STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235214	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clawson	535 N Main Clawson, MI 48017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake #'s MI00138924, MI00140828 and MI00142062 Based on observation, interview, and record review, the facility failed to ensure treatment in a dignified manner for two residents (R#'s 257 and R29) of eight residents reviewed for dignity. Findings include: A review of a facility provided policy titled Resident Rights revised 8/2021 was reviewed and read, .4. Respect and dignity. The resident has a right to be treated with respect and dignity . R257 On 2/14/24 at 12:08 PM, R257 was observed sitting in their wheelchair in the hallway. R257 was small in stature and appeared to weigh less than 110 pounds. R257 was dressed in an oversized bariatric hospital gown that exposed their chest and was pulled up on their right leg exposing their right upper thigh to their groin area. At that time, they were asked if they wanted to be dressed and said they would like to but didn't have any clothing. With R257's permission, an observation of their closet revealed a red t-shirt and a pair of gray sweat pants. R257 said those items were not his clothing, but since they admitted with only a sweatshirt and jacket the facility had provided them those items. When asked if they would like to be dressed in the borrowed clothing they indicated they would. On 2/14/24 at 2:05 PM, R257 was observed from the hallway in their room in their wheelchair. R257 was dressed in an oversized sweatshirt and an adult incontinence brief with no pants. At that time, CNA 'T' entered the room and retrieved the finished meal trays. CNA 'T' was not observed to address R257 wearing no pants or assist them with dressing. 48680 R29 On 2/12/24 at 9:53 AM, R29 was observed in their room with the door wide open with a roommate sitting on a towel in the wheelchair located in the middle of the room. R29 did not have on pants, a brief or anything to cover their bottom half. R29 was interviewed to ask how has their care been in the facility and R29 went on to say the workers and residents were rude and had no manners. They said the staff handled them roughly and they needed assistance with activities of daily living. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/24 at 1:13 PM, R29 was observed in their room with no pants, brief or anything covering their bottom half. R29 said that they were waiting to be changed. A record review revealed that R29 was admitted to the facility on [DATE] with diagnoses that included: cognitive communication deficit, muscle weakness and altered mental status with a Brief Interview for Mental Status(BIMs) score of 4/15, indicating cognitive impairment. On 2/12/24 at 1:30 PM, an interview with Certified Nurse Assistant (CNA) GG was held to see if R29 was resistive to care and why the resident still did not have on any clothing. CNA GG said R29 was not resistive to any care and did not know why they were not dressed. On 2/12/24 at 2:00 PM, the Director of Nursing (DON) was interviewed and asked why would a resident not be dressed with pants or brief so late in the day and the DON said all residents should be up and dressed. The DON was asked if R29 was resistive to care because they were still undressed and exposed and the DON indicated R29 was usually cooperative.

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 34208 Based on interview and record review the facility failed to ensure visitation rights for one resident (R601) of one resident reviewed for visitation rights. Findings include: On 4/16/24 at 10:45 AM, a review of R601's closed clinical record was conducted and revealed they were cognitively intact and their own responsible party upon admission to a private room in the facility on 3/27/24 for sub-acute rehabilitation. A review of progress notes was conducted and revealed the following: A nursing note dated 4/7/24 at 10:10 PM, that read, .Resident had a visit from her significant other .Resident significant other was reminded of visiting hours of the facility due to his previous visiting times of coming after midnight and leaving near 4am <sic> .After midnight the nurse reminded the visitor that facility visiting hours resume tomorrow . A nursing note dated 4/9/24 at 11:17 PM, that read, .Resident's boyfriend arrived at facility and was notified that visiting hours were over around 9 p.m. Writer gave him a 10-minute curtsey <sic> visitation and made DON (Director of Nursing)/Administrator aware. Writer and another staff nurse notified visitor it was time to leave .Writer informed visitor if he doesn't leave the facility, police assistance will be utilized . A nursing note dated 4/9/24 at 11:38 PM, that read, .Resident came to nurse's station and appeared to be upset. She started yelling, stating she wants to leave on her own accordance .Resident contacted family-brother and he agreed to pick her up . A nursing note dated 4/10/24 at 12:00 AM that read, Brother arrived to facility and tried to encourage resident to stay a few more days .Resident declined .Resident and family pack <sic> all belongings and brother accompanied resident with belongings out of facility . On 4/16/24 at 11:45 AM an interview was conducted with Unit Manager 'O'. They were asked if the facility had designated visiting hours and said they did not think so, but did not know for sure. On 4/16/24 at 11:55 AM, an interview was conducted with Social Worker 'P'. They were asked if the facility had designated visiting hours and said they thought visiting hours were only until 9 PM, or later if the approved by the Administrator or Director of Nursing. On 4/16/24 at 12:00 PM, an interview was conducted with the facility's Administrator regarding R601's significant other being asked to leave during their visits. The Administrator said R601 had a history of drug abuse and it was believed the significant other was providing R601 with drugs. When asked what led to the facility's suspicion of R601's drug use, the Administrator said, She would act different after he left. They were asked to provide any documentation or evidence of the different behavior and any assessments or documentation from R601's physician regarding the suspicion, however; no additional documentation was provided by the end of the survey. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility provided document titled, Resident Rights revised 2/2024 was conducted and read, .5. Self Determination .d. The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner, that does not impose on the rights of another resident .

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 This citation pertains to intake #MI00138924. Based on interview and record review the facility failed to ensure personal funds were readily accessible for one resident (R11), of one resident reviewed for personal funds resulting in the resident expressing anger and frustration of not having control over their personal funds. Findings include: On 2/13/24 at 10:30 AM during resident council, R11 said there is a problem with their funds since being transferred from a sister facility. R11 said since they transferred they had not received their monthly payment. R11 said the Business Office Manager (BOM) and Administrator had been trying to work on it, and stated, it's held up in the other facility. A record review revealed that R11 was admitted to the facility on [DATE] from a sister facility with a diagnosis of cerebral palsy, brief psychotic disorder and muscle weakness. R11 scored 14/15 on the Brief Interview for Mental Status indicating intact cognition. On 2/14/24 at 9:43 AM, R11 was interviewed about the extent of the funds that were held up. R11 Stated that when transferred from the sister facility the old facility wrote a paper check for 70 dollars and that was all they arrived with beside their personal items. R11 said there had been several conversations with the BOM and all they could tell R11 was they were working on getting the funds to the facility. R11 said if the facility was getting paid, then they should have access to their remaining funds. R11 went on to say that after the facility was paid they should have access to their 60 dollars a month but didn't since their transfer from the other facility. R11 said they wanted access to their money so they could purchase needed and desired items. On 2/14/24 at 10:00 AM, the Administrator was interviewed and asked about resident's personal funds. The Administrator said the BOM handled all financial obligations. They were then asked how residents accessed their funds if the BOM was out of the office and said they would call the BOM and ask them to walk them through the process in order to ensure residents could receive their funds. On 2/14/24 at 10:11 AM, The BOM was interviewed via telephone and asked how often residents or their legal representatives receive statements of personal account activity. The BOM said they were supplied quarterly. The BOM was then asked how residents received money when they were out of the facility, off-hours, or on weekends and said the Activities Director handled it when they were out of the facility and the manager on-call handled it on the weekends. The BOM was then asked about R11 and if they knew what the hold on personal funds for R11 was about. The BOM replied R11 transferred to the facility on [DATE] from another facility and they received their closed account from the transferring facility. They went on to say that around 1/19/24 they received a copy to contest it as they didn't receive the Social Security money for February. The BOM said R11's money was in limbo because R11 transferred facilities. The BOM was asked where the resident funds were and said they did not know. The BOM was not in the facility at the time of the interview and was asked who in the facility could provide any information regarding R11's accounts and statements and said they were the only one with access to that information and would not be returning to the facility until 2/19/24. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/24 at 10:30 AM, the Unit Manager (UM) 'I' was interviewed and asked how residents received funds on the weekends they were on-call, UM 'I' replied that she was not sure how residents got money on the weekend because the BOM is the only one who handles money. On 2/14/24 at 11:12 AM the Activities Director was interviewed and asked how residents accessed their money when the BOM was not available. The Activity Director said they would be the person that that residents could come too for money. The activities director was then asked did she have access to personal funds accounts the activities director stated no she did not the BOM would give her a spread sheet of all the residents with money and she would give money based off that she and she only had a specific limit amount she could give residents per day. No additional information was provided by the exit of survey.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 32568 This citation pertains to intake #MI00142062, MI00139621 Based on observation, interview, and record review, the facility failed to maintain a clean, comfortable, and homelike living environment for 18 residents (R1, R8, R10, R19, R24, R26, R28, R31, R38, R47, R60, R87, R96, R98, R204, R252, R256 and R504) and seven of seven anonymous residents who attended the resident council interview. This had the potential to affect all 99 residents who resided in the facility. Findings include: On 2/12/24 at 8:30 AM until 2/14/24 at approximately 10:00 AM, the hall floor leading to the therapy gym was observed with dried white/yellowish crystallized footprints on the right and left side of the hall. It was unknown what substance would have produced the soiled footprints. It was further noted the hallway had a faint urine odor. On 2/12/24 between 9:43 AM and 9:52 AM, an observation of the second floor unit was conducted. The following was observed: Upon exiting the elevator onto the second floor of the facility, a strong odor of urine was detected. R19's room was observed with a dirty unmopped floor littered with trash. The trash can in the room and bathroom was observed without a trash bag. There were multiple areas on the floor with dried substances of various colors. The rim of the toilet was observed with dried urine and what appeared to be pubic hairs stuck to it. The heating and cooling unit was observed caked with dust, dirt, and debris. R8's room was observed with a dirty unmopped floor, littered with trash and debris, such as dirty disposable gloves. R47's room was observed with a large dried brown substance that extended from behind the headboard to around the side of the bed. R47 was observed taking items in and out of the closet located on R1's side of the room. The inside of the closet was observed littered with food crumbs and multiple empty plastic cups. On 2/12/24 at 10:31 AM and 2/14/24 at 9:23 AM, R504's privacy curtain was noted to be heavily soiled with white, yellow and brownish substances. R504's roommate's curtain was also noted to be heavily soiled on the side that faced R504's bed. On 2/12/24 at 10:41 AM, R252 was in their room seated at the foot of the bed in a chair. They were asked about their stay in the facility and said their bed was very uncomfortable. They said they sank down into the mattress and could feel the springs in their back. They were asked if they let anyone in the facility know about their concern and said they did about a week ago and was told the maintenance department would address it. R252 went on to say if they didn't get a new mattress they were going to have to sleep in the chair. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/12/24 at 11:10 AM, an interview was conducted with R24. R24 reported the facility often ran out of bed sheets, towels, and wash cloths. When they run out, they go without their bed sheets changed and either need to wait to get care or not get cleaned up thoroughly. On 2/12/24 at 3:26 PM, Emergency Medical Service (EMS) personnel were observed transporting R256 to the facility for admission. EMS Staff 'J' was overheard to inform the nurse on the hallway the bed they were preparing to transfer R256 had soiled sheets. It was noted on 2/12/24 (prior to R256's arrival to the facility) the bed had been made and ready to accept a new admission. At that time, Central Supply Staff 'K' arrived to the unit and told EMS staff 'J' they would change the room assignment. Staff 'K' then proceeded to another room with another bed that had a top sheet and a bottom sheet, but no blanket. Staff 'K' was observed to pull back the top sheet and it was observed the bottom sheet had several stains scattered on it. Staff 'K' retrieved another top sheet, bottom sheet and blanket from the linen cart and made the bed. On 2/12/24 at approximately 3:30 PM, an interview was conducted with EMS Staff 'J'. They were asked about the soiled sheets they discovered on the bed and said the bottom sheet appeared to have a, giant urine stain on it. They said they removed the sheets from the bed and put them on the floor near the door to the room. On 2/12/24 at 3:35 PM, the sheets removed from the bed by EMS staff 'J' were observed on the floor in the room. At that time, the bottom sheet was observed to have a large, yellow stain on it. On 2/12/24 at 3:30 PM, Laundry Staff UU was queried regarding the linen supply for the building. Laundry Staff UU stated that the linen supply could sometimes be short. When queried about a back-up supply of linens, Staff UU pointed to 1 covered rack in the laundry room, which had a hand written sign on it with instructions to not remove items from this rack. The rack contained bed linens, but did not have any back-up towels or wash cloths. When queried about more back-up towels/wash cloths, Staff UU stated what was available was in the 4 linen rooms on the floors. On 2/12/24 at 3:45 PM, Central supply staff (CS) K was queried regarding the back-up supply of linens for the facility. CS K revealed a locked office, which contained a back-up supply of new bed linens and towels, which were still in bags and boxes. CS K stated she tried to keep these linens locked up for a back-up supply. When queried about a process for identifying when the active supply was not sufficient, and when to replenish the active supply, CS K was unable to provide an explanation. On 2/12/24 at 3:50 PM, the 4 clean linen rooms on the units were observed, and it was noted that the supply of clean linens was sparse (3 towels, 7 wash cloths, small stack of bed linens, etc.). On 2/13/24 at approximately 9:30 AM, R47's bed was observed without any bed sheets. On 2/13/24 at 9:54 AM, an observation of R19's room revealed his bed sheet was soaked with urine. When queried, CNA 'S' stated, Oh. He must have just did that because I was just in there. R19 was observed pouring his own coffee from around the corner from his room. On 2/13/24 at 10:42 AM, an interview was conducted with a group of residents, including residents who were a part of the resident council. Seven residents attended the interview and were queried about the care and services in the facility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Multiple residents reported their bed sheets were not changed regularly, the facility was short of linens including bed sheets, towels, and washcloths. One resident who wished to remain anonymous stated, My sheets haven't been changed in a very long time. On 2/13/24 at 1:02 PM, R47's bed remained without any bed sheets. On 2/13/24 at 1:52 PM, R47 was observed sleeping on her bed without any bed sheets or blankets. At that time, an interview was conducted with Certified Nursing Assistant (CNA) 'N'. When queried about who was responsible to ensure residents' beds were made with sheets and blankets, CNA 'N' reported the CNAs were responsible and explained clean linens were not always available. CNA 'N' reported there was one staff person who washed the linens. They brought 25 sets of bed sheets up for each side (2 North and 2 South) twice a day. The clean linens were brought to the second floor at 2:00 PM for the day shift and 10:00 PM for the afternoon shift and if they ran out after that, the CNAs had to wait until 2:00 PM the next day. At that time, an observation of the clean linen closet on the 2 North Unit revealed one flat bed sheet and two pillow cases. On 2/13/24 at approximately 2:00 PM, an observation of the shower room at the front of the 2 South hallway was observed. The shower did not have a knob or handle to turn on the water. At that time, an interview was conducted with CNA 'P' who indicated it had been broken for a long time. On 2/13/24 at approximately 2:15 PM, an observation of the second floor dining room was conducted. A resident entered the dining room with two cups. The resident attempted to fill the cups with water from the automatic water dispenser. The water was observed to trickle slowly from machine which resulted in the resident becoming frustrated and not completely filled her cups. On 2/13/24 at 2:29 PM, CNA 'N' was observed using the automatic water dispenser to fill a resident's cup with water. The water was observed tricking out of the machine. It took CNA 'N' approximately five to ten minutes to fill a cup. When queried, CNA 'N' reported the water dispenser had been like that for a long time and expressed frustration with the amount of time it took to get water from it to provide to residents. On 2/13/24 at 2:35 PM, an observation of the shower at the back of the 2 South Unit was conducted. A wooden platform that appeared to be a boarded up bathtub was observed in disrepair with cracks and chipped paint. Multiple hangers and garbage bags were littered on top of the platform. The temperature of the shower room was observed to be cold. Upon running the water in the shower, it took approximately five minutes before the water began to warm up and did not appear to be a comfortable water temperature for shower. On 2/14/24 from 12:05 until 12:30 PM, an observation of rooms for presence of and accuracy of times on clocks was conducted. The following was observed: R38's room did not have a clock. They were asked if they would like a clock and said, Yeah, that would be cool. R87's room did not have a clock. R87 was asked if they would like one and said, It would be nice. They also said they would like some of the lights fixed in their room. They said the lights over bed #2 did not work. At that time, it was confirmed the lights over bed #2 did not work. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R98's room was observed to not contain a clock. They were asked if they would like one and said, I would love a clock. R96's clock in the room presented the time as 1:35, despite the actual time being 12:15 PM. R204's clock in the room presented the time as 2:15, despite the actual time being 12:26 PM. R#'s 60, 31, 28, 10, 26, 47, and 1's rooms did not contain clocks. 34208 On 2/14/24 at 12:03 PM, an interview was conducted with Housekeeper 'R'. They were asked if the facility experienced any issues with housekeeping staff. They said there were issues and, They just let everyone go. They were asked if there were any staff responsible for floor care and said they thought there was floor care staff but they didn't know when they worked. Review of Resident Council Concerns (meeting minutes) and the associated Resident Council Concern Follow-Up Forms from August 2023 to January 2024 revealed the following: August 2023 - .Housekeeping/laundry .Not enough linen .Rooms not being clean . Follow up included, Verbal counsel to laundry staff and housekeeping staff for not doing there <sic> job correctly and redirecting them on there <sic> job duty. September 2023 - .Rooms are not being clean .Floors are not being mopped in the bathroom . Follow up included, Staff meeting were <sic> we discuss what needs to be done in there <sic> 8 hrs (hours). The proper way to clean rooms and what is a proper deep clean. October 2023 - .Not enough linen .Housekeeper not sweeping the floor before mopping the room . Follow up included, .Housekeeping supervisor to meet with Admin (Administrator) to discuss having housekeeper around the clock 3 shift to ensure linens are available for staff .Encourage staff to vent to manager about concerns instead of residents . November 2023 - Housekeeping/Laundry was not addressed at this meeting. December 2023 - .Concerns regarding not being able to get up because the staff is waiting on linen . Resident are stating that staff will (tell) them it's <sic> not any linen (weekends are bad) . Follow up included, Talk to Housekeeping supervisor about the importance of having linen for all shifts so ADLs (activities of daily living) can be done .Talk with staff about there <sic> job duty and responsibility within there <sic> 8 hr (hour) shift. More linen was put out for delivery and weekend staff was ask <sic> to be more prompt when delivering . The Administrator did not sign off on any of the provided Resident Council Concern Follow-Up Forms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/15/24 at 10:34 AM, an interview was conducted with the facility's Administrator regarding the physical environment. They acknowledged concerns with the environment including linens and indicated the quality assurance committee had identified concerns. When asked about systemic failures in the building the Administrator said it was largely attributed to several (different) administrators over the last six months. Review of a facility policy titled, Safe and Homelike Environment, dated 1/11/21, revealed, .the facility will provide a safe, clean, comfortable and homelike environment .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment .The facility will provide and maintain bed linens that are clean and in good condition .Minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to Housekeeping Department . Report any unresolved environmental concerns to the Administrator .

