Infectious Disease Consult Note, dated 4/2/24, reflected, visit note dated 3/5/24 discharged (from hospital) on 2/20 on PO(oral) Augmetin 875mg PO TID(three times daily) and Levaquin 750 PO daily minimally x 6 weeks. Noted facility currently dosing Augmentin 500 TID; requested adjustment . The Consult Note included visit note dated 3/19/24 that included, At last appt he was to adjust fro 500 to 875 TID Augmentin, however, in records provided by facility, it seems they adjusted him to Amoxicillin. Will request confirmation and adjustment . Review of the Medication Administration Record(MAR), dated 2/20/24 through 4/3/24, reflected R56 received, Augmentin Oral Tablet 500-125MG (Amoxicillin & Pot Clavulanate) Give 1 tablet by mouth three times a day for Wound infection/Osteomyelitis until 03/24/2024 23:59 -Start Date-02/20/2024 2000-D/C Date-03/06/2024 0857. Continued review of the TAR reflected R56 received, Amoxicillin Oral Tablet 875 MG (Amoxicillin) Give 1 tablet by mouth three times a day for Wound infection until 03/26/2024 23:59-Start Date-03/06/2024 2000-D/C Date-03/19/2024. Continued review reflected, Amoxicillin-Pot Clavulanate Oral Tablet 875-125 MG (Amoxicillin & Pot Clavulanate) Give 1 tablet by mouth three times a day for Wound infection until 04/02/2024 23:59 -Start Date- 03/19/2024 2000 -D/C Date-04/02/2024 .(R56 received incorrect dose of Augmentin 2/20/24 through 3/5/24 and incorrect medication 3/6/24 through 3/19/24). Review of the facility Outpatient Consultation Report, dated 3/5/24, signed by facility staff 3/6/24, with directions to adjust R56 Augmentin to 875mg 3 times daily. Review of the facility Outpatient Consultation Report, dated 3/19/24, signed by facility staff 3/19/24, with directions to adjust R56 Amoxicilin to Augmentin 875mg TID. During an interview on 4/03/24 at 5:00 PM, Assistant Director of Nursing(ADON) K reported R56 antibiotic was changed on 3/6/24 form Augmentin 500mg TID to Amoxicilin 875mg by the first floor Unit Manager (UM) AA. ADON K reported on 3/19/24 UM AA corrected order to reflect Infection Disease Physician order to Augmentin 875mg TID. ADON K verified was medication error after reviewing R56 Consult Notes and reported should have been reported to Physician and did not see evidence Physician had been notified or medication error investigation. During an interview on 4/03/24 at 5:40 PM, Director of Nursing (DON) B reported would expect physician to be notified of medication errors and investigation to be completed. During an interview and observation on 4/05/24 01:22 PM, R56 had wound vac in place. R56 reported did not recall changes with antibiotics but also reported takes so many medications that he does not keep track. R56 reported did was not informed of medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/05/24 01:28 PM, UM AA reported Outpatient Consult Record were sent with residents to Consult visits for communication of changes. UM AA reported on 3/19/24 aware of R56 medication error and reported to ADON K who assisted correction of the orders because of confusion with computer entry. UM AA reported plan to start double check with new orders. Resident #63(R63) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R63 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included heart disease, kidney disease, pulmonary disease, hypertension (high blood pressure), brain cancer, pain, anxiety and depression . The MDS reflected R63 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact. During an interview on 4/02/24 12:27 PM, R63 was sitting in bed and appeared to be calm and pleasant and able to answer questions without difficulty. R63 reported concerns that she had received her roommate medications on 3/7/24 in the evening and did not realize until after because the nurse had woke her up to take them. R63 reported the nurse was not a regular nurse and also checked her blood sugar and reported had never had that done in past and was not diabetic. R63 reported spoke with ADON K about medication concern. R63 reported nurse entered room after medication had been taken and appeared upset and grabbed medication cup out of R63 trash that had roommates room and bed number written on it. Review of R63 EMR, dated 3/7/24 to current, with no mention of medication error. Review of R2(R63 roommate) Medication Administration Record(MAR), dated 3/7/24, reflected she received the following evening medication: Keppra Oral Tablet 1750 MG (Levetiracetam) for EPILEPSY. metFORMIN HCl Tablet 1000 MG for diabetes. Lyrica Oral Capsule 150 MG for pain. Insulin Aspart Solution Inject as per sliding scale:if 200 - 250 = 2 unit;251 - 300 = 4 unit;301 - 350 = 6 units;351 - 