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Mission Point Nsg & Phy Rehab Ctr of Clawson	535 N Main Clawson, MI 48017

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #'s MI00139287, MI00139337, MI00139621, MI00140002, MI00140168, MI00141836, MI00141773, MI00142360, MI00142464, MI00142585, MI00141836, MI00142708, and MI00142709 Based on observation, interview and record review the facility failed to ensure an environment free from abuse for 16 residents (R#'s 6, 10, 19, 30, 35, 36, 49, 50, 60, 67, 74, 83, 86, 92, 303 and 352) of 31 residents reviewed for abuse/neglect/mistreatment. Findings include: R10 On 2/13/24 a facility reported incident (FRI) involving R10 and R86 was reviewed which indicated R10 punched R86 on 1/27/24. On 2/13/24 the medical record for R10 was reviewed and revealed the following: R10 was initially admitted to the facility on [DATE] and had diagnosis of Schizophrenia, seizures, hyperlipidemia, anxiety disorder, unspecified mood disorder, and hypertension. A review of R10's MDS (minimum data set) with an ARD (assessment reference date) of 8/21/23 revealed R10 had a BIMS score (brief interview for mental status) of 12 indicating moderately impaired cognition. R86 On 2/13/24 the medical record for R86 was reviewed and revealed the following: R86 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Anxiety. A review of R86's MDS with an ARD of 10/13/23 revealed R86 had a BIMS score of six indicating severely impaired cognition. A Practitioner progress note dated 1/27/24 revealed the following: chief complaints/ History of present illness: Complaining of injury to the left wrist sustained during his altercation with another resident-apparently got scratched during the course .SKIN .as above- skin abrasion (without any separation of the skin edges) on the left wrist .Assessment and plan Left wrist skin abrasion/-needs cleaned with antiseptic solution and dressed with an antibiotic ointment -Monitor for cellulitis Monitor for behavior changes and separate involved residents . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/24 a review of the facility investigation pertaining to the altercation between R10 and R86 revealed the following: The Administrator interviewed [Nurse F], regarding the incident with [R86] and [R10]. She stated, I was at my med cart and [another resident]came and said [R86] hit R10]. I quickly went to the dining room to see what was going on. When I entered the dining room, [R86] was trying to hit [R10] again because he wanted the book returned to the bookshelf. [Certified Nursing AssistantG]came in the dining room and separated [R86] and [R10]. [R10] sustained a small cut to his face, and I cleaned it with saline. I called the [local] Police Department d/t (due/to) [R86's] aggressive behaviors. The Police Officers came, and they spoke with [R86], and he was calm afterwards. There were no other incidents with the residents The Administrator interviewed [CNA G] regarding the incident with [R86] and [R10] on 1-27-2024. At approximately 4pm on 1-27-2024, I heard a commotion coming from the dining room on the 2nd floor. I hear [Nurse F], the nurse, calling out for me. I enter the dining room and saw [R10] getting up from the chair and [R86] kept screaming, he knocked over the bookshelf And I reply, [R86], that doesn't give you the right to put your hands on him. And when I looked at [R10], I saw blood on his face. I asked [R86] to leave the dining room and he replied, he knocked over the bookshelf. He kept repeating it over and over. As I was talking to [R86], I'm backing him out of the dining room. I was successful in getting him out of the dining room and there were no further incidents . The Administrator interviewed [R86] and asked him was there an issue with you and [R10]. [R86] said, he took the book, and I told him to leave it alone. I asked him, [R86], did you hit [R10] and he said, Yes, I told him to leave the books alone. The Administrator interviewed [R10] and asked what happened with [R86] and he said, he hit me. [R10] continued by stating, I was looking at a book and he wanted to fight me. These aren't his. I asked [R10] if he was he hurt, and he said, Well he hit me. CONCLUSION: Based on chart reviews, staff and resident interviews, it is substantiated that [R86] hit [R10] because [R86] wanted [R10] to leave the books alone . R60 On 2/13/24 a facility reported incident (FRI) involving R60 and R303 was reviewed which indicated R60 fondled R303's breast on 8/24/23. On 2/13/24 the medical record for R60 was reviewed and revealed the following: R60 was initially admitted the facility on 7/15/23 and had diagnose including Dementia and Muscle weakness. R60's MDS (minimum data set) with an ARD (assessment reference date) of 1/21/24 revealed R60 had a BIMS score (brief interview of mental status) of six indicating severely impaired cognition. A behavior note dated 8/24/23 revealed the following: 8/24/2023 .Behavior Notes - Please describe the behavior that was observed & was it distressing to the resident?: Male Resident (R60) who resides on 2 South, fondled breasts of female Resident (R303) while she was in her Geri Chair in the hallway, outside of her room on 2 North .What was happening before the behavior occurred?: Male Resident wandering in hallway in his wheelchair .What non-pharmacological interventions were attempted?: Separated Male Resident immediately, from Female Resident . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R303 On 2/13/24 the medical record for R303 was reviewed and revealed the following: R303 was initially admitted to the facility on [DATE] and had diagnoses including Cerebral infarction and Anoxic brain damage. A review of R303's MDS (minimum data set) with an ARD (assessment reference date) of 10/21/23 revealed R303 had a BIMS score (brief interview of mental status) of zero indicating severely impaired cognition. On 2/13/24 A review of the facility reported investigation pertaining to to R60 fondling R303's breast revealed the following: INCIDENT SUMMARY: On Thursday, August 24, 2023, at approximately 4:15pm resident [R60] was observed touching the breast of resident [R303] by Business Office Manger [BOM L] who was walking down the hallway on the second floor. Both residents were separated immediately. Nurse [Nurse M] was notified, and a skin and pain assessment was completed with no issues identified . A witness statement from BOM L revealed the following: On 8/24/823 I, [BOM L], witnessed [R60] touching [R303]'s breast. She was sitting in a Geri chair in the hallway, fully dressed. He was reaching over touching [R303] breast moving them up and down, in a fluffing manner. When I walked up [R60] stopped. The resident, [another resident in the facility] also told me [R60] was foundling the resident. I informed the aids . On 2/13/24 at approximately 3:40 p.m., BOM L was queried regarding R303's breast being fondled and which resident they witnessed grab R303's breast and they indicated they could not remember but that it was the resident who was transferred to the first floor [R60]. On 2/14/24 at approximately 11:45 a.m., during a conversation with the Administrator, Director of Nursing (DON) and the Corporate Clinical Operations (KK), the DON was queried regarding the altercation between R10 and R86. The DON indicated that R10 is very territorial of the main dining room on the second floor and that R86 had knocked over some books an that upset R10 and R10 punched them. The DON was queried regarding the altercation of R60 grabbing R303's breast in the hallway and they indicated that BOM L witnessed it and that they transferred R60 to the first floor to get them away from R303. 32568 R19 and R36 Review of a FRI submitted to the State Agency revealed on 1/22/24 alleged R19 hit R36 in the stomach. On 2/12/24 at 10:25 AM, R19 was observed lying in bed. R19 appeared disheveled. When queried about any issues he had with other residents in the facility, R19 pointed in the direction of his roommate and reported he did not like that he turned on the air conditioning. When queried about whether he had been in any fights with any other residents in the facility, R19 denied any fights and stated, Do you mean at the other facility?. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/12/24 at 11:36 AM, R36 was observed lying in bed. When queried about any issues he had with other residents in the facility, R36 stated, I was assaulted two times by R19 who was a previous roommate. R36 stated, He (R19) spit on me. He aimed for my face and it landed on my shoulder. Then he punched me in the stomach and rib cage. Another time he punched me in my legs. R36 reported he told the staff about the incidents. Review of R19's clinical record revealed R19 was admitted into the facility on [DATE] with diagnoses that included: schizoaffective disorder. Review of a MDS assessment dated [DATE] revealed R19 had moderately impaired cognition. Review of R36's clinical record revealed R36 was admitted into the facility on [DATE] and was readmitted on [DATE] with diagnoses that included: metabolic encephalopathy. Review of a MDS assessment dated [DATE] revealed R36 had intact cognition and no behaviors. Review of R19's progress notes revealed an IDT (Interdisciplinary Review Note) dated 1/23/24 that noted, Resident reviewed in behavior management for behaviors .Will continue to monitor . There were no documented progress notes prior to 1/23/24 that indicated any behaviors had occurred or what behaviors were monitored. Review of R26's progress notes revealed a Nursing Progress Note dated 1/22/24 that noted, Resident alleged room mate hit him in the stomach. Room mate claims 'he never hit him' .Resident is changing rooms . ' Review of an investigation conducted by the facility into the alleged physical abuse by R19 toward R26 revealed the following: .(R19) .is alert and oriented x (times) 3 .(R36) .is alert and oriented x 4 .On 1/22/24, (R36) reported to (LPN 'Z'), that his roommate (R19) came over to his bed and punched him in his stomach for no reason .Conclusion: .The Social Worker met with (R36) on 1/22/24 and he stated that (R19) hit him and spit on him. (R36) was interviewed again by the Administrator on 1/30/24 and was asked various questions surrounding the allegation and he couldn't answer. He didn't recall anything ever happening (It should be noted that on 2/12/24, three weeks after the alleged incident R36 clearly recalled the incident from 1/22/24) .(R19) was interviewed by the Social Worker on 1/22/24 and he stated he didn't punch him (R36) but he spit on him. The Administrator interviewed him again on 1/30/24 and asked what occurred and why did he punch his roommate in the stomach, and he said (R36) punched him in the eyeball, so he punched him in the stomach. He stated, 'I am too nice to people and then they want to start fights with me .The allegation was substantiated. Review of R19's care plans revealed a care plan revised on 2/12/23 that noted, I have a hx (history) of alleging being hit, and it has been alleged that I have a hx of hitting others . no new interventions to address physical behaviors were initiated until 2/12/24, almost three weeks after the allegation was made and 12 days after the allegation was substantiated by the facility. Review of R36's care plans revealed a care plan revised on 2/12/24 that noted, .I have a hx of alleging being hit, and it has been alleged that I have a hx of hitting others . No additional interventions to address the physical behaviors were initiated until 2/12/24, 13 days after the allegation of physical abuse between R19 and R36 was substantiated by the facility. 41415 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R35 and R92 Review of a Facility Reported Incident (FRI) dated 8/3/23, documented in part . (R35 name) and his roommate (R92 name) had a physical altercation . heard screaming coming out of the room of (room number) . walked the hall and seen (R35 name) hitting (R92 name) in the head several times with a brush and (R92 name) was grabbing (R35 name) by the shirt and trying to hit him with a plastic fork . the incident report documented that R35 was petitioned out to the hospital due to this incident and would be moved to another room upon their return to the facility. This incident was observed by one of the facility CNA's (certified nursing assistant). The resident-to-resident abuse incident was substantiated by the facility's Administrator. Review of the medical record documented R35 was admitted to the facility on [DATE], with a readmitted [DATE] and diagnoses that included: dementia, violent behavior, bipolar disorder, schizophrenia, and anxiety disorder. Review of the medical record revealed R92 was admitted to the facility on [DATE] with a readmitted [DATE] and diagnoses that included: dementia and anxiety disorder. R83 and R50 Review of a FRI submitted to the SA documented in part, . Staff at the facility witnessed (R50 name) shove (R83 name) . Certified Nursing Assistant (CNA Q name) observed (R50 name) shove (R83 name) . At this time the facility cannot substantiate abuse . Review of the statement provide by CNA Q documented in part . (R50 room number) pushed the resident in (R83 room number) against the door on the North side at approx. 3:45 PM . Review of the medical record revealed R83 was admitted to the facility on [DATE] with diagnoses that included: dementia, bipolar disorder, anxiety, and psychotic disorder with delusions. On 2/12/24 at approximately 3:40 PM, R83 was interviewed and asked about the incident and did not respond. Review of the medical record revealed R50 was admitted to the facility on [DATE] with a readmitted [DATE] and diagnoses that included: dementia, adjustment disorder with depressed mood/anxiety, and mood disorder. On 2/12/24 at 10:16 AM, R50 was interviewed and asked if they recalled the incident, the resident was unable to verbalize a response. Although unsubstantiated by the facility, the SA substantiated this allegation of abuse being that it was witnessed by the facility staff. R92 and R74 Review of the medical record revealed R92 was admitted to the facility on [DATE] with a readmitted [DATE] and diagnoses that included: dementia and anxiety disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Nursing note (R92) dated 12/9/23 at 6:37 PM, documented in part . Patient kicked by another resident in the main dining room, patient kicked back. Patient was saying prior to incident, You are all bitches. Police notified, report taken . Review of the medical record documented R74 was admitted to the facility on [DATE], with diagnoses that included: dementia. Review of a Nursing note (R74) dated 12/9/23 at 6:33 PM, documented in part . Patient kicked another resident in the main dining room. Police notified . Residents separated . R74 and R35 Review of a FRI submitted to the SA documented in part, . On 12/15/2023 Housekeeper . observed resident (R35 name) throw a punch at resident (R74 name) after (R74 name) approached (R35 name) for calling him a racial slur. Residents were separated and (R35 name) was sent to the hospital for a Psych evaluation . Police was notified . Review of the medical record documented R35 was admitted to the facility on [DATE], with a readmitted [DATE] and diagnoses that included: dementia, violent behavior, bipolar disorder, schizophrenia, and anxiety disorder. Review of a Behavior Notes (R35) dated 12/15/23 at 1:28 PM, documented in part . Writer was notified that resident (R35) punched resident in room (R74's room number) in the face. Resident hit his assigned CNA (Certified Nursing Assistant) as she was rolling his wheelchair to his room . was taking resident to his room to get him away from the other resident . Were these effective? NO . Resident already received PRN Ativan . Further review of the notes revealed R35 was petitioned to the hospital a few hours later due to their behaviors. Review of the medical record documented R74 was admitted to the facility on [DATE], with diagnoses that included: dementia. R49 and R6 Review of a FRI submitted to the SA documented in part . (R6 name) said that (R49 name) hit him with him <sic> call light . On 2/14/24 at 11:52 AM, R49 was observed lying on their back in bed. When asked about the incident with R6, R49 explained they were once roommates. R49 went on to say that R6 came to their side of the room and turned on the light and hit R49 with their fist. R49 stated I hit him back. R49 stated the staff moved R6 to another room after the incident. R49 stated they felt safe in the facility. On 2/14/24 at 11:55 AM, R6 was observed sitting in the wheelchair in the doorway of their room. When asked, R6 stated the guy in (R49's room number) punched him in the face when they were nicely asking for R49's help. The resident confirmed they were happy with the room change and replied they felt safe in the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/24 at 2:05 PM, the Administrator who also serves as the facility's Abuse Coordinator was interviewed regarding the multiple resident to resident abuse incidents, the Administrator stated they were recently employed with the facility and was not employed with the facility for some of the incidents. The Administrator acknowledged they would be working with their regional staff moving forward to implement better protocols, procedures, and interventions. On 2/14/24 at 2:25 PM, the Social Service Advocate (SSA) D was interviewed regarding the multiple resident to resident abuse incidents documented above, and SSA D acknowledged the concern and stated the facility recently started a behavior management program with hopes to decrease and manage the resident behaviors and resident to resident altercations. No further explanation or documentation was provided by the end of the survey. 49083 R67 and R83 A review of the facility reported incident to the State Agency revealed: .Facility incident report received via online submission on: 1/16/24, 5:26 PM Incident Summary, problem occurred 01/16/2024 at 04:30 PM, a group of residents playing cards reported R83 walked into the dining room and slapped R67. R30 witnessed the incident. On 2/14/24 at 8:10 AM, an interview was conducted with R30 who witnessed the incident. R30 stated, I was playing cards and saw from the other side of the room R83 walked up on R67 and slapped her in the face super hard. R30 further implied that a few moments after the incident Social Services D entered the dining room where the incident occurred and R30 told Social Services Staff D what happened. R30 further said after that incident, R83 was transferred from the second floor to the first floor. On 2/14/24 at 8:44 AM, an interview was conducted with Social Services D, they said R30 flagged her down when she entered the dining area she was informed of R83 walking up to R67 and slapping her in the face. Social Services Staff D further revealed R67 was evaluated and had no physical findings nor recollection of the incident. R83 was transferred from the second floor to the first floor of the facility and no further altercations have occurred. A review of the clinical record revealed R83 admitted to the facility on [DATE] with a diagnoses that included: dementia, bipolar disorder, anxiety, psychotic disorder, and history of traumatic brain injury. A documented Brief Interview for Mental Status (BIMS) score totaled 3 indicating severely impaired cognition. On 2/14/24 at 12:43 PM, R83 was observed on the first level of the facility walking the hallway independently with a steady gait. At that time, an interview was attempted and R83 made eye contact but mumbled speech that could not be understood. A review of the clinical record revealed R67 admitted to the facility on [DATE] with diagnoses that included: of diabetes, adjustment disorder, and anxiety. R67's BIMS score totaled 4 indicating severely impaired cognition. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/24 at 2:09 PM, R67 was observed sitting in their wheelchair in the dining room. An interview was attempted, however R67 did not offer a response regarding the inquiries of the incident. On 2/22/24 at 01:58 PM, Review of the facilities Abuse, Neglect, and Exploitation Policy Implemented: 01/28/2022 Revised: 06/2023 stated: .It is the policy of this facility to provide protections for the health, welfare and rights of each resident . A facility document titled Abuse, Neglect and Exploitation was reviewed and revealed the following: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview and record review, the facility failed to ensure an environment free from physical restraints for one resident, (R70) of one resident reviewed for restraints resulting in the likelihood for physical discomfort and psychosocial distress utilizing the reasonable person concept. R70 was originally admitted on [DATE] from another skilled nursing facility for long term care. R70's admitting diagnoses included: protein calorie malnutrition, dementia, contracture of both knees, history of falls and suicidal ideations. Based on the Minimum Data Set (MDS) assessment dated [DATE], R70 had Brief Interview for Mental Status (BIMS) score of 3/15, indicative of severe cognitive impairment. R70 needed 2-person assistance with their mobility/repositioning in bed, 1-person assist with eating, and 2-person assist for transfers to their Geri (recliner with wheels) chair. R70 was able to answer simple yes/no questions with cues. An initial observation was completed on 2/12/24, at approximately 8:30 AM. R70 was observed lying on their back in their bed, slightly turned on the left side. R70 had their eyes closed, dressed in a facility provided gown. R70 had a low air loss mattress. R70 had two pillows placed length wise stuffed and secured under the fitted mattress cover. The pillows were completely stuffed under the sheet on both sides in such a way only the raised perimeter on both sides of the mattress, were visible. The pillows stuffed under the sheet were approximately two feet in length, placed along the mid trunk/back areas. There was no room in the bed for R70 to move with the pillows secured under the sheet. R70's call light was folded and clipped on to the cord and was hanging behind the headboard of the bed. R70 did not respond to any questions. R70 also had a Geri-chair (recliner chair with wheels) parked inside the closet. A 2nd observation was completed on 2/12/24, at approximately 11:30 AM. R70 was observed in their bed, on their back, slightly leaned over to the left as before. R70 had their eyes closed and they were in the same gown as before. R70 had the pillows on either side secured with the fitted mattress cover as before. A follow up observation was completed later that afternoon, at approximately 1:30 PM. R70 was observed in the same position, on their back, slight turned over to the left with two pillows firmly secured under the fitted mattress cover. The resident was lying in the same position with the pillows, they were not dressed and had their eyes closed. Staff members were observed walking down the hall and attending to R70's roommate's needs during these observations. Two additional observations were completed later that day at approximately 3:15 PM and 4:15 PM. During both observations R70 was observed lying on their bed in the same position, not dressed, with pillows secured on either side. During the observation at 3:15 PM, R70 had their eyes open, and they were attempting to move their right leg in bed and seemed uncomfortable in that position. There was no room in R70's bed to reposition their leg with the pillows secured on both sides. R70 did not respond to any questions. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/24, two follow up observations were completed at approximately 8 AM and 9:30 AM. R70 was observed lying on the bed slightly turned to the right side; not dressed in a gown; with a pillow on either side of the mattress secured under the fitted sheet. At approximately 10:55 AM, R70 was observed on lying on their back, slightly turned to the right side as before. Review of R70's Electronic Medical Record (EMR) revealed a care plan due to fall risk, risk with skin integrity, and mobility due to their diagnoses and comorbidities. R70's Kardex (care card) revealed that R70 needed turning and repositioning during CNA (Certified Nursing Assistant) rounds. R70's EMR did not have orders, consent and/or plan of care to use pillows that were secured on either side of the bed. An interview was completed with CNA T on 2/13/24, at approximately 12 PM. CNA T was assigned to care for R70 during the shift. CNA T was queried on why R70 had these items secured under the sheet on both sides. CAN T reported that those were pillows and they had used that to keep R70 in bed; to prevent them from rolling out of bed. CNA T added they were not allowed to use anything else, so they had used the pillows secured under the sheet. An interview with Unit Manager I on 2/13/24, at approximately 12:30 PM was conducted. Unit Manager I was queried if it was an acceptable practice to secure pillows under fitted sheet in bed and they reported that would be a restraint and that was not acceptable. Unit Manager I was informed of the multiple observations for R70 and how they were positioned during those observations. Unit Manager I reported that R70 was at risk for skin integrity and needed frequent repositioning, staff should not be using secured pillows in bed, and they would follow up. An interview was completed with Director of Nursing (DON) on 2/13/24, at approximately 5:30 PM. The DON was notified on use of pillows secured under the sheet and multiple observations R70 and how they were positioned in bed. When the DON was queried if that was an acceptable practice, they reported it was not acceptable. The DON added that they had many residents transferred from another facility recently and the staff were doing their best. A facility provided document titled Restraint Free Environment with a revision date of 6/23 read in part, Each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. 1. A physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. 2. Physical restraints may include, but are not limited to: a. Applying leg or arm restraints, hand mitts, soft ties, or vests that the resident cannot remove. b. Using bed rails to keep the resident from voluntarily getting out of bed. c. Tucking in a sheet tightly so that the resident cannot get out of bed, or fastening fabric or clothing so that a resident's freedom of movement is restricted. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review the facility failed to ensure allegations of abuse and injuries of unknown origin were reported to the State Agency in a timely manner for four residents (R2, R22, R37 and R44) of 31 residents reviewed for abuse/neglect/mistreatment. Findings include: R2 and R37 On 2/13/24 a facility reported investigation (FRI) was reviewed that as initially reported to the State Agency on 6/21/23 that indicated an allegation that R2 had a resident altercation with R37 on 6/13/23. On 2/13/24 the medical records for R2 and R37 were reviewed and revealed the following: R2 was initially admitted to the facility on [DATE] and had diagnoses including Paranoid schizophrenia and Restlessness and Agitation. R37 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Psychotic disorder with delusions. A review of the facility reported investigation pertaining to the altercation between R37 and R2 that was submitted to the State Agency on 6/21/23 and took place on 6/13/23 revealed the following: Investigation Summary [R2] and [R37 On 6/21/23 at approximately 10:30 a.m. documentation was brought to the attention of [previous Administrator], .that happened on 6/13/23. It was written in the documentation that resident [R2] grabbed [R37's] arm and would not let go .[Nurse W] separated the two and reported to the Director of Nursing (DON). On 6/21/23 Interview/statement of [Nurse W] - [Nurse W] stated, This statement is written in regards to the incident that occurred on June 13, 2023, between two residents [R2] and [R37]. [R2] was observed in the hallway outside of her door yelling at residents and staff. [R2] also used a chair to prevent residents and staff from passing her in the hallway. [R2] was wheeled in front of the 2 south nursing stations for closer observation. [R37], a resident on 2 south was trying to walk pass [R2], when [R2] grabbed [R37's] right wrist. Writer observed this aggressive behavior from [R2]. Writer requested [R2] release [R37]. Writer pleaded with [R2] to release [R37] arm and had to intervene in order for [R2] to release [R37]'s arm. MD (Medical Doctor) notified, DON notified, Administrator called with no answer multiple times. Writer assesses [R37] arm for injuries, none noted at that time. [R37] is grimacing in pain and verbalized ouch, the writer gave her tramadol 50mg (milligrams) for pain. The writer called [R2]'s daughter to help diffuse the situation to no avail, as [R2] did not respond well to her daughter. The writer called MD again. New order to call emergency services for psych evaluation for [R2] due to unsafe behavior towards other residents, staff, and herself. [R2]became combative and aggressive with emergency personnel i.e. police and Ems (emergency medical services) and had to be sedated. DON notified; Administrator called. MD aware as well as responsible parties . Based on the investigation, the facility was able to substantiate that [R2] did grab [R37], .All staff were re-educated on the abuse policy and reporting. The Director of Nursing was given a written warning write up, and education on the reporting of abuse and neglect .When (date and time) did the problem occur? 06/13/2023 at 11:47 PM . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/14/24 at approximately 11:18 a.m., during a conversation with the facility Administrator (Abuse Coordinator), the Administrator was queried when to report and submit allegations and investigations when resident to resident altercations occur in the facility and they indicated that they are required to report to the State Agency within two hours of the facility being made aware of the allegation and the five business days for the complete investigation to be submitted. 41415 R44 On 2/12/24 at 10:24 AM, R44 was observed sitting in the community room with multiple dark colored purple/maroon bruising observed to the top of both hands and both upper/lower arms. Dried blood was observed smeared of the left cheek of the resident. When asked, R44 was unsure of were the bruising or smeared blood came from. Review of the medical record revealed R44 was admitted to the facility initially on 6/29/18 with a readmitted [DATE], that documented diagnoses of dementia. Review of the physician orders revealed no documentation of an anticoagulant (blood thinner) to have been prescribed to the resident, with the exception of an aspirin. Further review of the record revealed no documentation of blood work to have been recently obtained from the resident. Review of a Nurse Practitioner (NP) note dated 8/28/23, documented in part . Skin: No visible rash, wound or abnormal bruising . Review of a Nursing note dated 11/3/23 at 1:07 AM, documented in part . Skin assessment completed upon rounding: Writer observed various bruising with small red rash, bumps and noted scars all over front/back torso, neck and BL (bilateral) arms . Writer notified MD (medical doctor) . gave verbal 1x order for Benadryl 25 mg PO (by mouth) only r/t (related to) itching . Review of the hospice documentation revealed the resident was signed on to hospice services on 1/5/24. Review of a Hospice Progress Note dated 2/5/24 at 12:48 PM, documented in part . Staff nurse says he slid to the floor, due to bed deflating . no injuries noted. Has scattered bruising on skin, but no new concerns at this time . Review of the medical record and care plans revealed no identification of the root cause of R44's scattered bruising. On 2/14/24 at 2:05 PM, the Director of Nursing (DON) and Administrator (who also services as the facility's abuse coordinator) was interviewed and asked about R44's bruising observed to both upper extremities and the DON stated they were unaware of the bruising on R44 and did not know the cause of the bruising. The DON was asked to look into it and to follow back up with the surveyor. The Administrator was then asked if the bruising was reported to the State Agency (SA), the Administrator stated it was not. No further explanation or documentation was received by the end of the survey. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48680 R22 On 2/12/24 at 9:56 AM R22 was observed in their room. R22 was observed with bruising (yellow, green and purplish in color) on the left side of their face, under both eyes and neck. When asked what occurred to their face R22 replied that they did not know and the bruising was painful. Record review revealed R22 was admitted to the facility on [DATE] with the diagnosis of altered mental status, unspecified dementia and unsteadiness on feet. R22 scored 0/15 on a Brief Interview for Mental Status, indicating severely impaired cognition. On 2/12/23 at 3:00 PM, the facility was asked to provide and reports of accidents or incidents R22 was involved in. There were no documents provided that indicated an investigation into the bruising had occurred. On 2/13/23 at 12:17 PM an interview was conducted to with the Administrator and the Corporate Clinical of Operations and they were asked about the facility's protocol for addressing injuries of unknown origin. The administrator replied, they would meet with staff and interview them and if the resident is able, they would also be interviewed. The Corporate Clinical of Operations interjected and said they would report the injury to the state and start the investigation. The Administrator was asked if she was familiar with R22 and said they were not, but on 2/12/24 the Director of Nursing (DON) reported to her R22 had just a little bit of bruising on face under just the left eye. The Administrator was then asked how this bruising occurred, and said she did not know. The Administrator was asked for an investigation but said it was not completed yet. They were then asked if the incident should have been reported to the State Agency and and said it should have. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility provided document titled Abuse, Neglect and Exploitation was reviewed and revealed the following: . VII. Reporting/Response -1. The facility will implement the following: 2. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 3. Assuring that reporters are free from retaliation or reprisal. 4. Post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint. 5. Reporting to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service. 6. Taking necessary actions as a result of the investigation, which may include, but are not limited to, the following: a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences. b. Defining how care provision will be changed and/or improved to protect residents receiving services; c. Training of staff on changes made and demonstration of staff competency after training is implemented; d. Identification of staff responsible for implementation of corrective actions; e. The expected date for implementation; and f. Identification of staff responsible for monitoring the implementation of the plan. 7. The facility will define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI (Quality Assurance Performance Improvement)Committee. a. Refer to the QAPI Coordination in Situations of Abuse, Neglect, and Exploitation Policy. 8. See policy titled, Reporting Suspected Crimes under the Federal Elder Justice Act . No additional information was proved at the exit of the survey.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake #'s MI00139287,MI00141773, and MI00141879, MI00142355. Based on interview, and record review, the facility failed to thoroughly investigate allegations and instances of abuse for nine residents (R#'s 93 86, 83, 352, 35, 50, 74, 92, and 552) of 28 residents reviewed for abuse investigations. Findings include: Multiple intakes were received by the State Agency that alleged abuse. A review of a facility provided policy titled, Abuse, Neglect and Exploitation revised 6/2023 was conducted and read, .V. Investigation. A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; .6. Providing complete and thorough documentation of the investigation . R86 and R93 On 2/12/24 at 4:12 PM, an interview was conducted with R93 in their room. They were asked if they recalled a physical altercation at any point during their stay with R86. They said they did not. On 2/14/24 at 9:30 AM, an interview was conducted with R86 in the second floor dining room. They were asked if they recalled a physical altercation at any point during their stay with R93. R86 denied any physical altercation and said, Me and (R93) are cool. A review of R93's clinical record was conducted and revealed they admitted to the facility on [DATE] with diagnoses that included: Schizoid personality disorder, anxiety disorder, and violent behavior. R93's most recent Minimum Data Set (MDS) assessment indicated R93 had mildly impaired cognition (demonstrated by a Brief Interview for Mental Status Score of 8/15) and was independently ambulatory. A review of R93's progress notes was conducted and revealed the following: An Incident Note entered into the record by Nurse 'X' on 12/25/23 at 8:19 PM that read, Writer was notified that resident was in dining room fighting with another resident. Writer then separated residents and closed dining room. Noted resident has scratches on right outer lip and left nose .Management notified . A late entry progress note for 12/25/23 at 10:13 PM entered into the record by the Director of Nursing (DON) that read, .Resident had an altercation with another resident in the dinning room. Responsible party notified, Physician notified, Administrator notified, DON notified. Immediate intervention implemented: separate resident . A progress note entered into the record from Dr. 'Y' dated 12/26/23 at 6:40 AM that read, .Patient was seen by video conferencing .Complaining of facial injuries-got involved in a fist fight with another resident and both got injured . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R86's clinical record was conducted and revealed they admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included: unspecified dementia psychotic disturbance, psychotic disorder with delusions, and anxiety disorder. R86's most recent MDS assessment indicated they had intact cognition (demonstrated by a Brief Interview for Mental Status score of 13/15) and was independently ambulatory. A review of R86's progress notes was conducted and revealed a note entered into the record by Nurse 'X' on 12/26/24 at 6:34 AM that read, . Writer was notified that resident was physically fighting in the dining room area. Writer observed resident fighting/hitting resident (R93) .Noted small cut to right outer chin area . On 2/13/24 at 2:22 PM, A review of a facility provided investigation folder for the incident between R93 and R86 was reviewed and revealed only a face sheet and a pain assessment for each R86 and R93. The documents provided did not include a summary, or any statements from any residents or staff. 41415 R50 and R83 Review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) on 9/5/23, documented in part . Staff at the facility witnessed (R50 name) shove (R83 name), no injuries reported at this time . (R50 name) when question was asked what occurred, and since he cannot verbalize, he gestured that (R83 name) grabbed him and he pushed her away. At this time the facility cannot substantiate abuse . Review of the medical record revealed R50 was admitted to the facility on [DATE] with a readmitted [DATE] and diagnoses that included: dementia, adjustment disorder with depressed mood/anxiety, and mood disorder. Review of the medical record revealed R83 was admitted to the facility on [DATE] with diagnoses that included: dementia, bipolar disorder, anxiety, and psychotic disorder with delusions. Review of an investigation file provided by the Administrator, contained one statement by the staff that witnessed the incident on 9/5/23, which documented (R50 room number) pushed the resident in (R83 room number) against the door on the North side at approx . 3:45 PM . The file did not contain a statement summary from either resident involved in the incident or an investigation into the root cause of the incident. On 2/12/24 at 10:16 AM, R50 was interviewed and asked if they recalled the incident, the resident was unable to verbalize a response. On 2/12/24 at approximately 3:40 PM, R83 was interviewed and asked about the incident and did not respond. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/24 at 12:27 PM, the Administrator (who also serves as the abuse coordinator) was interviewed and asked about the investigation into the incident that involved R's 50 and 83 on 9/5/23. The Administrator stated they were recently hired at the facility and was not employed with the facility at that time. On 2/14/24 at 2:16 PM, the Social Services Advocate (SSA) D was interviewed and asked about the investigation into the incident on 9/5/23 that involved a resident-to-resident altercation with R's 50 and 83 and SSA D replied they remembered R50 to have pushed R83 but could not recall the investigation into the altercation. No further explanation or documentation was provided by the end of the survey. R35 and R352 Review of an incident summary provided to the SA documented in part, . On Wednesday, October 25, 2023, during resident (R352's name) therapy session he told the physical therapist . that earlier in the day resident (R35's name) hit him . reported the allegation to Nurse (nurse name) . Upon further interview with (R352 name) he stated that he was in the hallway and (R35's name) was passing by in his wheelchair and started yelling and telling him to move and then (R35 name) hit him on his arm . Upon interview of (R35's name) he stated that he did not hit anyone. There were no witnesses to this incident . Review of the medical record documented R35 was admitted to the facility on [DATE], with a readmitted [DATE] and diagnoses that included: dementia, violent behavior, bipolar disorder, schizophrenia, and anxiety disorder. This was the second documented incident regarding a resident-to-resident incident/abuse allegation where R35 was the perpetrator. Review of the medical record documented R352 was admitted to the facility on [DATE] with diagnoses that included: cancer and cognitive communication deficit. Review of an investigation file provided by the Administrator contained one statement from the therapist that documented the resident reported to have been hit three times by R35 and the therapist reported to the nurse. There was no additional documentation contained in the investigation file. No further explanation or documentation was provided by the end of the survey. R92 and R74 Review of the medical record revealed R92 was admitted to the facility on [DATE] with a readmitted [DATE] and diagnoses that included: dementia and anxiety disorder. Review of a Incident Note (from R92's medical record) dated 12/9/23 at 6:37 PM, documented in part . Patient kicked by another resident in the main dining room, patient kicked back. Patient was saying prior to incident, You are all bitches. Police notified, report taken . Residents separated . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an investigation file provided by the Administrator into the incident that occurred on 12/9/23 with R92 and R74, contained the face sheets of both residents, a pain assessment, SSA D follow up note and a staff statement that documented . (R74 name) followed (R92 name) to the window seat after (R92 name) left the table where they were sitting at . There was no additional documentation contained in the investigation file. Review of the medical record documented R74 was admitted to the facility on [DATE], with diagnoses that included: dementia. No further explanation or documentation was provided by the end of the survey. R74 and R35 Review of an FRI submitted to the SA documented the following in part . (R35 name) allegedly struck resident (R74 name) in the dining room . Police notified . (R35 name) was sent to the hospital for a psychologic evaluation . On 12/15/2023 Housekeeper (housekeeper name) observed resident (R35 name) throw a punch at resident (R74 name) after (R74 name) approached (R35 name) for calling him a racial slur. Residents were separated and (R35 name) was sent to the hospital for a Psych evaluation . Review of the medical record documented R35 was admitted to the facility on [DATE], with a readmitted [DATE] and diagnoses that included: dementia, violent behavior, bipolar disorder, schizophrenia, and anxiety disorder. Review of a Behavior Notes dated 12/15/23 at 1:28 PM, documented in part . Writer was notified that resident punched resident in room (R74's room number) in the face. Resident hit his assigned CNA (Certified Nursing Assistant) as she was rolling his wheelchair to his room . was taking resident to his room to get him away from the other resident . Were these effective? NO . Resident already received PRN Ativan . This indicated the interventions the staff implemented were not effective to protect other residents from R35. This was R35's third known resident to resident altercation. Review of the medical record documented R74 was admitted to the facility on [DATE], with diagnoses that included: dementia. Review of a Behavior Notes (R35) dated 12/15/23 at 2:35 PM, documented in part . MD (medical doctor) called writer and said give PRN Haloperidol 5mg tablet until injection does arrive and DO NOT give Ativan . Review of a Nursing note (R35) dated 12/15/23 at 4:19 PM, documented the resident was again petitioned to the hospital for their behaviors. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/24 at approximately 12:35 PM, the Administrator (who also served as the abuse coordinator) was interviewed and asked about the investigations and corrective actions regarding the incidents that involved R's 35 and 352 in October of 2023, the incident that occurred on 12/9/23 with R's 92 & 74 and the incident that occurred on 12/15/23 with R's 35 & 74. The Administrator replied they were recently hired and was not employed with the facility at the time of either incident. When asked, the Administrator acknowledged the concern of the multiple resident to resident abuse incidents and the concern of the facility staff to not have implemented effective corrective actions to protect residents against the ongoing abuse following the supposed investigation of the above documented incidents. No further explanation or documentation was provided for any of the questioned investigations by the end of the survey. 48680 R22 On 2/12/24 at 9:56 AM, R22 was observed in their room with their roommate standing by the bathroom door. R22 was observed with bruises (yellow, green, and purplish in color) on the left side of their face, under both eyes and on their neck when asked what occurred to their face, R22 replied that they did not know what happened and stated that the bruises on their face was painful and hurt. R22 was not cognitively intact to question and interview about the facial bruising. Record review revealed that R22 was admitted to the facility on [DATE] with the diagnosis of altered mental status, unspecified dementia and unsteadiness on feet. With a Brief Interview for Mental Status(BIMs)score of 00. A record review revealed that on 2/8/24 a progress note stated that R22 had bruising to the face and when the nurse that was on duty asked the resident did she fall, R22 could not recall what took place. The progress note also showed that the on duty nurse asked other coworkers did R22 have a fall. On 2/12/23 at 3:00PM, the facility was asked to provide and accidents and incidents that R22 was involved in so the documents the facility provided could be used to identify the injury of unknown origin on R22. There were no documents provided in regard to R22's facial bruising. On 2/13/23 at 12:17 PM, an interview was conducted with the Administrator who is the facilities abuse coordinator, and the Corporate clinical of operations and they were asked What was the facility protocol for injuries of unknown origin, the administrator replied, with an investigation, we would meet with the staff and interview them. If the resident is able to describe what happened we would interview the resident as well. The administrator further replied, sometimes residents do not recall so we don't rely on residents in that case. The Clinical of operations interjected and stated we would report the injury to the state and start the investigation and still report it within two hours. (continued on next page)