400 = 8 units Greater than 400 call pcp(documented blood sugar was 98, which was significantly different that the other evening blood sugars that were mostly over 200). Review of R63 MAR, dated 3/7/24, reflected R63 have received medication that included narcotic pain medications, blood pressure medication, and busPIRone HCl Tablet 10 MG for anxiety. During an interview on 4/03/24 04:32 PM, ADON K reported R63 reported thought she got wrong medication in past. ADON K reported was unsure who and informed him but followed up with R63 about one week ago. ADON K reported after speaking with R63 reported to both DON B and NHA A. ADON K reported determined R63 concern occurred on 3/7/24 with agency staff BB. ADON K reported no medication error compliance reports were completed to his knowledge. ADON K reported determined R63 received roommate seizure meds, same dose of pain narcotics. ADON K reported wound expect Physician to be notified of medication errors and was unable to locate evidence Physician was notified. ADON K reported no other residents were in involved. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 4/10/24 1242 PM, DON B provided medication error report for R63 dated 4/4/24 that occurred 3/7/24 with documentation of R63 and Physician notification.

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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. 46954 Based on observation, interview, and record review, the facility failed to ensure opened medications were appropriately labeled and stored (R15, R41, R294, R297) in 3 of 5 medication carts reviewed for labeling and storage, resulting in the potential for decreased medication efficacy and adverse side effects. Findings include: On 4/4/24 at 7:56 AM, Two East Medication cart was reviewed in the presence of Licensed Practical Nurse (LPN) R. During the medication pass, two undated inhalers were observed after LPN R administered the inhalers. The name on the outside of the box reflected R297's name with no open date on the boxes or the actual inhalers themselves. LPN R confirmed the absence of opened dates on the inhalers and stated that the inhalers should have been dated when opened and was unsure of where the inhaler had come from or when it had been opened. Review of R297's medical record revealed an active order for Anoro Ellipta Inhalation Aerosol Powder 62. 5-25 MCG/ACT and an active order for Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder. On 4/4/24 at 8:56 AM, Two East Medication Cart was reviewed in the presence of LPN O. During the medication pass and review, an Albuterol Inhaler was observed open and undated. The inhaler was noted with label indicating R15's name with no open date indicated. LPN O confirmed that the inhaler was an active medication for R15, acknowledged it was opened and undated, and had no idea when it was opened. Further review of the medication cart revealed an opened and undated Advair Diskus Inhalation Aerosol Powder Breath Activated 500-50 MCG/ACT (Fluticasone-Salmeterol) for R15 and an opened and undated Atropine Sulfate Ophthalmic Solution 0.01 % eyedrops for R41. Review of the Physician Orders reflected that the medications were currently active. On 4/4/24 at 9:47 AM, the One East Medication Cart was reviewed in the presence of LPN X. During the review an opened Fluticasone-Salmeterol inhaler box with a pharmacy label indicating R294's name was noted. No open date was indicated on either the box or inhaler. LPN X confirmed that the inhaler was an active medication and was unsure when the inhaler was opened. Review of R294's medical record revealed an active order for Resident # 294 Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 250-50 MCG/ACT (Fluticasone-Salmeterol. In an interview on 04/10/24 at 11:44 AM, Director of Nursing (DON) B stated that the expectation for labeling medications is to label the box and the actual inhaler or bottle with the open date. If a medication is discovered opened with no opened date, the medication should be discarded and reordered from pharmacy.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on observation, interview and record review, the facility failed to ensure dentures were received timely for one (Resident #68) of one reviewed for dental services. Findings include: Review of the medical record reflected Resident #68 (R68) admitted to the facility on [DATE], with diagnoses that included diabetes, dysphagia (difficulty swallowing) and history of transient ischemic attack (TIA) and cerebral infarction. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/16/24, reflected R68 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The same MDS was coded No in section L (Dental) for, A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose) and F. Mouth or facial pain, discomfort or difficulty with chewing. The admission MDS, with an ARD of 9/14/23, reflected coding of No in section L (Dental) for, A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose). The MDS was coded Yes for, B. No natural teeth or tooth fragment(s) (edentulous). On 04/03/24 at 08:35 AM, R68 was observed in bed. R68 stated he did not have any teeth and was working on getting new dentures before admitting to the facility. R68 reported he had seen the dentist at the facility. He reported difficulty eating due to not having any teeth or dentures. A dental consult note for 9/28/23 reflected, .Edentulous [no teeth] .does not have dentures, unhappy with his chewing ability; oral mucosa appears pink and shiny . A dental consult note for 10/9/23 reflected, .Patient was scheduled to be treated today, but was not treated. Reason: Patient was Not Due for treatment: edentulous . A dental consult note for 10/20/23 reflected, .Patient has no dental concerns .Patient has had dentures made in the past but they didn't fit and could not be worn. He is having trouble chewing and would like to have new ones made. This will benefit his nutrition and general health. Explained to patient that due to having severe ridge resorption adhesive will have to be used. Patient understood. Took preliminary upper and lower impressions for complete dentures . During an interview on 04/04/24 at 01:21 PM, Unit Manager (UM) G reported being responsible for the facility's ancillary services, including dental services. UM G reported she sent the dental group several emails about R68. He was being seen every time the dental group came to the facility, which was about every two to three months, per her report. UM G reported it looked like R68 signed the consent for dentures on 10/20/23. She reported R68 was seen by the dentist on 2/1/24, but nothing was noted about dentures. UM G stated she could send a message to the dental group to inquire. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/05/24 at 11:13 AM, UM G reported she had contacted the facility's dental group, and was informed they had not started R68's dentures. UM G was told the process for new dentures was started through someone else, and the facility's dental provider could not start a new process for dentures until the old one was discontinued. UM G stated the facility's dental provider reported they would be looking into how to get the old group to discontinue that process so they could start it. UM G reported the facility's dental provider group had never conveyed to the facility that R68 was in the process of getting dentures with another dental group.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on interview and record review, the facility failed to ensure nutritionally adequate meals were served in accordance with dietary preferences, provided a repetitive breakfast menu, and failed to provide requested dietary items for one (Resident #287) of three reviewed and 10 of 13 residents that attended the Resident Council meeting, resulting in food preferences not being honored and the potential for unmet nutritional needs. Findings include: Resident #287 (R287) Review of the Admission Record reflected R287 was admitted to the facility on [DATE] with diagnosis which included dependence on renal dialysis, end stage renal disease, heart failure, generalized anxiety disorder, type one diabetes mellitus, acquired absence of right leg below the knee, and muscle weakness. A Social Services Note dated 3/28/23 at 4:55 PM reflected R287's Brief Interview for Mental Status (BIMS) was scored 13 out of 15, indicating cognitively intact. R287's Care Plan indicated that he required supervision for assistance for most Activities of Daily Living. In an observation and interview on 04/02/24 at 9:42 AM, R287 was overheard speaking loudly to a staff member. R287 was very displeased with his breakfast and the staff member exited his room with the breakfast tray. After gaining permission to enter his room and talk, R287 was observed sitting on the side of his bed with the bedside table in front of him. R287 was nicely groomed and easily conversant. He reported that he was pissed because I get served garbage every single day. R287 was visibly frustrated and stated that the food has caused him to have severe gastrointestinal issues. He reported that his stomach pains were so severe that he canceled his Dialysis appointment the day prior. R287 went on to describe that the food taste is unacceptable, that the food is cold, his toast is soggy, and that the oatmeal was stiff