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Mission Point Nsg & Phy Rehab Ctr of Clawson	535 N Main Clawson, MI 48017

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The interview continued the administrator was then asked was she familiar with R22 and the administrator stated no but the DON reported too her on 2/12/24 that R22 had just a little bit of bruising on face under just the left eye. The administrator was then asked how this bruising occurred, the administrator stated she did not know where the bruising came from, so the administrator was then asked for a copy of the investigation that they had completed for the injury since it was unknown. The administrator stated she did not have one completed. The administrator was then asked should this have been something that should be reported to the state agency. The administrator stated Yes it should have been reported. No additional information was proved at the exit of the survey. 49083 R552 R552 was admitted to this facility on 12/14/23 with diagnoses that included: quadriplegia (paralysis of all four limbs), sacral wound, anxiety, depression, and malnutrition. The admission and progress note indicated R552 was alert and orientated, and able to make needs known. On 2/14/24 at 4:23 PM, a telephone interview was conducted with R552. R552 said that on 12/30/23 morning care was provided by two Certified Nurse Assistants (CNA) CNA C and CNA B. While being repositioned, R552 claimed that CNA C pulled and yanked his wrist in an upward angle movement towards CNA B who was on the opposite side of the bed which resulted in pain and discomfort to his shoulder. R552 said when he yelled, that hurt both CNAs ignored him and left the room. R552 stated his shoulder remained painful and felt like it was dislocated. R552 said his mother arrived at his bedside a few hours afterwards and was concerned of the alleged mistreatment and the police were notified by calling 911. On 2/15/24 at 3:51 PM, a record review of the filed police report dated 12/30/23, indicated officers were called to the scene for a suspicious circumstance and mistreated by staff. R552 said to police while being repositioned, he was grabbed by his wrist quickly and up and believed he dislocated his shoulder. R552 said he let both staff members know he was hurt, but they ignored him. The filed police report further revealed that the police arranged transportation by ambulance to nearby hospital for further evaluation of the shoulder. On 2/15/24 at 8:30 AM, During a record review of the requested facility documentation of incident, LPN E indicated in handwritten statement .he also stated the CNA pulled his arm and messed up his shoulder . On 2/15/24 at 9:42 AM, an interview was conducted with Social Services D and Corporate H. When queried about the incident related to the shoulder, Social Services D and H had no knowledge of an alleged shoulder injury. As the interview continued, Social Service H stated he did recall the officer mentioned something related to the shoulder but no follow up was investigated.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49272 This citation pertains to intake #'s #MI00139436 Based on interview and record review the facility failed to document an involuntary discharge, notify the ombudsman and allow the resident to stay at the facility through the appeals process for one (R503) of one residents reviewed for involuntary discharge. Findings include: The unanimous complainant alleged that the resident was given an involuntary discharge without an appeal and forced to leave the facility. It should be noted that an attempt was made to contact the resident named in the complaint however the phone number on file in the electronic record for R503 was not in service. On 2/13/24 at 12:13 PM an interview was conducted with social services advocate D. When asked why R503 was issued an involuntary discharge they stated that the resident could care for themselves, was independent, and ultimately no longer met criteria. Additionally Social Services Advocate D stated that there was an incident with another resident (no additional details were provided regarding this incident) and R503 was no longer happy at the facility, attempts were made to set up placement in a group home but R503 agreed to transfer to another long-term care facility the next day. Social Services Advocate D stated that the 30-day notice was given, and the resident was notified of her appeal rights, but the resident did not request an appeal during the time they remained in the facility. Social Services Advocate D reported that the resident did not have any concerns regarding transferring to another facility and R503 was her own responsible party. Social Services Advocate D stated that the resident was served the involuntary discharge notice on the August 15th, someone from the state visited the resident on August 16th and stated that there was a page missing from the document, so a second copy was provided, and the resident was transferred in the early morning hours of August 17th. Social Services Advocate D stated that the administrator that served the resident the involuntary discharge is no longer employed at the facility. This surveyor requested a copy of the signed involuntary discharge form and any documentation to further support the discharge. On 2/13/24 1:05 PM Social Services Advocate D reported that they were unable to locate a copy of the involuntary discharge form that the resident signed. On 2/13/24 at 1:19 PM An interview was conducted with ombudsman SS, they stated that they did not recall receiving notice of an involuntary discharge for the date in question. Ombudsman SS stated that they would check their notes upon their return home and would give an update if possible. On 2/14/24 at 9:08 AM ombudsman SS stated that they were unable to locate any Letters of care delivery change (LOCD) or an involuntary discharge notice for R503. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/24 9:19 AM social services advocate D was queried regarding if R503 was ever provided an LOCD, since social services advocate D previously stated that R503 no longer met criteria to stay in their facility. Social services advocate D reported that R503 was not served an LOCD and stated that the involuntary discharge was served based on behaviors (which contradicted their original claim that the involuntary discharge was based on the resident being independent and no longer meeting criteria). They again stated that they were unable to locate any documentation of the actual involuntary discharge notice form and that they speculated that it may have been shredded once the previous administrator's office was cleaned out upon his exit from the facility. On 2/15/24 at approximately 9:15 AM an interview was conducted with the director of nursing (DON). When asked what knowledge they had on the involuntary discharge of R503, they reported that it occurred prior to the time they started in the DON role however, stated that the missing document should have been scanned into the electronic record and that the facility should be more careful to ensure things are scanned into PCC (Point Click Care, the electronic record used by the facility). Record review revealed an administrative progress note from 8/15/23 at 10:58 AM that stated resident was given the involuntary discharge notice and was tearful, a second administrative note from 8/16/23 at 11:01 AM stated State approached writer and stated social services advocate D told her today she didn't get all pages of involuntary. She was re-given the page for appeal .she at first didn't want to sign it and then she did send over to (name redacted). On 2/14/24 at 9:32 AM a request was sent via email for the facilities policy for involuntary discharge. No policy was received by the end of the survey.

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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** 41415 Based on observations, interviews, and record reviews the facility failed to ensure a comprehensive plan of care was revised and modified to reflect a resident centered and individualized behavior plan of care for one (R57) of ten residents reviewed for accidents/supervision. Findings include: On 2/12/24 at 10:10 AM, R57 was observed in their room sitting on a chair with the overhead bed table in front of them. The resident was facing down to the floor and did not lift their head to make eye contact with the surveyor. A limited interview was conducted at that time. After the interview the resident began to sing loudly as the surveyor exited the room. On 2/13/24 at 10:58 AM, R57 was observed attempting to drop themselves to the floor in the hallway, yelling profanities as three staff members held them up and attempted to deescalate R57's behavior by offering the resident snacks and putting on music for the resident to listen to. Review of the medical record revealed R57 was admitted to the facility on [DATE], with diagnoses that included: Alzheimer's disease, dementia, anxiety disorder, and schizophrenia. Review of an Admission Note dated 12/20/23 at 8:47 PM, documented in part . Resident has dementia and is very confused. Resident was wandering through the hallway and into other resident's rooms. Resident was assisted on to the floor by assigned CNA (Certified Nursing Assistant). Resident refused care, would not allow writer to perform a skin assessment. Resident was yelling and scooting on the floor around the room and hallway . Review of a Nursing note dated 12/24/23 at 7:02 AM, documented in part . appears agitated at this time refusing morning care . Resident combative with staff x2 punching, scratching, kicking. Not easily redirected. Diazepam 2 mg (milligram) administered as ordered . Review of the care plans revealed no implementation of a plan of care that documented interventions to address the resident's behaviors/mood. Review of a Nursing note dated 1/11/24 at 2:52 PM, documented in part . Resident AOx2 (alert and oriented time two) with behavioral issues of hitting boxing pulling TV off wall pulling computer off station throwing it to the floor. Resident is very difficult to redirect, staff unable to care for resident . called to transfer resident to hospital, nurse to notify family of transfer to hospital. Resident sent to hospital via ambulance . Review of a Social Service note (late entry) dated for 1/11/24 at 3 PM, documented in part . Writer was leaving office when she saw two police officers with resident. Resident was in his room, very agitated. Resident was hitting closet doors, and spit on the window. Yelling and using profanity . Resident was calm until EMS (emergency medical services) arrived . Resident was sent out 911. This note was documented by the Social Services Advocate (SSA) D. (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 a care plan titled . COGNITION/BEHAVIOR/CODE/STATUS/DISCHARGE . I have a dx (diagnosis) of Alzheimer's disease and am very forgetful. I have a dx of schizophrenia and anxiety disorder. I do receive psychotropic medications. I am legally blind. I have a hx (history) of hitting/punching staff. Yelling and calling others names . Initiated on 1/11/24 by SSA D. The care plan documented the following interventions, . Administer medications as ordered. Monitor/document for side effects and effectiveness . Analyze key times, places, circumstances, trigger, and what de-escalates behavior and document. Behavior management review per policy . Assess and anticipate my basic needs: food, thirst, toileting needs, comfort level, body positioning, pain etc . Encourage/provide snacks when agitated . Give me as many choices as possible about care and activities . Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed . Provide cues and reminders as needed . Redirect me from others rooms, since I can't see . This care plan and interventions was implemented more than three weeks after the resident admission into the facility. Review of a Social Service note dated 1/16/24 at 2:45 PM, documented in part . Behavior. Writer was leaving office and heard yelling from (room number). Aide and writer went into room (room number of a different resident). Resident from room (R57's room number) was pulling resident's arms, trying to get resident out of (room number). Resident had knocked down (room number of a different resident) resident's tv and messed up bed. Writer redirected resident from (room number of a different resident) back to his room . Review of the care plans revealed no new and/or modified interventions implemented after this incident. Review of Behavior Notes dated 1/17/24 at 6:04 AM documented in part . resident observed ambulating in hallway in and out of rooms yelling wooah undressing taking his brief/clothes off appears agitated . snack offered and accepted. Resident sat and listened to the TV . interventions effective for short periods of time . no PRN (as needed- medications) available . behaviors non harmful . Review of the care plans revealed no new and or modified interventions implemented after this incident. On 2/14/24 at 2:01 PM, the Director of Nursing (DON) was interviewed and asked about the interventions and supervision levels for R57. The DON was not familiar with the interventions for R57, however said they felt the facility had enough staff to handle the behaviors and mood of R57. The DON was read the incidents noted above and was again asked what interventions were implemented to protect R57 from their destructive behaviors and what interventions were implemented to protect other residents from R57's behaviors and the DON did not have a response. On 2/14/24 at 2:29 PM, the SSA D was interviewed and asked what interventions were implemented to protect R57 from their own behaviors as well as protecting other residents from R57's behaviors and SSA D replied that R57 is easily redirected and has never swung on anyone. The behavior incidents noted above was read including the note regarding R57 entering the room of another resident, knocking down their television and pulling at their arms and R57 being combative with staff and SSA D did not have a reply, however stated R57 was admitted from their sister facility and the facility's behavior group recently came to the facility to do an in-service with staff regarding behaviors. The SSA D stated they could not find the in-service to provide to the surveyor for review. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further explanation or documentation was provided by the end of the survey.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #'s MI00142029 and MI00142062 Based on observation, interview and record review the facility failed to ensure appropriate Nursing standards were utilized for two residents (R28 and R38) of two residents reviewed for Medication administration. Findings include: R28 On 12/12/24 the medical record for R28 was reviewed and revealed the following: R28 was initially admitted to the facility on [DATE] and had diagnoses including dementia, adult failure to thrive and encounter for palliative care. A Physicians order with a start date of 11/8/23 revealed the following: Ativan Tablet 1 MG (milligram) (LORazepam) Give 1 tablet by mouth two times a day for anxiety-D/C (discontinued) Date 02/12/2024 1933. A second Physicians order dated 11/22/23 revealed the following: Morphine Sulfate Oral Solution 20 MG/5ML (Morphine Sulfate) *Controlled Drug* Give 0.25 ml (milliliters) by mouth every 2 hours as needed for pain/sob (shortness of breath). A review of R28's comprehensive plan of care revealed the following: I have a terminal prognosis, end of life and receiving care and comfort only with Hospice Services. Date Initiated: 12/12/2023 A review of R28's February 2024 Medication Administration Record revealed R28 only received four doses of their Ativan on 2/3 (0800 dose), 2/4 (0800), 2/6 (0800) and 2/7 (0800). On 2/14/24 at approximately 9:41 a.m., during a conversation with Nurse EE, Nurse EE was queried regarding R28's Ativan and they indicated that it never came from pharmacy because there was no proof of use log for February. Nurse EE indicated that the other Nurses had forgotten to order it. Nurse EE was queried regarding R28's morphine and they indicated they did not have that on the cart either and there was not proof of use log for it and that the pharmacy never received the right order for it. On 2/14/24 at approximately 2:07 p.m., during a conversation with the Director of Nursing (DON) the DON was queried regarding R28's Ativan and Morphine orders. The DON indicated that the pharmacy never received the order for the morphine because it was entered wrong in their EMR (electronic medical record) by the ordering Nurse and that the ordering Nurse had indicated it was a verbal order and not prescriber entered or prescriber written which would send the order to the pharmacy. The DON was queried regarding R28's Ativan that was documented as administered in four days in February 2024 and DON indicated that there was no Ativan for R28 and they had run out in January 2024. The DON was queried how the Nursing staff were documenting that the Ativan was administered and they indicated they did now know because R28 did not have any Ativan in February. 49083 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R38 Review of the clinical record revealed R38 was admitted to the facility in September 2023, and most recently readmitted [DATE] with the diagnoses that included: diabetes, hypertension, dry eye syndrome, alcoholism, and right leg amputation. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) total of 15 indicating intact cognition. On 2/13/24 at 8:56 AM, Licensed Practical Nurse (LPN) AA was observed preparing the morning medication for administration to R38. LPN AA retrieved one vial of Lantus insulin from R38's medication compartment, and it was identified there was no open date for the insulin. LPN AA contacted a physician by phone. LPN AA stated that the physician instructed to use another residents Lantus for R38's dose until the order was refilled. LPN AA said she did not think she could do that and attempted to locate another vial of Lantus within the medication cart and stock room. Upon return, LPN AA indicated there was no Lantus and did not adminiter the medication at that time. LPN AA indicated ordered Flonase (allergy relief nasal spray) and GenTeal ophthalmic solution (eye drops for dry eyes) was not available and would have to be ordered. On 2/13/24 at 12:47, A review of R38 Medication Administration Record (MAR) revealed, ordered Lantus insulin, Flonase nasal spray, and GenTeal eye drops scheduled for 9:00AM, were not administered to the resident. On 2/13/2024, R38 was asked if he was provided with ordered Flonase Allergy spray and GenTeal lubricating eye drops. R38 replied he had not received either of those medications in at least two days. The MAR was reviewed and documentation revealed: Flonase nasal spray administered: 2/11/2024 and 2/12/24 at 9:000AM GenTeal eye drops administered: 2/11/2024 and 2/12/24 at 9:00AM, 1:00 PM, 9:00PM despite the nurse saying it was not available and R 38 stated he had not received. A review of a facility provided document titled Medication Reconciliation revealed the following: the resident's current medication list matches the physician's orders for the purpose of providing the correct medications to the resident at all points throughout his or her stay .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 This citation pertains to intake #'s MI00139621 and MI00142062. Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADLs) showers and baths were provided to one (R18) of five Residents reviewed for ADL care with potential for negative physical, psychosocial outcomes, and loss of dignity for residents who are dependent on staff for assistance. Findings include: R18 was originally admitted to the facility after a hospitalization on [DATE]. R18's admitting diagnoses included heart failure, lymphedema, morbid obesity, spinal stenosis, chronic respiratory failure, adjustment disorder with depressed mood, and osteoarthritis of bilateral knee. Based on a Minimum Data Set (MDS) assessment dated [DATE], R18 had Brief Interview for Mental Status (BIMS) score of 15/15, indicative of intact cognition. An initial observation was completed on 2/12/24 at approximately 9:40 AM. R18 was observed sitting in their wheelchair next to their bed. R18 had a facility provided gown on. R18 had a wide wheelchair, wider than 24 inches (seat width). The room had a strong offensive odor. During this observation an interview with R18 was completed. During the interview R18 reported that they were not getting the care they needed at the facility. When queried further R18 reported that they were not getting the showers and they had one shower a few weeks ago. When queried further, R18 reported that they had to use the shower room next to their room and their wheelchair would not fit through the doorway. R18 continued to explain that they had to park their wheelchair outside the shower room door and had to use a walker to walk from the doorway to the shower chair and they were not comfortable walking that distance with out any assistance. R18 also reported that when they had asked for staff assistance, staff would leave the supplies in the shower room and were not providing any assistance to get to the shower chair from the door and back to the wheelchair after their shower. R18 was queried if they were getting any bed baths and R18 stated No. R18 reported that they were doing the bed baths on their own and they were not able to reach and clean all areas of their body. R18 reported that they were not getting any assistance form the facility staff with their bed baths. A follow up observation was completed on 2/12/24 at approximately 1:25 PM. R18 was sitting up in their wheelchair in the room. R18 was queried if they had refused showers. R18 reported they were not offered the assistance they needed for showers, and they had refused a couple of times because staff were not providing the help they needed. R18 reported that they had requested the staff to provide some privacy, but they did not feel safe to walk with walker from the doorway to shower without any staff assistance. They reported they could walk a few steps with a walker and added that they were in a different room (private room) that had shower because of infection. R18 reported that their wheelchair did not fit through the shower room door in that room; they had to walk only a few steps from the doorway, and they were able to manage the best they could. On 2/13/24, at approximately 12:30 PM, there was a strong offensive odor from R18's area of the room to the hallway outside of the room. R18 was observed in their bed with their eyes closed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R18's Electronic Medical Record (EMR) revealed a Kardex/care card for Certified Nursing Assistants (CNA) that read under the Bathing section, Bathing - I need 1 person assist to bath; Encourage me to take shower in the shower room. If I continue to refuse shower assist me with washing up at bedside or in the bathroom; Shower/Bathing/Bed Bath scheduled - Assist of 1- Tuesdays and Fridays AM. A review of the R18's care plan revealed a care plan dated 10/2/23, that read I need 1 person assist to bath and toileting assist of 1 dated 1/24/24. R18's shower task revealed that R18 had one bed bath (on 1/20/24) and had refused on 1/30/24 and 2/2/24. There was no other documentation on refusal for showers/bed baths on R18's clinical record. An interview with Unit Manager I was completed on 2/13/24, at approximately 12:30 PM. Unit manager I was queried on residents' showers/baths and the facility's documentation process. Unit manager I reported that typically showers were scheduled twice every week and whenever a resident asks for one the staff would try and accommodate it and staff documented on the EMR under shower task. Unit manager I was then queried on R18's showers/bed baths. They reviewed R18's EMR and confirmed that R18 had received one bed bath in 30 days, there were two documented refusals and there was no documentation that indicated R18 was offered assistance with showers/bed baths. Unit manager I was queried about R18's concern with wheelchair not fitting in the shower room doorway; and staff not assisting them to walk from doorway to shower and back. Unit manager reported that R18 refuses at times, but they understood the concern and follow up. An interview was completed with Director of Nursing (DON) on 2/13/24, at approximately 5:20 PM. The DON was queried on the resident showers. The DON reported they were scheduled and offered twice a week and CNA's were documenting on task record on EMR. The DON was queried about R18's shower/bed bath concerns and their bariatric wheelchair not fitting in to shower room doorways and staff not assisting with showers and to walk from doorway to shower/back. They reported that R18 was refusing after they had a room change from a private room to their current room. When queried on difference between the distance that R18 had to walk to get to shower and back to their wheelchair and level of assistance they needed based on record review and resident interview, the DON reported that they did not realize that R18 had to walk farther in the community shower room and would follow up on the concern. A facility policy request on ADL's was sent to the facility administrator via e-mail on 2/13/24 at 11:07 AM. Facility provided an eighteen page document from a nursing manual under the title Personal Hygiene and Bed Making. The contents of the provided document copy were not clear due to quality of print.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to provide an ongoing activities program for five (R32, R47, R86, R93, and R98) of five residents reviewed for activities, seven of seven residents who attended the confidential resident council interview, and six additional residents (R50, R94, R75, R57, R84, R1) resulting in behaviors, expression of boredom, and diminished quality of life. This had the potential to affect all 99 residents who resided in the facility. Findings include: On 2/12/24 between 9:51 AM and 11:22 AM, the following observations were made of the 2 North Unit. R47 wandered aimlessly in the hallway of the unit, into the dining room, and at times walked through the dining room and entered the 2 South Unit which was on the other side of the dining room. R47 rambled nonsensically. R47 grabbed plastic cups from the dining room and disposable gloves and put them in her room. R47 was observed folding clothing on their roommate's bed and getting into their roommate's space. At 10:05 AM, R47 attempted to open the treatment cart located on the unit. At 10:07 AM, R47 dug through the trash behind the nurse's station, removed used disposable gloves, and carried them around. At 10:29 AM, R47 was observed behind the nurse's station without any staff present. At 10:45 AM, R47 touched the clean masks located at the nurse's station. At 10:49 AM, R47 was observed behind the nurses station going through a staff member's purse. At 11:14 AM, R47 was observed behind the nurses station. At 11:22 AM, R47 stood behind her roommate who was in a wheelchair and talked non-stop and nonsensically before she began rearranging the roommate's bed. During that time, a large room (dining and activity room) between the 2 North and 2 South Units was observed with residents seated in the room. A television was on, but no other activities were observed between 9:51 AM and 11:22 AM. No diversional activities were provided to R47 during that time. On 2/12/24 at approximately 3:15 PM, R32 was observed propelling in a wheelchair through the hallway. R32 stopped at the nurse's station and asked the surveyor what there was to do. R32 wheeled to R50's doorway where he was seated in a wheelchair and sat there. At that time, R47 brought an empty food tin from her room and talked non-sensically trying to hand it to various staff and residents. R47 approached the garbage bin attached to the medication cart and began pushing the tin into the overflowing trash that contained dirty napkins, cups, and used gloves. On 2/12/24 at 3:22 PM, R47 wandered aimlessly through the hallway, into the dining room, and behind the nurse's station. R47 repeatedly touched items on the medication cart where Licensed Practical Nurse (LPN) 'F' and Certified Nursing Assistant (CNA) 'N' stood. R47 began singing and dancing near the medication cart. On 2/12/24 at 3:37 PM, 13 residents were observed in the dining room. The television was on and no additional activities were observed. No staff was present in the dining room. On 2/12/24 at 4:20 PM, R32 remained seated in a wheelchair at R50's doorway. At that time, R50 was asked what activities were provided to the residents. R50 indicated there were no activities provided. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	No activities were observed in the dining room. R86 was observed busily moving throughout the dining room, straightening things up, attempting to direct other residents. No staff was present in the dining room. On 2/12/24 at approximately 4:30 PM, R86 and R94 were seated in the dining room with several other residents. When queried about what the residents did for fun at the facility, R86 reported there used to be several activity staff members, but the facility fired them all and now there is only one girl and no more activities. R94 nodded in agreement with R86. Both R86 and R94 said they were bored. R86 said he had to keep an eye on the other residents in the room. On 2/12/24 at 4:49 PM, the Director of Nursing (DON) was asked where to find the Activities Director. The DON reported Activities Director 'O' was not working and would return the following day. At that time, the DON was asked where to find any activities staff. The DON reported Activities Director 'O' was the only staff member in the activities department. When queried about who provided activities for the residents that day, the DON reported nobody provided activities. On 2/13/24 at 8:36 AM, R47 was observed wandering around the hallway. R47 appeared distressed and stated, This is just horrible. I don't even know what to do! R47 touched the food cart and stated, Everything is just all stuffed in here and I don't like it! It's horrible! It's horrible! This just isn't right! On 2/13/24 at 9:56 AM, several residents were observed in the second floor dining room after breakfast. There were no activities provided. R47 was observed folding clothing on her bed and walking in and out of her room talking nonsensically. On 2/13/24 at 10:03 AM, R75 walked into the dining room and stood behind R57 who was asleep in a chair. R75 began loudly expressing expletive language. R86 walked over to R75 and attempted to redirect her from behind R57. R86 explained that R57 was blind and gets really angry which was why he was trying to get R75 to move away from him. There was no staff in the dining room and no activities besides the television. On 2/13/24 at 10:42 AM, a confidential interview was conducted with seven residents, some of whom attend resident council meetings. When queried about what the residents did to occupy their time in the facility, all seven residents indicated there was a significant decrease in activities in the past two and half to three weeks. One resident reported the facility fired everyone and said there was only one activity staff person, which was Activities Director 'O'. The resident explained since that happened, there were less activities, sometimes no activities, nothing in the evening, and nothing on the weekends. They said, I would like to watch a movie and have some popcorn!. Another resident stated, I just want to watch a movie and eat some snacks, like potato chips! We used to do that. A third resident reported just as she started participating in activities they took it all away and expressed disappointment. All seven residents agreed there were no activities on the weekend since the staff was decreased, only a couple activities provided throughout the week, and nothing in the evenings. A review of the facility's activity schedules for January 2024 and February 2024 was conducted and revealed the following: January 2024: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Four of five Mondays had the same scheduled activities (Coffee/Chat at 10:30 AM, Keep It Moving at 11:30 AM, and Grill Cheese at 2:30 PM). Four of five Tuesdays had the same scheduled activities (Coffee/Chat at 10:30 AM, Keep It Moving at 11:30 AM, and Fancy Nails at 2:30 PM). It was noted there were no scheduled activities on 1/23/24. Four of five Wednesdays had the same scheduled activities (Coffee/Chat at 10:30 AM, Keep It Moving at 11:30 AM, and Bingo at 2:30 PM). It was noted there were no scheduled activities on 1/24/24. Four of Four Thursdays had the same scheduled activities (Coffee/Chat at 10:30 AM, Keep It Moving at 11:30 AM, and Movie/Popcorn at 2:30 PM). Friday Activities included three of four Fridays with Coffee/Chat at 10:30 AM, and Keep it Moving at 11:30 AM. It was noted there were no scheduled activities on 1/19/24. The activity schedule further revealed no activities scheduled after 2:30 PM on weekdays. According to the schedule, the only activity offerings for Saturdays and Sundays were Activity Pack and Activity Closet. It was also noted there were no religious/spiritual offerings on the calendar. February 2024: The calendar was noted to haveCoffee/Chat scheduled every weekday at 10:30 AM, Keep It Moving every weekday at 11:30 AM, Grill Cheese at 2:30 PM on Mondays, Fancy Nails at 2:30 PM on Tuesdays, Bingo at 2:30 on Wednesdays, and Movie/Popcorn at 2:30 PM on Thursdays. It was further noted with the exception of 2/11/24, every Saturday and Sunday were scheduled for Activity Pack and Activity Closet. February's calendar did not have and religious/spiritual offerings scheduled. On 2/13/24 at 1:06 PM, multiple residents were wandering the hallway of the 2 North Unit and in the second floor dining room. There were no staff members present in the dining room or on the unit and no activities being provided. R84 approached R1 in the hallway and blocked R1 from entering her room. R47 wandered aimlessly about the unit. R47 pushed R1 in the wheelchair into the corner to face the wall. Several residents were observed in the dining room with no activities other than the television. On 2/13/24 at 1:17 PM, an interview was conducted with CNA 'N'. CNA 'N' reported the residents on the 2 North Unit required a lot of redirection, supervision, and could use more activities. CNA 'N' reported it was very difficult to keep them occupied and there was not enough nursing staff to also provide activities for the residents. On 2/13/24 at 1:18 PM, 10 residents were observed in the dining room. There were no activities other than the television. R47 walked from the 2 North unit through the dining room to the 2 South Unit. A contracted hospice nurse entered the dining room and sat at a table. There were no other staff members in the dining room. R1 and another resident were heard yelling at each other in the hallway. R86 walked swiftly to the hallway and took the other resident by the arm and led her through the dining room and to the 2 North Unit. On 2/13/24 at 2:05 PM, R86 tried to move a resident seated in a wheelchair to another location. The resident began screaming to Let me go! Go away! I'm not going anywhere with you! On 2/13/24 between approximately 1:30 AM and 2:30 PM, no residents were observed in the first floor dining room which is where the receptionist explained activities were conducted (both the first and second floor dining rooms). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/13/24 at 4:53 PM, an interview was conducted with Activities Director 'O' who had been in that position for five years. When queried about who worked with her to provide activities to the 99 residents who resided in the facility, Activities Director 'O' stated, Nobody. Activities Director 'O' explained that up until January 2024, she had a full team of activities staff and the facility discontinued those positions. Activities Director 'O' reported she was responsible for developing and implementing all activities for the program, assessing residents, and updating care plans. Activities Director 'O' reported there were no activities in the evenings or on the weekends and if she was not working that day, there was nobody to do activities with the residents. Activities Director 'O' reported on weekends she left activity packets and the residents had access to the activity closet, but there were no structured activities and nobody to do activities with the residents who stay in their rooms or those who required more direction due to cognition. Activities Director 'O' reported the facility managers attempt to assist with activities at times, but it was not possible to provide a meaningful and ongoing program activities with only one activities staff person. R32 A review of R32's clinical record revealed R32 was admitted into the facility on [DATE] with diagnoses that included: metabolic encephalopathy and Alzheimer's Disease. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R32 had severely impaired cognition. A review of R32's Activities Assessments revealed the last assessment was completed in 2020. Review of R32's Activities Progress Notes revealed the last note was written in 2022. Review of R32's Activities Participation Notes revealed the last note was written in 2021. A review of R32's active care plans revealed a care plan initiated and last revised on 12/12/22 that noted, I am independent in meeting my social and emotional needs .Activities I find enjoyable are some arts/crafts, social gathering and having my nails polish <sic> .Invite me to schedule activities .Provide with activities calendar and notify me of any changes . A second active care plan initiated on 1/18/22 noted, I am dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) cognitive deficits .I enjoy reading magazines, watching TV and 1:1 room visits . R47 A review of R47's clinical record revealed R47 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: dementia and anxiety. Review of a MDS assessment dated [DATE] revealed R47 had severely impaired cognition, other behaviors, and wandered daily. A review of a Recreation assessment dated [DATE] revealed R47 enjoys walking around the unit, in the past enjoyed exercise/sports, music, walking/wheeling outdoors, TV/Movies, Talking/Conversing. A review of R47's care plans revealed the following initiated on 1/2/24: I am dependent on staff in meeting my social and emotional needs. The following interventions were initiated on 1/2/24, I enjoy walking around the units, talking with other residents. A care plan mentioned R47 was an architect. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a Palliative Care Consult progress notes revealed R47 had significant decline in cognitive and functional status in the past few years. R47 held a job in 2019 and began missing work and moved in with her daughter. R47 continued to work at a hardware store until February 2023 where she began doing repetitive things like sorting screws and other objects. When R47 moved in with her daughter she eventually had to move her to a memory care unit because she could not trust that she would not leave the home. R47 moved from the memory care unit to the current facility because they could not handle her there. It was documented R47 walks all day long around the unit .(R47) just walks trying to figure out where to go and how to fix things. It was documented in the note that R47's daughter became tearful because it has to be torture for her mother who has always been highly intellectual to be going through this. 34208 R86 On 2/14/24 at 10:12 AM, a review of R86's clinical record revealed they originally admitted to the facility on [DATE] and most recently readmitted to the facility on [DATE]. R86's diagnoses included unspecified dementia, psychotic disturbance, psychotic disorder with delusions, and anxiety disorder. R86's most recent Brief Interview for Mental Status (BIMS) score was 13/15, indicating intact cognition. A review of their tasks for activities included a task for one-to-one as needed activities, and self-directed activities. A review of the documentation for the two tasks for a 30-day look-back period was conducted and revealed two documented entries, Socializing with others in facility on 1/18/24 and Food Activity on 1/26/24. A review of R86's activity assessments was conducted and revealed one assessment documented on 1/18/24 despite them being originally admitted on [DATE] and readmitted on [DATE]. R86's care plans were reviewed and included a focus dated 1/17/24 that read, I am here for long term care and will be invited to participate in the activity program . R93 On 2/12/24 at 4:12 PM, an interview was conducted with R93 in their room. They were asked about life in the facility including the facility's offering for activities. R93 said they were not aware of any. On 2/13/24 at 2:24 PM, a review of R93's clinical record revealed they admitted on [DATE] with diagnoses that included: Schizoid personality disorder, anxiety disorder, and violent behavior. R93's most recent BIMS score was 8/15, indicating mildly impaired cognition. A review of their tasks for activities included a task for group activities, and one-to-one activities. A review of the documentation for the two tasks for a 30-day look-back period was conducted and revealed four documented entries, Food Activity on 1/23/24, Music on 1/26/24, Resident Council on 1/30/24, and another Food Activity on 2/1/24. A review of 93's activity assessments was conducted and revealed one assessment documented on 6/10/23. R98 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/24 at 9:20 AM, an interview was conducted with R98 about the facility's activity program. R98 said, It's boring here, there's nothing to do. R98 said their son brought them some puzzle books and they watched TV, but said they needed new puzzle books and could only watch so much television. R98 continued to say when they first admitted they went upstairs and participated in an exercise class. They went on to say the facility either doesn't have the exercise activity anymore or, they didn't like me, because they had not been invited back. R98 then said, It gets pretty boring sitting around. On 2/14/24 at 10:51 AM, a review of R98's clinical record was conducted and revealed they admitted to the facility on [DATE] with diagnoses that included: dementia, altered mental status, and chronic obstructive pulmonary disease. R98's most recent BIMS score was 11/15, indicating mildly impaired cognition. A review of their tasks for activities included a task for one-to-one activities, and group activities. A review of the documentation for the two tasks for a 30-day look-back period was conducted and revealed one documented entry for Paper Games/Word Search/[NAME] on 1/18/24, and no documented data for group activities. A review of the facility assessment dated [DATE] was conducted and read, .Ethnic, Cultural, or Religious Factors .Activities. The facility interviews the residents and families of activity preferences and based on their response .Access to Religious Services. The facility offers various religious services including but not limited to: Weekly Bible Study, Weekly Christian Services, Weekly Communion .Resident Preferences .Activities . The Activities Director completes an assessment of resident's likes/dislikes and preferences of leisure activities upon admission and quarterly. Entertainers are brought in for music therapy. The goal is to keep residents engaged and entertained .Services and Care We Offer Based on our Resident's Needs . Recreation Therapy/Activities .Activities are scheduled 7 days a week including AM and PM shifts .Individual and group activities are offered . The Facility Assessment indicated Activities Director 'O' was the only activities staff for the facility and they did not utilize volunteers. On 2/15/24 at 10:34 AM, an interview was conducted with the facility's Administrator. They were asked how many activity staff the facility employed and said they employed only one staff, who was the Activity Director. When asked why only one staff, the Administrator said the corporation recently underwent a, reduction in workforce where they downsized departments, including the activity department. They said only Activity Director 'O' remained and the activity aides were terminated. They were then asked if Activity Director 'O' was capable of providing an ongoing, comprehensive, resident centered activity program based on the needs and interests of the residents and said they thought Activity Director 'O' was capable with help from the other staff. When asked what other staff assisted Activity Director 'O' the Administrator said the Certified Nurse Aides and Department Heads assisted them. The Administrator was asked if Activity Director 'O' worked on the weekends and said they didn't. They were then asked what Activity Pack and Activity Closet were and said they thought it was an area where staff could go get puzzles, cards, or coloring sheets for the residents. They were asked if there were any organized group activities on the weekends and said there were not. Finally, the Administrator was asked about Religious/Spiritual offerings and said they were not aware there were none offered. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a facility policy titled, Activities, implemented 1/1/24, revealed the following: It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being .Activities will be designed with the intent of .create opportunities for each resident to have a meaningful life .promote or enhance physical activity .cognition . emotional health .Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence .Reflect cultural and religious interests of the residents . .Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. These include, but are not limited to, considerations for .Resident who exhibit unusual amounts of energy or walking without purpose .Residents who engage in behaviors not conducive with a therapeutic home like environment .Resident who exhibit behaviors that require a less stimulating environment to discontinue behaviors not welcomed by others .Residents who lack awareness of personal safety .