and lumpy. R287 stated that he has learned to rely on the evening snack to meet his needs, but the snack is insufficient. R287 stated that they will bring him a bag of chips and if he requests more, he is told that there are no more snacks available. He stated that even the staff agrees that the food is unappetizing. He continued to speak in an elevated voice stating again that the food here is bull*hit, and it pisses him off. R287 stated that he has not had a good meal since he was admitted and to make matters worse, for the Easter meal the residents were served a tuna fish sandwich or a hot dog. He stated that no one has come to speak with him about his concerns or gather food preferences despite the fact that he had expressed his concern to multiple staff members. R287 acknowledged that he is a diabetic and a renal dialysis patient, so, nutrition is very important to him. He reported that he enjoys fruits and vegetables and likes to have a sandwich as an evening snack. R287 also stated that someone from dietary will come around room to room with a computer and fill out the resident's menu for three days. R287 stated that despite this, food items will not come as requested. In a follow up interview on 04/10/24 at 9:29 AM, R287 stated that he had had oatmeal for breakfast this morning, however, the oatmeal was lukewarm. R287 questioned why the facility does not provide breakfast meat in the morning. He stated that the breakfast meal is extremely repetitive, mostly consists of scrambled eggs, and that it would be nice to have additional choices such as omelets and overall, a better variety available. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 04/02/24 at 10:01 AM, Dietary Manager Q entered the room to speak with R287. Again, R287 elevated his voice and was visibly upset about the quality of the food. Dietary Manager Q apologized. When queried about the Easter Dinner, Dietary Manager Q acknowledged that she knew about the tuna fish sandwich being served as the Easter Dinner meal and stated that she had heard about it and [supply company] normally sends a holiday menu but unfortunately it did not happen this time. R287 reported to Dietary Manager Q that he loves fruit and salads and would rather consume a salad then whatever meal is being served. Dietary Manager Q stated that she would obtain a food preference form for R287. Dietary Manager Q returned with a plate of assorted fruits and cottage cheese. R287 was very thankful. On 04/02/24 at 10:14 AM, R287 was overheard audibly crying to a staff member about how terrible the food is at the facility and how he would rather go home. In an observation on 04/02/24 at 10:15 AM, the resident refrigerator was located. Inside the refrigerator contained two containers of yogurt, medication pass, and some resident food brought in from the outside. A tour of the unit revealed that there did not appear to be a pantry or a dry storage for snacks. In an interview on 04/02/24 at 10:29 AM, Certified Nursing Assistant T reported that dietary brings a bowl containing snacks in the evening, otherwise, food is not stored on the unit. Review of the Dietary Menu revealed that on 3/31/24, the dinner that was served on Easter consisted of a tuna fish sandwich, three bean salad, peach crisp, sandwich bread, and a garnish described as lettuce and tomato. Further review of the Dietary Menu revealed that for the week three menu rotation, scrambled eggs were served 4 of the 7 days. One of the days offered egg of choice as an option. Only one of the 7 days offered a breakfast meat of some sort in the form of an egg and sausage casserole. Review of the Dietary Menu for week four reflected that the residents were offered scrambled eggs 4 out of 6 days. Two days offered egg of choice. Only one day offered a breakfast meat option in the form of grilled sausage patty. Review of the Nutrition Care Plan reflected an intervention initiated on 3/29/24 which stated honor food preferences as able. Review of a Nutrition Note from the hospitalization prior to admission to the facility dated 3/26/24 reflect that R287 was classified as underweight and had increased metabolic demands due to dialysis and chronic medical conditions but had weight gain as a desired goal and agreed to scheduled snacks. The Dietitian noted that R287 had good meal intake and enjoyed smoothies, cheese, and crackers with his dinner. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/05/24 at 1:09 PM, Registered Dietician (RD) I reported that when a resident first comes in, RD I will talk with them about any intolerance's, allergies, and any religious requirements for food. RD I stated that she works side my side gathering food preferences and the dietary technician will gather information regarding food preferences from the resident. The food preferences are updated in the menu system and added to the tray ticket. When asked if she was able to view R287's tray ticket on her computer, she reported she was able. When asked if R287's tray ticket contained any information regarding food preferences, she reported that it did not. A request for R287's Tray Ticket was fulfilled on 4/10/24 at 10:10 AM which reflected that R287 requested double portions of breakfast meat when meat is served, likes liver, ham, bacon, and meatballs, and dislikes yogurt. 27446 During a confidential resident group interview on 4/03/2024 at 10:21 AM, 10 out of 13 residents stated that someone would come into each of their rooms with a three-day menu and ask them what they wanted for each meal of the menu. The 10 residents stated they would not receive what they ordered of the menu, and the kitchen did not accommodate their likes and dislikes.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review, the facility failed to serve food that was an appetizing temperature and provide a holiday meal for two (Resident #286 and #287) of three reviewed and 10 of 13 residents that attended the Resident Council meeting resulting in food complaints, the potential for unsafe food temperatures, and weight loss. Findings include: During on observation on 04/02/24 at 9:00 AM, the breakfast meal cart was delivered to the first-floor unit. Shortly after arrival, a family member approached the cart and a staff member opened the doors and handed the family member a breakfast tray for Resident #286. The staff member walked away from the cart, leaving the meal cart doors open. The doors on the meal cart were left open for 11 minutes while staff passed trays. In an observation on 04/02/24 at 12:38 PM, upon exit from a resident room the meal cart was observed on the first-floor unit. Staff was passing lunch trays and leaving the doors opened in between tray passes. On 4/2/24 at 12:41 PM, a staff member wearing a hair net approached the meal cart and spoke with staff. Staff closed the doors to the meal cart. Resident #286 (R286) Review of the Admission Record reflected R287 was admitted to the facility on [DATE] with diagnosis which included weakness, overactive bladder, and depression.). The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/22/24, reflected R286's Brief Interview for Mental Status (BIMS) was scored 12 out of 15, indicating cognitively intact. In an observation and interview on 04/02/24 at 3:28 PM, R286 was in his room visiting with a family member. During the screening process, R286 stated that the food is often cold. Family Member P stated that cold food is often a problem, so she tries to make an attempt to approach the meal cart and obtain the tray for R286 as soon as the meal cart arrives at the unit. Family Member P stated that she has reported the concern in the past and the staff will order a new tray to replace the cold food tray which can be a slow process. Resident #287 (R287) Review of the Admission Record reflected R287 was admitted to the facility on [DATE] with diagnosis which included dependence on renal dialysis, end stage renal disease, heart failure, generalized anxiety disorder, type one diabetes mellitus, acquired absence of right leg below the knee, and muscle weakness. A Social Services Note dated 3/28/23 at 4:55 PM reflected R287's Brief Interview for Mental Status (BIMS) was scored 13 out of 15, indicating cognitively intact. (continued on next page)

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Aria Nursing and Rehab	707 Armstrong Lansing, MI 48911

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 04/02/24 at 9:42 AM, R287 was overheard speaking loudly to a staff member. R287 was very displeased with his breakfast and the staff member exited his room with the breakfast tray. After gaining permission to enter his room and talk, R287 was observed sitting on the side of his bed with the bedside table in front of him. R287 was nicely groomed and easily conversant. He reported that he was pissed because I get served garbage every single day. R287 was visibly frustrated and stated that the food had caused him to have severe gastrointestinal issues. He reported that his stomach pains were so severe that he canceled his Dialysis appointment the day prior. R287 went on to describe that the food taste is unacceptable, that the food is cold, his toast is hard, and that the oatmeal was stiff and lumpy. R287 stated that he has not had a good meal since he was admitted and to make matters worse, for the Easter meal the residents were served a tuna fish sandwich or a hot dog. In a follow up interview on 04/10/24 at 9:29 AM, R287 stated that he had had oatmeal for breakfast this morning, however, the oatmeal was lukewarm. In an observation and interview on 04/02/24 at 10:01 AM, Dietary Manager Q entered the room to speak with R287. Again, R287 elevated his voice and was visibly upset about the quality of the food. Dietary Manager Q apologized. When queried about the Easter Dinner, Dietary Manager Q acknowledged that she knew about the tuna fish sandwich being served as the Easter Dinner meal and stated that she had heard about it from other residents and [outside company] normally sends a holiday menu but unfortunately it did not happen this time. Review of the Dietary Menu revealed that on 3/31/24, the dinner that was served on Easter consisted of a tuna fish sandwich, three bean salad, peach crisp, sandwich bread, and a garnish described as lettuce and tomato. 27446 During a confidential resident group meeting on 4/03/202 at 10:21 AM, 10 out of 13 residents stated and all agreed that the breakfast toast was hard, the sausage was half done, and the food was cold for the residents who received their food in their rooms. Twelve out of 13 residents voiced they were very upset with the Easter dinner that was served. The residents stated for Easter lunch they were served hamburger helper, peas and applesauce, and for Easter dinner they were served a tuna sandwich, three bean casserole, a fruit cup, and peace cobbler which tasted terrible. The residents stated that no one asked the resident what they wanted for their Easter meals.

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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. 39083 Based on observation, interview, and record review, the facility failed to store food product safely, maintain plumbing, and practice good hand hygiene, resulting in the potential increased risk of foodborne illness, affecting all residents that consume food from the kitchen. Findings include: On 4/2/24 at 9:00 AM, a tray of non-pasteurized shell eggs, located in the white reach-in cooler next to the cookline, was observed to be stored on a rack over ready-to-eat, individually portioned salad dressing cups. At this time, Dietary Staff DD stated that they were responsible for placing the eggs over the salad dressing cups and that was only their third day working there. Dietary Manager Q proceeded to moving the tray of eggs in the proper location. According to the 2017 FDA Food Code Section 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor . On 4/2/24 at 9:17 AM, the water supply line for the overhead sprayer, located in the dish machine area, was observed to have a slow leak. At this time, water was observed to be accumulating on the floor under the leaking water line. According to the 2017 FDA Food Code Section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; P and (B) Maintained in good repair. On 4/2/24 at 9:25 AM, a box of single-use cups was observed to be stored on the floor in the 2nd floor pantry. At this time, Dietary Manager Q stated that staff must have brought the box up to resupply the cupboard and didn't remove the box to the proper storage area. On 4/2/24 at 9:30 AM, a box of single-use cups was observed to be stored on the floor in the 3rd floor pantry. On 4/3/24 at 10:30 AM, the box of single-use cups remained stored on the floor in the 2nd floor pantry, directly next to a boxed glue rodent trap. According to the 2017 FDA Food Code Section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted. (C) SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored as specified under (A) of this section and shall be kept in the original protective PACKAGE or stored by using other means that afford protection from contamination until used. (D) Items that are kept in closed PACKAGES may be stored less than 15 cm (6 inches) above the floor on dollies, pallets, racks, and skids that are designed as specified under S 4-204. 122. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/3/24 at 12:22 PM, [NAME] CC was observed to be prepping food on the cookline while wearing gloves. [NAME] CC then walked to the dry storage room, opened the door with gloved hands and retrieved a loaf of bread. [NAME] CC then proceeded to used the same gloves to pull bread slices out of the bread bag. At this time, [NAME] CC was queried on if they washed hand and changed gloves during that process and stated, Maybe I didn't, then proceeded to wash hands and change gloves. According to the 2017 FDA Food Code Section 3-304.15 Gloves, Use Limitation. (A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. P .