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272 There are two deficient practices. Deficient Practice Statement #1 This citation pertains to intake #'s MI00142170 and MI00142532. Based on interview and record review the facility failed to address a change in condition timely for one resident (R502) of one resident reviewed for a change in condition resulting in a delay of acute care treatment. Findings include: Review of a complaint submitted to the State Agency (SA) allegation of R502's change of condition to not have been timely identified and assessed. The medical record for R502 was reviewed and revealed the following: R502 was initially admitted to the facility on [DATE] with diagnoses that included: anxiety and manic depression. A review of R502's minimum data set (MDS) dated [DATE] revealed R502 had a Brief Interview for Mental Status (BIMS) score of fifteen, indicating R502 had intact cognition. A record review revealed [DATE] a progress note was written by licensed practical nurse (LPN) I that stated Writer reached out to (family member XX) due to concerns of father not being his normal self on phone call yesterday. Writer explained the nature of condition and also notified (family member XX) that resident has been refusing breathing treatment and that is going to effect the time line of (R502's) condition of pneumonia if treatments keep getting refused. Writer also notified (family member XX that he is also getting examined for a UTI as well, due to mental status change. A review of the medical record revealed no documented assessments or tests ordered to rule out a urinary tract infection and no documentation of the physician being notified of the change of condition. On [DATE] at 10:37 AM LPN YY wrote a nursing progress note stating Received call from [NAME] dispatch stating that resident called 911 and asked to check on him. Dispatch stated to call back if emergency services are needed. Entered room and observed (R502) laying in bed with blanket on and no pillow under his head. (R502) was upset stating that he is cold and needs two more blankets on him. Asked (R502) if he is ok and the reason he called 911. He stated that nobody will turn on his heat or give him blankets. Heat turned on and total of three blankets applied. (R502) then began yelling about needing a pillow. Pillow noted near head of bed. Attempted to assist (R502) putting pillow under his head. (R502) yelled at writer stating that his daughter brought him that pillow and he does not want to use that pillow. Assisted (R502) with pillow. Review of the medical record revealed no documentation of the resident to have been assessed or vital signs obtained. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] Physician assistant (PA) WW entered a late entry progress note dated for [DATE] but entered on [DATE] which stated in part .seen for f/u (follow up) bronchitis, completed ABT (antibiotic), no fever, no hypoxia, (blood pressure) ,d+[DATE], (heart rate) 65 (beats per minute), (respiratory rate) 15 (per minute), (temperature) 98.6 (degrees), (oxygen saturation) 95% on room air, awake .lung CTA (clear to auscultation), no wheezing . awake, oriented x2, bronchitis-resolved on exam, no further abt (antibiotic), Robitussin as needed for cough . R502 was transferred from the facility on [DATE] and expired on [DATE], PA WW documented this late entry the day after R502's death on [DATE]. Multiple attempts were made to contact PA WW ([DATE] at 2:18 PM, 4:16 PM), and was unsuccessful. On [DATE] at 7:30 PM, a late entry nursing progress note was entered by LPN E which stated Writer and oncoming shift nurse assessed resident. Resident was belching, no sputum or vomit was produced. Resident declined all 3 meals for the day. Resident was set up for tele visit with dr. Dr immediately ordered patient to be transported to hospital due to resident not at normal baseline. Resident had two emt (Emergency Medical Technicians) techs transported to (outside hospital) due to change in condition. On [DATE] at 7:47 PM Physician Y entered a physician note that stated in part patient was seen via video conferencing-with help of the nurse on duty .reported as having mental status change, becoming very delirious and agitated, no fever, review of systems, has had a persistent cough, no shortness of breath but has had a cough .appears very delirious-randomly agitated speaking loud, vital signs stable-reviewed, no audible rhonchi or wheezing .alert oriented x ?? .altered mental status/delirium/encephalopathy from an underlying focus of infection-? UTI verses other source-most likely he'll benefit by being evaluated on urgent basis in the ER. On [DATE] at 1:44 PM an interview was conducted with LPN I (the nurse that initially documented the change of condition on [DATE]), when asked what they remembered about a conversation with R502's family member regarding the change in condition they reported, they did recall the conversation and that the staff had been trying to obtain a urine sample to rule out a urinary tract infection for a few days but the resident had been refusing, LPN I further stated that she recalled R502's voice changing and that he was speaking in a high pitched voice and had been refusing his antibiotics and breathing treatments that were ordered for pneumonia. When asked how she proceeded after the family member alerted her to a change in condition, LPN I reported that she thought she let the doctor know LPN I was unsure if she spoke to the doctor before or after her call with R502's family member. When asked if there was any increased monitoring done due to the change in condition LPN I stated that were not aware of any. When asked if increased monitoring would normally take place with a change in condition present (alerted mental status change) and suspected pneumonia and/or urinary tract infection she stated it would depend on the doctor and the patient. When asked about not having an order to obtain an urine sample for an urinalysis LPN I stated that she assumed there was an order. Lastly LPN I stated that the resident had been sick for awhile and would have gotten better if he hadn't refused treatment and that R502 was a difficult patient. On [DATE] at 4:25 PM images of R502's death certificate was provided by family member I Death certificate listed pneumonia and hypoxia as the cause of death. On [DATE] at approximately 9:10 AM an interview was conducted via telephone with the DON. The DON stated that a change in condition should be reported to the physician as soon as possible and further reported not being aware of any concerns related to R502. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R502's vital signs revealed no documented vital signs (temperature, heart rate, blood pressure, oxygen level, respiratory rate) from [DATE] through [DATE]. Vital signs were recorded on [DATE], the date of his transfer to the hospital. A copy of the facilities change of condition policy was requested via email on [DATE] at 8:17 AM and the policy was not received prior to the end of the survey. 34208 Deficient Practice #2 This citation pertains to intake #'s MI00142029 and MI00142062. Based on interview and record review, the facility failed to ensure diabetic management and accurately ordering and administering medications after discharge from the hospital for one resident (R#254) of one resident reviewed for diabetic management and appropriate medication administration. Findings include: Complaints received by the State Agency alleged medications were not administered appropriately. On [DATE] at 10:09 AM, an interview was conducted with R254. They said they admitted to the facility on [DATE]. They were asked about their stay in the building and said the facility had not been administering their insulin correctly. When asked how it was administered, R254 said they were supposed to receive eight units of insulin as well as additional units per sliding scale but the facility had not been administering the eight units and had only been giving them the sliding scale dose. R254 said their sugars had been running in the 200's because they were not receiving the correct dosage. On [DATE] at 4:29 PM, A review of R254's clinical record was conducted and revealed they admitted on [DATE] from the hospital. R254's diagnoses included type one diabetes. R254's hospital discharge medication list was reviewed and revealed they were supposed to receive eight units of insulin as well as additional units per sliding scale before meals. R254's current orders at the facility were reviewed and revealed only an order to administer insulin per sliding scale, and did not indicate they were supposed to receive the additional eight units. On [DATE] at 10:30 AM an interview was conducted with Nurse 'VV' they were asked what R254's insulin orders were and confirmed they had an order to only administer insulin before meals per sliding scale. On [DATE] at 11:10 AM, an interview was conducted with the facility's Director of Nursing (DON). They were asked to compare R254's discharge insulin order and the current order at the facility and confirmed the facility order was incorrect based on the discharge order. A review of a facility provided policy titled, Diabetic Management: Hyper/Hypoglycemic Events revised , d+[DATE] was conducted and read, Policy: Residents with diabetes mellitus will be monitored and treated for hypoglycemia and/or hyperglycemia according to Clinical Practice Guidelines and per physician orders .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to intake #'s MI00139089, MI00140275, MI00142584 Based on observation, interview, and record review, the facility failed to provide adequate supervision for six (R37, R47, R84, R86, R302, and R505) of 11 residents reviewed for accidents, four of seven residents who wished to remain anonymous who attended the resident council group interview, and one (R1) additional resident, resulting in resident to resident altercations and negative interactions, falls, poor infection control, residents feeling unsafe, invasion of privacy, and wandering into potentially unsafe spaces. Findings include: R47 On 2/12/24 at 9:51 AM, an observation was made of R47 wandering aimlessly in the hallway of the 2 North unit, into the dining room, and at times walked through the dining room and entered the 2 South Unit which was on the other side of the dining room. R47 rambled nonsensically, removed plastic cups from the dining room and disposable gloves and placed them in her room. R47 was observed folding clothing on their roommate's bed, removing the roommate's clothing from the closet, and standing in their roommate's space. At 10:05 AM, R47 attempted to open the treatment cart located on the unit. At 10:07 AM, R47 dug through the trash behind the nurse's station, removed used disposable gloves, carried them around, and proceeded to continue to touch their roommate's belonging and furniture. At 10:29 AM, R47 was observed behind the nurse's station without any staff present. At 10:45 AM, R47 touched the clean masks located at the nurse's station. At 10:49 AM, R47 was observed behind the nurses station going through a staff member's purse. At 11:14 AM, R47 was observed behind the nurses station. At 11:22 AM, R47 stood behind her roommate who was in a wheelchair and talked non-stop and nonsensically before she began rearranging the roommate's bed. R47 was not redirected by staff during any of the above situations. On 2/12/24 at approximately 3:15 PM, R47 brought an empty food tin from her room and talked non sensically. R47 attempted to hand the tin to Certified Nursing Assistant (CNA) 'N' and Licensed Practical Nurse (LPN) 'F', as well as other residents who appeared irritated. R47 approached the garbage bin attached to the medication cart and began pushing the tin into the overflowing trash that contained dirty napkins, cups, and used gloves. R47 was not redirected by staff. On 2/12/24 at 3:22 PM, CNA 'N' was observed leaning on the medication cart, adjusting her false eyelashes, and talking to LPN 'F' who was preparing medications at the cart. R47 wandered aimlessly through the hallway and repeatedly walked behind the nurse's station. CNA 'N' and LPN 'F' did not redirect R47 from behind the nurse's station. R47 walked over to the medication cart and touched items on the medication cart, including the water pitcher and the pill crushing device. No redirection was provided. On 2/13/24 at 8:36 AM, R47 was observed wandering around the hallway. R47 appeared distressed and stated, This is just horrible. I don't even know what to do! R47 opened the food cart and stated, Everything is just all stuffed in here and I don't like it! It's horrible! It's horrible! This just isn't right! No redirection was provided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/24 at 1:06 PM, there were no staff members visible anywhere on the 2 North Unit. Multiple residents were wandering the hallways. A treatment cart was used to block the entrance to the nurses station. R47 pushed R1, who was seated in a wheelchair, into a cubby area where a scale was stored and left R1 in the cubby facing the wall. R1 was able to get herself out from the cubby area and wheeled back into the hallway. On 2/13/24 at 1:17 PM, an interview was conducted with CNA 'N'. CNA 'N' reported the residents on the 2 North Unit required a lot of redirection, supervision, and most of them had cognitive impairment. When queried about R47, CNA 'N' reported it was very difficult to keep her occupied and that she was constantly on the move and required a lot of supervision. A review of R47's clinical record revealed R47 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: dementia and anxiety. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R47 had severely impaired cognition, other behaviors, and wandered daily. A review of R47's progress notes revealed the following: On 7/13/23, 7/26/23, and 7/27/23 it was documented in Nursing Progress Notes that R47 wandered throughout the unit, in and out of other residents' rooms, picked up items from the medication cart and put them in her pockets, went behind the nurse's station. On 7/28/23, it was documented in a Nursing Progress Note that R47 fell and sustained a head gash that required 911 transport to the hospital. On 8/5/23, it was documented in a Nursing Progress Note that R47 and her roommate were observed yelling in each others' faces. On 8/22/23, it was documented in a Social Services Note that R47 went through her roommate's belongings and it upset her roommate. On 8/27/23, it was documented that R47 was anxious, pacing the second floor, wandering in and out of residents' rooms, and dressing and undressing in the hallway. On 9/16/23, it was documented that R47 was constantly entering other resident rooms, going behind nursing station, and obsessively folding clothes. On 12/21/23, it was documented R47 had an unwitnessed fall and sustained a laceration to the right side of her head that was bleeding. R47 was transferred to the hospital and was readmitted with sutures to her right posterior scalp. A review of R47's care plans revealed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan initiated on 10/17/23 that noted, BEAHVIOR <sic>/WANDERING: I wander throughout the building .intrudes into other rooms, delusions, expressions of confusion, fear, wanders, short attention span, excessive motor activity. I walk around the building all day. I walk into other residents' rooms. Interventions included .Ask me where I am trying to go and help me to get there if it is safe for me to do so .Remind me/Help me to toilet .Walk with me (Hold my hand to gently lead me, especially when I have a need for touch that is not related to care) .: A care plan initiated on 12/29/23 that noted, I am at an increased risk for falls r/t (related to) Confusion, wandering . On 2/13/24 10:42 AM, a confidential interview was conducted with a group of residents, some who regularly attend the resident council meetings. When asked about the care and services provided in the facility and if they felt safe, one resident stated, I feel safe as long as I avoid certain residents. When queried about what other residents were doing that made them feel unsafe, the resident stated, They go in your room, dig in your drawers. A second resident said some residents scream all the time. They need better security around here. A third resident reported a resident always tried to hold their hand. A fourth resident reported they had to keep their door closed to avoid other residents from wandering in. 38271 R37 and R84 On 2/12/24 a facility reported incident between R37 and R84 was reviewed which indicated R84 hit R37 on 1/27/24. On 2/13/24 the medical record for R37 was reviewed and revealed the following: R37 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Psychotic disorder with delusions. A review of R37's MDS (minimum data set) with an ARD (assessment reference date) of 11/8/23 revealed R37 had a BIMS (brief interview for mental status) of three indicating severely impaired cognition. A review of R37's comprehensive plan of care revealed the following: Focus-I have potential to demonstrate behaviors r/t (related to) my condition that will present as poor impulse control. My delusions at times will make me see people or things in a different likeness. I have the potential for mood difficulties r/t major depression and anxiety. Date Initiated: 07/14/2021 . The medical record for R84 was reviewed and revealed the following: R84 was admitted to the facility on [DATE] and had diagnoses of polyosteoarthritis, protein-calorie malnutrition, Covid-19, Alzheimers Disease and Atherosclerotic heart disease. A review of R84's MDS with an ARD of 11/23/23 revealed R84 had a BIMS score of three indicating severely impaired cognition. A review of R84's comprehensive plan of care revealed the following: Focus-I have potential to demonstrate physical behaviors (hitting, kicking, resistive to care, biting, slapping, repetitive movements) r/t History of harm to others. I also will pull chair from up under resident while they are sitting in the chair. Date Initiated: 10/20/2023 . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility reported incident between R37 and R84 revealed the following: [Nurse CC], RN Midnight staff, was interviewed by the Administrator and she stated [R84] and [R37] were fine and calm earlier in the shift. At approximately 5:30am, I was at the nurse's station, and I heard someone yell, Stop and I got up to see what was going on. As I walked toward the residents, I heard [R84] saying, she broke into my house, and she has my house keys. Before I could get to the residents, [R84] hit [R37] on the right arm . R302 and R84 On 2/12/24 a facility reported incident was reviewed which indicated R84 wandered into R302's room and hit R302 with a glove box on 9/5/23. On 2/13/24 the medical record for R302 was reviewed and revealed the following: R302 was initially admitted to the facility on [DATE] and discharged on [DATE]. A review of the facility investigation pertaining to the altercation revealed the following: On Tuesday, September 5, 2023, at approximately 7:30pm [CNABB] was walking down the hallway and observed resident [R84] wander into resident [R302] room. [R84] entered the wrong room as her room is directly across from [R302]room and she thought that [R302]was in her bed. [R84] told [R302] to get out of her bed and [R84] repeated get out of my bed. [R84] became frustrated and grabbed an empty glove box sitting next to [R302] bed and hit her with it and started throwing things off her nightstand onto the floor. [CNA BB] intervened and called [Nurse F] to assist and removed [R84] from [R302] room and she was escorted back to her room . Both residents have cognitive impairments and are unable to recall the incident. Staff did conduct 30-minute monitoring for 24 hours and no other issues have occurred. The .Police were contacted as well and families and physicians. Both residents are long-term residents and remain in the facility without further incident and remain at their baseline . R84 and R1 On 2/13/24 at 1:06 PM, R84 approached R1 in the hallway. R84 was on foot and R1 was seated in a wheelchair. R1 stated angrily to R84, You told me to get something and then when I did, it wasn't there! Both R1 and R84 appeared confused. R84 became upset and argumentative with R1. R84 approached R1 in an intimidating way, talking very close to R1's face, stating loudly, Tell me! Tell me what you are talking about! and repeatedly blocked R1 from moving in her wheelchair. At that time, CNA 'N' entered the unit and walked past R84 anf R1 while they were arguing and R84 was blocking R1 from moving in her wheelchair. R1attempted to enter her room and R84 walked inside R1's room and blocked her from entering. R86 On 2/12/24 at approximately 1:05 p.m., R86 was observed in the large dining room on 2nd floor. R86 was observed to be taking the lunch plates from R63 while they were still eating their meal and placing them back in the meal cart. R63 was observed to be yelling out stop. I'm still eating No staff were observed in the room providing any supervision to the residents. On 2/13/24 at 2:05 PM, R86 tried to move a resident seated in a wheelchair in the dining room to another table. The resident began screaming to Let me go! Go away! I'm not going anywhere with you! There was no staff present in the dining room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/24 the medical record for R86 was reviewed and revealed the following: R86 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Anxiety. A review of R86's MDS with an ARD of 10/13/23 revealed R86 had a BIMS score of six indicating severely impaired cognition. A review of R86's comprehensive plan of care revealed the following: Focus-I have potential to demonstrate physical behaviors to staff (hitting, kicking, resistive to care, biting, slapping, repetitive movements r/t Dementia. I think I am in charge the dining room on the second floor and like to control the tv, and what resident's are in there at certain times. Date Initiated: 10/27/2023 .Interventions: Staff to redirect and make sure I am not trying to direct other residents. Date Initiated: 01/21/2024 . On 2/14/24 at approximately 2:40 p.m., during a conversation with Social Services Advocate D (SSA D), SSA D was queried regarding the supervision of residents with Dementia. SSA D indicated that the facility staff are aware of who has cognitive impairments via their careplans and that they should be supervising them appropriately if they have Dementia. SSA D was queried regarding the multiple residents identified with resident to resident altercations and they reported that the staff are aware of resident behaviors and who needs to be watched. 49272 R505 On 2/12/24 at 4:13 PM, R505 was observed wandering in hallway then entering another resident's room. R505 entered room [ROOM NUMBER], walked to the window where they found a Styrofoam drinking cup, removed the straw, put it in their mouth, back in the cup then took a drink. This surveyor notified CNA Q who discarded the Styrofoam cup then proceeded to tidy up residents' room without re-directing R505. At 4:18 PM R505 was observed to remove the mesh/Velcro stop sign/barrier from another resident's doorway. R505 entered the room and was stopped from going any further by another resident. The unknown resident grabbed R505's arm and physically re-directed her back to the hallway. Observations of the hallway lasted 25 minutes and no staff were observed to intervene or re-direct residents during that time. A review of R505's care plan revealed that resident is able to ambulate in the hallways independently with staff to observe and assist when unsteady and to re-direct as needed. On 2/15/24 the director of nursing (DON) was queried regarding R505 not be properly monitored in the hallway. DON said the the resident just came to their facility within the last month and that they need to bump up their staff on the second floor. No explanation was offered for why staff weren't observed in hallway other than not having enough staff for the current resident population.