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review, the facility failed to ensure appropriate infection control practices during medication administration for one (Resident #297) of four reviewed for medication administration, resulting in the potential for cross contamination and the spread of infection. Findings include: Resident #297 (R297) Review of the Electronic Medical Record (EMR) reflected that R297 was admitted to the facility on [DATE], with diagnoses that included chronic obstruction pulmonary disease, congestive heart failure, and muscle weakness. During a medication administration observation on 4/4/24 at 7:56 AM, Licensed Practical Nurse (LPN) R administered two inhalers to R297 in her room. LPN R placed the Anora Ellipta inhaler and the Advair inhaler boxes directly on a tabletop in R297's room and later removed the two inhalers and placed them directly on the bed, without a barrier beneath the inhalers on either observation. After administration, LPN R placed the inhalers back into the boxes and into the medication cart. During an interview on 04/10/24 at 11:44 AM, Director of Nursing (DON) B reported a barrier should have been used beneath the inhalers.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on interview and record review, the facility failed to offer influenza and pneumococcal immunizations per Centers for Disease Control and Prevention (CDC) recommendations for two (Resident #6 and Resident #56) of five reviewed. Findings include: Resident #6 (R6): Review of the medical record reflected R6 admitted to the facility on [DATE], with diagnoses that included cerebrovascular disease, chronic respiratory failure with hypoxia and diabetes. According to the medical record, R6 was his own responsible party and gave consent to receive the influenza vaccination on 12/15/23 and 12/19/23. R6's medical record did not reflect documentation of an influenza vaccination being given for the 2023/2024 influenza season. According to CDC, .Everyone 6 months and older in the United States, with rare exception, should get an influenza (flu) vaccine every season . (https://www.cdc.gov/flu/prevent/flushot.htm) Resident #56 (R56): Review of the medical record reflected R56 was [AGE] years old and admitted to the facility on [DATE], with diagnoses that included alcohol dependence with withdrawal and nicotine dependence (cigarettes). R56's medical record reflected they were their own responsible party and consented to pneumococcal immunization on 2/20/24. R56's medical record did not reflect documentation of pneumococcal immunization being given. Per the CDC PneumoRecs Vax Advisor, the recommendation for R56 was, Give one dose of PCV15 or PCV20. If PCV20 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccinations. The recommended interval between PCV15 and PPSV23 is at least 1 year . During an interview on 04/10/24 at 01:16 PM, Infection Preventionist (IP) K reported using the CDC PneumoRecs Vax Advisor for pneumococcal immunization guidance. IP K reported he would ask the previous IP about the influenza immunization for R6 and the pneumococcal immunization for R56. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/24 at 03:04 PM, IP K reported he spoke with the previous IP, and R6 had three other immunizations since their admission that were spaced apart due to not wanting to administer too close together. IP K reported he was unable to locate documentation that R6 had been given an influenza immunization. IP K stated R56 was under [AGE] years of age, and when he admitted to the facility, it was for wounds. IP K reported it did not look like R56 had any risk factors that would have made him a candidate for early pneumococcal immunization. IP K reported he could consult with the physician to see if he felt the pneumococcal immunization was appropriate (based on R56's risk factors).

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 39083 Based on interview and record review, the facility failed to audit emergency carts, resulting in the potential for emergency carts to be ill-equipped to respond to emergency care, affecting residents on two halls in the facility. Findings include: On 4/2/24 a review of the 2 [NAME] Emergency Cart Checklist, notes that the last date the audit was completed was March 9th, 2024. A review of the 3 [NAME] Emergency Cart Checklist, notes the last date the audit was completed was January 11th, 2024. During an interview on 4/3/24 at approximately 3:30 PM, Director of Nursing B was queried on the emergency cart audits and stated that Nursing is responsible for completing the audit daily and that the Unit Manager is responsible for ensuring the audits are being done. A review of the facility's Emergency Cart Policy, reviewed 01/2023, it notes, . 5. It is the responsibility of nursing to visually verify each Emergency cart daily and document on ER cart audit form that a check has been completed. Checks are completed per audit form by verifying the number on the lock: If any items are not secured (locked) such as backboard, AED, oxygen cylinder nasal cannula tubing and suction machine with tubing they must be check for functioning status. The cart is to be secured at all times with a plastic lock. When the lock/seal is broken, and items are used it is the nurses responsibility to have cart restocked and resealed. 6. Monthly Unit Manager or designee will unlock or break seal and complete an audit of entire Emergency Cart to assure: a. Correct contents, b. Function of oxygen and suction machine c. Cleanliness of cart and contents d. Relock/reseal the cart.

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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. 39083 Based on observation and interview, the facility failed to maintain proper backflow protection, and store equipment in a safe manner, resulting in the potential for contamination of the potable water supply and contamination of care equipment, affecting all 92 residents in the facility. Finding include: On 4/3/24 at 1:25 PM, a hose spigot with the hose attached, located in the laundry room, was observed to not be provided with a backflow protection device (a device commonly used in plumbing to preclude the backflow of contaminants into the potable water supply. At this time, Maintenance Director EE stated they will acquire a backflow device for the hose. On 4/3/24 at 1:31 PM, a large box of single service bowls was observed to be stored on the floor in the Emergency Supply Room. At this time, Maintenance Director EE moved the box off of the floor. On 4/3/24 at 1:35 PM, an exterior hose spigot with the hose attached, located at the back loading bay, was observed to not be provided with a backflow protection device. On 4/3/24 at 2:00 PM, three boxes of gloves and one box of gowns were observed to be stored on the floor in the 2 [NAME] storage room. On 4/3/24 at 2:01 PM, an oxygen canister, located in the 2 [NAME] oxygen room, was observed to not be secured. On 4/3/24 at 2:07 PM, two boxes of gloves and one box of absorbent pads were observed to be stored on the floor in the 2 East storage room. On 4/3/24 at 2:15 PM, one box of gloves was observed to be stored on the floor in the 3 [NAME] storage room. According to the 2018 Michigan Plumbing Code, incorporating the 2018 edition of the International Plumbing Code, Section 608 Protection of Potable Water Supply, 680.1 General. A potable water supply system shall be designed, installed and maintained in such a manner as to prevent contamination from nonpotable liquids, solids or gases being introduced into the potable water supply through cross connections or any other piping connection to the system .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39083 This citation pertains to intake number MI00143255. Based on observation and record review, the facility failed to maintain the pest control program, resulting in pests throughout the building, affecting all 92 residents in the facility. Findings include: During an interview on 4/2/24 at 2:24 PM, Resident #67 stated that they consistently have ants on the floor in their room and uses their wheelchair to run over the ants and squish them. At this time, numerous live and dead ants were observed on the floor nearest to the window. Resident #67 continued to say that the facility has not addressed the ants in their room. On 4/2/24 at 2:29 PM, multiple ants were observed on the floor throughout room [ROOM NUMBER]. On 4/3/24 at 12:18 PM, multiple ants were observed on the floor at the cookline, feeding on food debris. At this time, food debris was observed on the floor at the cookline and under the preparation table across from the cookline. On 4/3/24 at 12:31 PM, an ant was observed on the floor in the 1st floor dining room. On 4/3/24 at 1:35 PM, the door leading to the back loading dock was observed to have a significant gap, greater than the width of a pen, potentially allowing for pest entry. On 4/3/24 at 2:10 PM, mice droppings were observed in room [ROOM NUMBER] on the floor in the corner of the room, on the left side of the window wall. According to the pest management company's Service Inspection Report, dated 2/1/2024, it notes in the open conditions, Condition: Hole in wall - Various holes in the walls that are lager enough to allow insects access to those voids. Please patch as needed. Last Inspected 1/2/2024 . Condition: Spillage on floor - dead insects on the floor in various areas that need to be cleaned up. Last Inspected 1/2/2024.