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F 0692 Level of Harm - Minimal harm or potential for 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** 47283 Based on observation, interview, and record review the facility failed to ensure that resident weights were obtained timely and nutritional interventions by the dietician were implemented timely for two (R70 and R82) of seven residents reviewed for nutrition resulting in the potential for weight loss with decline in nutritional and overall functional status. Findings include: A facility provided document titled Weight Monitoring with a revision date of 1/21 read in part, A comprehensive nutritional assessment will be completed upon admission on residents to identify those at risk for unplanned weight loss/gain or compromised nutritional status. Assessments should include the following information: a. General appearance (e.g., robust, thin, obese, or cachectic) b. Height c. Weight d. Food and fluid intake e. Fluid loss or retention f. Laboratory/Diagnostic Evaluation Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. Interventions will be identified, implemented, monitored, and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards to maintain acceptable parameters of nutritional status. Weight will be obtained upon admission, readmission and weekly for the first four weeks after admission and at least monthly unless ordered by the physician . R70 R70 was originally admitted on [DATE] from another skilled nursing facility for long term care. R70's admitting diagnoses included protein calorie malnutrition, dementia, contracture of both knees and difficulty swallowing. Based on the Minimum Data Set (MDS) assessment dated [DATE], R70 had Brief Interview for Mental Status (BIMS) score of 3/15, indicative of severe cognitive impairment. R70 needed 2-person assistance with their mobility/repositioning in bed, 1-person assist with eating, and 2-person assist for transfers to their Geri (recliner with wheels) chair. R70 was able to answer simple yes/no questions with cues. An observation was completed on 2/13/24 at approximately 9:10 AM. Staff were serving breakfast on 1-South hallway. R70 was observed in their bed lying on their back. CNA T who was assigned to care for the resident, was assisting R70 with their breakfast at approximately 9:30 AM. The breakfast tray had cut up sausages, scrambled eggs with a glass of orange juice. The breakfast tray did not have any other drinks. R70 had a water cup on their bedside table. The tray ticket read, Diet: 5-minced and moist - thin liquids. CNA T reported that R70 needed assistance with their meals, and they usually ate well. At approximately 9:50 AM, CNA T was taking the tray back to the cart and reported that R70 ate 100% of their breakfast. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second observation was completed on 2/14/24, at approximately 9:30 AM. R70 was observed sitting up in their Geri-chair in the therapy room. Therapy Staff member HH (Certified Occupational Therapy Assistant) was working with R70 on improving their eating skills and R70 had their breakfast tray on the table. At approximately 10 AM, an interview was completed with staff member HH. Staff member HH was queried on what was served on R70's breakfast tray. Staff member HH reported that the breakfast tray had mechanical soft meat (minced meat), eggs, a glass of milk and a glass of orange juice and confirmed that there were no other items on the tray. Staff member HH reported R70 ate 100% of their breakfast. It was noted that R70 did not receive the nutritional supplement that was recommend by the Registered Dietitian on 2/12/24 for breakfast on 2/13/24 and on 2/14/24. Based on multiple observations on 2/12/24, 2/13/24 and 2/14/24 throughout the day R70 did not receive any snacks between the meals. Review of R70's Electronic Medical Record (EMR) revealed that R70 had a significant weight loss since admission to this facility on 1/9/24, 7.9 lbs. in 28 days. A review of R70's weight record revealed the following weight data: 2/5/24 at 12:48 113.7 lbs. 1/9/24 at 20:54 121.6 lbs. Further review of R70's EMR revealed that R70 was followed by the physician and dietician related to weight loss. R70 had a public guardian in place, and they were a full code. A progress note dated 2/12/24 at 14:48 by the regional dietician read in part, Resident is triggering for 7.9 lbs. (pounds)weight loss x 1 month. Physician aware of weight change and message left for guardian. General diet with minced and moist textures .Mirtazapine in place which may aid in stimulating appetite. Resident usually accepts supplement. RD recommends adding 4 oz. of health shake with an additional 200 k calories and 6 grams of protein. R70 had a physician visit on 2/6/24 for a palliative care consult and it was pending approval from R70's guardian. R70's intake record revealed that R70 consumed 75-100% percent of their meals on most days. An interview was completed with Regional Registered Dietitian (RD) II on 2/13/24, at approximately 10:50 AM. Regional RD II was queried about the facility's weight process ad they reported that every resident was weighed on admission, and they were weighed weekly for four weeks and then they weighed the residents monthly or more frequently as needed based on the clinical assessment. They also confirmed that all weights were recorded under the weight tab on resident's EMR. The Regional RD II also reported that they assessed and followed up on high-risk residents and the facility's Certified Dietary Manager (CDM) followed up on the rest of the resident assessments. An interview was completed with Unit Manager I on 2/13/24 at approximately 12:30 PM. Unit manager was queried on the not following the facility's weight process for a high-risk resident (R70) with weight loss and not receiving the supplements that were recommended by the RD for breakfast. Unit Manager II reported that they understood the concern and they would follow up with their staff. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Director of Nursing (DON) was completed on 2/13/24 at approximately 5:30 PM. The DON was queried about the why facility's weight process not followed for R70 with no weekly weights, why R70 was not receiving the supplements as recommended timely with recent weight loss. The DON also reported that R70 had weight fluctuations when they were at the other facility and the physician had followed up. The DON reported they understood the concern about the supplement and the weekly weights and that R70 should have received supplements timely as recommended and they would follow up with the team. An interview was completed with the facility Certified Dietary Manager (CDM) JJ on 2/14/24, at approximately 10:25 AM. Certified Dietary Manager JJ was queried on the time frame for residents to get the recommended supplements and explained the facility kept supplements in house and residents should receive it the next day. They were queried on R70's supplements. Certified Dietary Manager JJ reviewed R70's EMR and the facility's tray cart system and confirmed that R70 had an order to receive a supplement for breakfast. When reported that R70 did not receive their supplement, they reported that they would follow up with the facility's Dietary Manager. 49272 R82 Clinical record review for R82, revealed they were admitted on [DATE] and didn't have their weight taken until 6/5/23. R82's next two weights were on 7/3/23 and 8/4/23 (three total weights were documented for first two months of his stay at the facility). A review of the admission note revealed the resident's weight was 140. 1lbs upon admission and weights for 7/3/23 and 8/4/23 were documented as 267 pounds and 263 pounds. This discrepancy was not addressed in the clinical record until 8/16/23. On 8/16/23 R82's weight was documented as 120.0 pounds. CDM JJ documented, Res. admitted from another SNF (skilled nursing facility), weight listed as 140# (pounds) in admit documents, admit weight appears to be inaccurate. Further record review revealed that the resident required 1:1 assistance with meals. A review R82's orders revealed an order dated 1/17/24 for, vital signs and weights monthly and a second order placed on 2/12/24 for weekly weights times 4. No previous weight orders were found. On 2/14/24 at 9:34 AM an interview was conducted with Certified Dietary Manager (CDM) JJ. When asked about the facility's policy for monitoring weights for new admissions they reported their policy is to weigh each resident within 24 hours, maximum of 48 hours, then every week for four weeks and monthly after that. When asked who ensures that the required weights are completed CDM JJ stated the nurses are responsible however she provides oversight approximately twice a week. The timeliness of the weights and the weight discrepancies were shared with CDM JJ and they reported they would follow-up. On 2/14/24 at approximately 11:30 AM CDM JJ followed up and was was unable to explain why the weights were missed but said they discovered the discrepancy in August per their note and confirmed that the resident should currently be getting weighed weekly which was not happening, they offered no explanation as to why. The facilities Weight Monitoring policy stated, Weight should be obtained upon admission, readmission and weekly for the first four weeks after admission and at least monthly unless ordered by the physician.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview, and record review facility failed to appropriately position the resident while administering the enteral tube feeding (liquid nourishment and water administered directly into the stomach through a PEG [Percutaneous Endoscopic Gastrostomy] tube) for one (R4) of two residents reviewed for tube feeding resulting in the potential of aspiration pneumonia, respiratory distress and rehospitalization . Findings include: R4 was admitted to the facility on [DATE] after hospitalization . R4's admitting diagnoses included post-polio syndrome, colitis (inflammation of the colon), malnutrition, Gastro-esophageal Reflux Disease (GERD), and dysphagia (difficulty swallowing). Based on the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7/15, indicative of significant cognitive impairment. An observation was completed on 2/12/24 at approximately 11:15 AM. During this observation R4 was observed in their bed lying on their back with head of bed flat. R4's bed control was observed on the foot end of the bed, not within reach for the resident. R4 was getting their enteral feeding through the PEG tube during the observation. When this surveyor queried how they were doing, R4 reported that they were not comfortable. R4 reported that they were tired and sleepy. A review of R4's Electronic Medical Record (EMR) revealed a physician order dated 2/9/24 that read Osmolite 1.5 at 50 ml./Hr.(milliters per hour) run until 1000 ml dose complete providing 1500 kilo calories. Hang 900 ml free water set auto flush at 45 ml/hr. until water dose is complete. A review of R4's care plan dated 1/19/24 read I am dependent with tube feeding and water flushes; I need head of the bed elevated 30 degrees during and one hour after tube feed. R4 also had a care plan to monitor breath sounds due to the risk of aspiration. An interview was completed with LPN A on 2/12/24 at approximately 11:20 AM. LPN A was queried why R4's head of bed of bed was flat while their tube feeding was running. LPN A reported that earlier during the day CNAs (Certified Nursing Assistant) went in to R4's room to assist and change the brief. They reported that they understood the concern and said staff should have elevated the head of bed but probably forgot to do it after care. An interview was completed with Unit Manager I on 2/13/24 at approximately 12:30 PM. They were queried if it was appropriate to leave the head of bed flat when tube feeding was running. Unit manager I reported that head of bed should be up, or the resident could aspirate. When they were informed of the observation of the bed being flat with tube feeding being delivered, Unit Manager I reported that that was not acceptable. An interview as completed with Director of Nursing (DON) on 2/13/24, at approximately 5:15 PM. The DON was queried on the observation of R4's head of bed flat while tube feeding was being administered. The DON reported that that was not an acceptable practice and added that they would check R4's lung sounds and educate the staff members. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility provided documents titled Care and Treatment of Feeding Tubes with a revision date of /23, read in part, Tube feeding and medication administration: a. Date bottle/bag of enteral formula. b. Disposable equipment to be replaced daily. c. Position head of bed to upright position-at least 30 Degrees. d. Check tube placement e. Administer enteral formula, medications, and flushes per physician's order .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview, and record review the facility failed to implement a resident centered care plan regarding dialysis care and failed to ensure consistent ongoing communication with the dialysis entity for one (R6) of one resident reviewed for dialysis. Findings include: On 2/13/24 at 8:15 AM, R6 was observed sitting in their wheelchair at the doorway of their room, a limited interview was conducted at that time. Shortly after, R6 was observed from the hallway, sitting on their bed, with their shirt removed and a PICC (Peripherally inserted central catheter) line observed in the chest area. Review of the medical record revealed R6 was initially admitted to the facility on [DATE], with a readmitted [DATE] and diagnoses that included end stage renal disease and dependence of renal dialysis. R6 required staff assistance for all Activities of Daily Living (ADLs). Review of the medical record revealed multiple incomplete and missing communication forms between the dialysis center and the facility from April 2023 to February 2024. Review of the care plan titled I need dialysis (specify type hemo/peritoneal- this was not specified) r/t (related to) renal failure initiated on 12/15/23, documented the following interventions . Coordinate my lab draws with the dialysis center . Do not draw my blood or take my B/P (blood pressure) in _____ arm with graft . Educate me on hemo/peritoneal dialysis: I need to report warmth, pain, swelling in fistula arm, lifting, blood pressure or lab draws should not be done on my fistula arm . Emergency treatment of my access site is: if bleeding/hemorrhaging is noted: Apply direct pressure to the site & call the MD (medical doctor) immediately. If infection/bacteremia/septic shock is noted (i.e.: temp (temperature), warmth, swelling, or drainage): Call the MD (Medical Doctor) immediately . Monitor me and document/report to MD any peripheral edema. Evaluate reports or signs of pain, numbness/tingling, note swelling distal to access . Monitor me and document/report to MD PRN (as needed) any s/sx (signs or symptoms) of infection to access site: Redness, Swelling, local warmth or drainage . Monitor me and document/report to MD PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds . Review of the medical record and plan of care failed to document if the resident had an arteriovenous (AV) fistula, an AV graft, or a Central venous catheter (CVC) and failed to identify what part of the body the dialysis access was implanted. Further review of the medical record revealed no documentation of the name of the dialysis center the resident attended. On 2/14/24 at 1:40 PM, the Director of Nursing (DON) was interviewed and asked why there were multiple incomplete and missing dialysis communication forms for R6. The DON was also asked why the resident's dialysis care plan was not resident specific and asked to clarify the access site and the monitoring and maintenance the facility staff was responsible for regarding R6 access site. The DON stated they would look into it and follow back up. Shortly after the DON provided a revised dialysis care plan. No further explanation or documentation was provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to intake #'s MI00138924, MI00139621, MI00142062, and MI00142469 Based on observation, interview, and record review, the facility failed to ensure there was sufficient nursing staff for the residents on the second floor to address wandering residents, residents who required toileting assistance, and residents with dementia and behaviors for seven (R32, R47, R75, R86, R57, R84, and R1) residents reviewed for staffing , resulting in incontinence, negative resident to resident interactions, residents wandering into potentially unsafe areas, and poor infection control. This had the potential to affect all residents who resided on the second floor. Findings include: R32 On 2/12/24 at 10:39 AM, R32 was observed self propelling in a wheelchair on the hallway of the 2 North Unit. No staff were visible on the unit at that time. R32 stated, Where is everyone? I have to go to the bathroom really badly. Please take me!! When queried if she had been taken to the bathroom yet that morning, R32 reported she did not know, but reported she just really had to have a bowel movement at that time. Certified Nursing Assistant (CNA) 'BB' was at the end of the hallway. When notified that R32 had to go to the bathroom badly, CNA 'BB' stated, Ok and continued into another resident's room. At 10:42 AM, R32 became tearful and stated, Can't you just take me? Please! I have to go so bad! Please! It was explained to R32 that a staff member had to assist her. No staff members were visible on the unit. R32 continued to self propel down the hallway looking for someone to take her to the bathroom. At 10:44 AM, Housekeeper 'NN' was observed pushing R32 back to the other end of the hallway in her wheelchair. R32 was tearful and yelled, I have to go to the bathroom!! Housekeeper 'NN' told R32 she would let someone know. R32 was visibly upset and said she went into the dining room and there was not anyone in there either. R32 stated, I really have to go. I don't want to go here. No nursing staff were observed on the unit or in the dining room. At approximately 10:50 AM, a strong bowel movement odor was observed coming from R32. R32 stated, Please. Who is going to help me. I'm going to ruin my clothes! R32 was asked if she was able to activate the call light in her room and she said she did not know how and stated, Can't you just take me? It's right there! (R32 pointed to the bathroom located in her room). At approximately 10:53 AM, a staff member was observed behind the nurse's station. When notified that R32 needed to be taken to the bathroom, the staff member stated, Let me see if I can find an aide for you. At 11:00 AM, 20 minutes after R32 first expressed her need to be assisted to the bathroom, CNA 'N' entered the unit and assisted R32. On 2/12/24 at approximately 11:15 PM, CNA 'N' exited R32's room after assisting her with using the toilet and cleaning her. CNA 'N' reported R32 had been incontinent. CNA 'N' was not sure who the other CNA was assigned to the unit. A review of R32's clinical record revealed R32 was admitted into the facility on [DATE] with diagnoses that included: metabolic encephalopathy and Alzheimer's Disease. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R32 had severely impaired cognition and frequently, but not always, experienced bowel incontinence. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of R32's Kardex (CNA care guide) revealed R32 required staff to assist and stay with me while I am in the bathroom and to toilet after meals. The Kardex indicated R32 requires extensive assistance by two staff for toileting and that she was incontinent. A review of R32's care plans revealed an intervention revised on 7/12/23 that noted, I require (extensive assistance) by (2) staff for toileting . R47 On 2/12/24 at 9:51 AM, an observation was made of R47 wandering aimlessly in the hallway of the 2 North unit, into the dining room, and at times walked through the dining room and entered the 2 South Unit which was on the other side of the dining room. R47 rambled nonsensically, removed plastic cups from the dining room and disposable gloves and placed them in her room. R47 was observed folding clothing on their roommate's bed, removing the roommate's clothing from the closet, and standing in their roommate's space. At 10:05 AM, R47 attempted to open the treatment cart located on the unit. At 10:07 AM, R47 dug through the trash behind the nurse's station, removed used disposable gloves, carried them around, and proceeded to continue to touch their roommate's belonging and furniture. At 10:29 AM, R47 was observed behind the nurse's station without any staff present. At 10:45 AM, R47 touched the clean masks located at the nurse's station. At 10:49 AM, R47 was observed behind the nurses station going through a staff member's purse. No staff were visible on the unit at that time. On 2/13/24 at 10:03 AM, R75 walked into the dining room and stood behind R57 who was asleep in a chair. R75 began loudly expressing expletive language. R86 walked over to R75 and attempted to redirect her from behind R57. R86 explained that R57 was blind and gets really angry which was why he was trying to get R75 to move away from him. There was no staff in the dining room. On 2/13/24 at 1:06 PM, there were no staff members visible anywhere on the 2 North Unit or in the second floor dining room where multiple residents were located. Multiple residents were wandering the hallways. A treatment cart was used to block the entrance to the nurses station. R84 approached R1 in the hallway. R84 was on foot and R1 was seated in a wheelchair. R1 stated angrily to R84, You told me to get something and then when I did, it wasn't there! Both R1 and R84 appeared confused. R84 became upset and argumentative with R1. R84 approached R1 in an intimidating way, talking very close to R1's face, stating loudly, Tell me! Tell me what you are talking about! and repeatedly blocked R1 from moving in her wheelchair. R 1 attempted to enter her room and R84 walked inside R1's room and blocked her from entering. R47 pushed R1, who was seated in a wheelchair, into a cubby area where a scale was stored and left R1 in the cubby facing the wall. R1 was able to get herself out from the cubby area and wheeled back into the hallway. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/13/24 at approximately 1:17 PM, CNA 'N' entered the 2 North unit and redirected R84 back to her Unit. Prior to that, there were no staff visible on the unit. An interview was conducted with CNA 'N'. CNA 'N' reported the residents on the 2 North Unit required a lot of redirection, supervision, and most of them had cognitive impairment. When queried about R47, CNA 'N' reported it was very difficult to keep her occupied and that she was constantly on the move and required a lot of supervision. When queried about if there were any other CNAs assigned to the unit, CNA 'N' reported there were five total for the floor, she was responsible for approximately 16 residents, and she did not know where the other CNA was who also worked on the 2 South Unit. CNA 'N' reported there were two nurses for the entire second floor, one for 2 North and one for 2 South. The 2 North Unit extended around the corner to a center hallway that was not visible from the long part of the 2 North Unit where the nurse's station was located. When queried if there was enough nursing staff to provide care and supervision to the residents on the 2 North Unit, CNA 'N' reported at times there were six CNAs for the whole floor and that worked out better than when there were only five CNAs for the second floor. A review of the assignment sheet for 2/13/24 revealed there were two CNAs and one nurse assigned to the 2 North Unit and five CNAs and two nurses for the entire second floor. A review of the daily census for 2/12/24 revealed there were a total of 33 residents on that unit. A review of R47's clinical record revealed R47 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: dementia and anxiety. Review of a MDS assessment dated [DATE] revealed R47 had severely impaired cognition, other behaviors, and wandered daily. Further review of R47's clinical record revealed progress notes that documented multiple incidents of R47 wandering into other residents' rooms, falls with injuries, and resident to resident altercations. A review of R84's clinical record revealed R84 was admitted into the facility on [DATE] with diagnoses that included: Alzheimer's Disease. A review of R84's MDS assessment dated [DATE] revealed R84 had severely impaired cognition. A review of R84's care plans revealed a care plan initiated on 10/20/23 that noted, I have potential to demonstrate physical behaviors (hitting, kicking, resistive to care, biting, slapping, repetitive movements) r/t (related to) History of harm to others. I also will pull chair from up under resident while they are sitting in the chair . On 2/13/24 at 10:03 AM, R75 walked into the dining room and stood behind R57 who was asleep in a chair. R75 began loudly expressing expletive language. R86 walked over to R75 and attempted to redirect her from behind R57. R86 explained that R57 was blind and gets really angry which was why he was trying to get R75 to move away from him. There was no staff in the dining room. On 2/13/24 at approximately 1:20 PM, 10 residents were observed in the dining room. There were no staff present in the dining room. R47 walked from the 2 North unit through the dining room to the 2 South Unit. R1 and another resident were heard yelling at each other in the hallway of the 2 North Unit. No staff were present to intervene. R86 heard the yelling and walked swiftly to the hallway and took the other resident by the arm and led her through the dining room and back to the 2 South Unit. On 2/13/24 at 2:05 PM, R86 tried to move a resident seated in a wheelchair in the dining room to another table. The resident began screaming to Let me go! Go away! I'm not going anywhere with you! There was no staff present in the dining room. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of R86's clinical record revealed R86 was admitted to the facility on [DATE] and had diagnoses that included dementia and anxiety. A review of R86's MDS dated [DATE] revealed R86 had severely impaired cognition. A review of R86's care plans revealed the following care plan initiated on 10/27/23: .I have potential to demonstrate physical behaviors to staff (hitting, kicking, resistive to care, biting, slapping, repetitive movements r/t (related to) Dementia. I think I am in charge the dining room on the second floor and like to control the TV, and what residents are in there at certain times . An intervention initiated on 1/21/24 noted, Staff to redirect and make sure I am not trying to direct other residents . A review of R57's clinical record revealed R57 was admitted into the facility on [DATE] with diagnoses that included: Alzheimer's Disease, schizophrenia, and legal blindness. A review of a MDS assessment dated [DATE] revealed R57 had severely impaired cognition, highly impaired vision, and physical behaviors. On 2/13/24 at approximately 3:30 PM, an interview was conducted with with the Scheduler 'TT'. When queried about any issues the facility has had with staffing, Scheduler 'TT' reported that staffing could be better and that it had been challenging hiring nurses and CNAs. On 2/15/24 at 8:03 AM, an interview was conducted with Licensed Practical Nurse (LPN) 'F'. LPN 'F' reported the facility had a lot of residents admitted from another sister facility and we are trying to do our best. LPN 'F' reported the newly admitted residents had a lot of behaviors and there was not enough staff to monitor them. LPN 'F' reported there were two nurses assigned to the entire second floor and stated, I can't monitor the team when I am all the way down in the corner. LPN 'F' reported she was responsible for over 30 residents. It was further explained that the second floor used to have six CNAs assigned and now only five were assigned. LPN 'F' reported the company eliminated several positions and we are doing the best we can do. On 2/15/24 10:34 AM, an interview was conducted with the facility's Administrator regarding staffing. They said the staffing assignments were made based on acuity. They were asked how they measured and took into account acuity of residents when making nurse and aide assignments, or whether they just divided the number of residents by the number of staff and made the assignments based on numbers. The Administrator said they had no tangible tool they used and the Director of Nursing (DON) determined the needs of the residents and appropriate staffing.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47283 Based on interview and record review the Facility failed to ensure that the regular in-service/training and competency evaluations based on performance review every 12 months for the 8 Certified Nursing Assistants (CNA) (N, Q, T, LL, MM, OO, PP and RR) resulting in the potential for unmet resident care needs. Findings include: On 2/14/24 and 2/15/24 facility was requested to provide the annual competency evaluations for the for the following staff members: 1. CNA N: Date of Hire (DOH) - 04/20/22 2. CNA T: DOH - 10/8/12 3. CNA LL: DOH - 12/10/20 4. CNA MM: DOH - 9/24/20 5. CNA Q: DOH -10/11/04 6. CNA OO: DOH - 11/8/04 7. CNA PP: DOH - 11/5/90 8. CNA RR: DOH - 3/10/21 Facility administration provided the copies of completed training transcripts for 5 of the requested staff that did not meet the 12 hours of annual training requirements for Certified Nursing Assistants. The facility provided documents titled Certified Nurse Aide Competency Check List for CNAs LL, MM, Q, OO, N, PP, and T that were completed between 2/5/24 and 2/8/24. These evaluations were not based on employment date or date of hire. The documents read that staff passed the competencies verbally for all competencies. The demonstration section and the observer's signature section of all documents were blank for all above staff members. There was no evidence that these trainings were provided based on the outcomes of individual performance reviews. A review of the facility assessment with a review date of 1/30/24 revealed that facility did not have a staff development coordinator. An interview was completed with the facility Administrator on 2/15/24, at approximately 9:15 AM. The Administrator was queried on who was responsible to complete the annual competency training for the staff. The Administrator reported that department managers were responsible for staff training and annual competencies for staff were completed as online training. On 2/15/24 at approximately 10:35 AM, during the Quality Assurance and Performance Improvement (QAPI) program review Survey Team Coordinator, Administrator was queried on who was responsible in the facility to ensure to train and track the annual required training for the CNAs. Administrator reported that the facility did not have any designated staff member at this time. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was completed with the Director of Nursing (DON) on 2/14/24, at approximately 4:20 PM. The DON was queried if the facility had a designated staff member to train and track the required training for the CNAs. The DON reported that they did not have any designated staff member to train and or track the required training since the facility's last annual survey and they were doing some training for the nurses. The DON reported that CNAs were completing the online trainings.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview, and record review the facility failed to ensure irregularities identified by the pharmacist was reviewed by the physician for two (R's 25 & 20) of five residents reviewed for the pharmacist drug regimen review. Findings include: Review of a facility policy titled Medication Regimen Review revised 3/22 documented in part, . The pharmacist shall document . the nature of any identified irregularities . the attending physician has documented a valid clinical rational for rejecting the pharmacist's recommendation . The pharmacist shall communicate any irregularities to the facility . Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing . Written communications from the pharmacist shall become a permanent part of the resident's medical record . R25 On 2/12/24 at 9:48 AM, R25 was observed lying on their back in bed sleeping. The resident continued to sleep and did not awake with verbal stimuli. Review of the medical record revealed R25 was initially admitted to the facility on [DATE], with a readmitted [DATE] and diagnoses that included: dementia, hallucinations, and major depressive disorder. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 3, which indicated severely impaired cognition. Review of a Pharmacy Progress Note dated 11/19/23 at 10:37 PM, documented in part . Medication Regimen Review . See report for any noted irregularities . Review of the medical record revealed no identification of a pharmacy report for the date of 11/19/23. The report was requested from the Director of Nursing (DON) at that time. On 2/13/24 at 11:35 AM, review of the pharmacy report documented the following in part . Practice guidelines for major depression in primary care recommend continuing the same dose for 4-9 months following the acute phase. Whether a patient is to continue therapy in this maintenance phase depends on the established history of previous depressive episodes and the physician assessment. A trial dose reduction may be reasonable at this time . The resident has been using Zoloft 50 mg (milligram) since 5/2023. If this therapy is required to prevent future depressive episodes, please document to that effect in your progress notes . RESPONSE: (left blank) . (Physician) signature/date (left blank) . Review of the physician orders revealed an order for Zoloft 50 MG at bedtime for depression. Review of the physician notes revealed no documentation of a rationale on why the pharmacist recommendation was not reviewed, acknowledged, or responded to. Review of the medical record revealed no observations of depression identified by the facility staff. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/24 at 1:37 PM, the DON was interviewed and asked why R25's pharmacy report for November 2023 was not provided to the physician for review and the DON could not provide an answer. When asked the DON said the pharmacist emails them (the DON) of the irregularities every month. The DON said from there they are supposed to go into the physician's book for review. The DON was unable to provide an answer as to why R25's November 2023 report was not implemented in that process. No further explanation or documentation was provided by the end of the survey. 49272 R20 On 2/12/24 at 10:43 AM,R20 was observed asleep in bed, on her back, low air loss mattress in place, spouse at the bedside, he denied having any concerns with his wife's care and reported she was unable to answer questions. Review of the medical record revealed R20 was initially admitted to the facility on [DATE] with a recent readmitted [DATE] and diagnoses that included: heart failure, Alzheimer's dementia, Huntington's Disease and Parkinson's Disease. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 5, which indicated severely impaired cognition. Review of the Pharmacy Progress Note dated 1/16/24, documented in part . Medication Regimen Review . See report . Review of the medical record revealed no identification of a pharmacy report for the date of 1/16/24. The report was requested from the Director of Nursing (DON) at that time. On 2/13/24 at approximately 1:30 PM, a review of the pharmacy report documented the following in part . Practice guidelines for major depression in primary care recommend continuing the same dose for 4-9 months following the acute phase. Whether a patient is to continue therapy in this maintenance phase depends on the established history of previous depressive episodes and the physician assessment. A trial dose reduction may be reasonable at this time. This resident has been using Zoloft 50mg (milligrams) since 8/2023. If this therapy is required to prevent future depressive episodes, please document to that effect in your progress notes .RESPONSE (left blank) . (Physician) signature/date (left blank) . On 2/15/24 at approximately 9:06 AM an interview was conducted with the director of nursing (DON) regarding the facilities policy for monthly medication regimen review. The DON stated that the reports are supposed to go in the doctor's logbook for review, they further stated that they recently discussed (with the medical director and medical records staff) putting a system in place to ensure the doctor signs and executes them appropriately. No explanation was given for why this had not been completed for R20's January report.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on interview and record review, the facility failed to ensure accurate administration and indication for use of an antibiotic medication for one resident (R21) of five residents reviewed for unnecessary medication resulting in the potential for adverse side effects and antibiotic resistance. Findings include: A Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed R21 was admitted the facility on 7/15/23 with diagnoses of non-traumatic brain dysfunction, hypertension, dementia, and a seizure disorder. Their Brief Interview for Mental Status (BIMS) totaled 7, indicating severe impaired cognition. On 2/14/24 at 10:04 AM, a record review revealed R21 was ordered: Bactrim DS Tab 800-160 milligram (mg) (antibiotic medication) 1 tab every 12 hours for bacterial infection for 7 days starting on 1/13/24. Record review of the Medical Administration Record (MAR) documented the following: 1/13 medication not administered, 1/14 one of two doses scheduled administered, 1/20 one of two doses scheduled administered. Documentation reviewed from the MAR confirmed R21 did not receive the total amount of prescribed antibiotic and there was no clinical indication documented to justify what type of bacterial infection R21 was being treated for. On 2/14/24 at 10:28 AM, A review of the facility infection control program was conducted with Registered Nurse (RN) DD, who functions part-time as the facility's Infection Control Nurse. RN DD confirmed there was no documentation of communication between the ordering Registered Nurse FF and the physician. RN DD confirmed R21 did not receive the total doses ordered and there is no clinical indication to the type of bacterial infection. Upon further record review and interview, RN DD stated R21 was not listed within the facility's Infection Report which would have triggered a personalized care plan for infection. Record review of a facility provided document titled, Non-Controlled Medication Orders with a revision date of 8/2020 read, .Medication orders specify diagnosis or indication for use .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49083 Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than five percent. Six medication errors were observed from a total of 29 opportunities for four out of five residents (R38, R69, R82, R62) resulting in an error rate of 20.69%. Findings include: R38 On 2/13/24 at 8:56 AM, Licensed Practical Nurse (LPN) AA was observed preparing the morning medications for administration to R38. LPN AA retrieved one vial of Lantus from R38's medication compartment, and it was identified there was no open date for the insulin. LPN AA contacted a physician by phone. LPN AA stated that the physician instructed to use another resident's Lantus for R38's dose until the order was refilled. LPN AA said they didn't think they could do this and attempted to locate another vial of Lantus within the medication cart and stock room. Upon return, LPN AA indicated there was no Lantus. Medication administration observation continued for R38's morning administration. LPN AA indicated ordered Flonase (allergy relief nasal spray) and GenTeal ophthalmic solution (eye drops for dry eyes) was not available and would have to be ordered from central supply and pharmacy. On 02/13/24 at 12:47, record review of R38 Medication Administration Record (MAR) revealed, ordered Lantus insulin, Flonase nasal spray, and GenTeal eye drops were not administered to the resident. On 02/13/24 at 02:10, LPN AA stated she needed to contact pharmacy to confirm when the meds would be arriving and stated she contacted central supply by leaving a voicemail. On 02/13/24 at 02:20 PM, an in person interview with Central Supply K confirmed the voicemail was retrieved from LPN AA minutes prior to meeting with this surveyor. Central Supply K indicated the above missing medications were not in the facility and need to be reordered. Record review of the facility policy for Medication Reconciliation Effective: 11/2016 Revised: 06/2023 . the resident's current medication list matches the physicians orders for the purpose of providing the correct medications to the resident at all points throughout his or her stay . 49272 On 2/13/23 at 9:32 AM, nurse EE was observed preparing morning medications for R69, which included the administration of amlodipine 5mg (milligram). Review of R69's medication administration record (MAR) after completion of my observation revealed LPN EE did not document that she gave R69's amlodipine 5mg. On 2/13/24 at 9:43 AM, nurse EE was observed preparing morning medications for R82, which included metoprolol 25mg extended release. Nurse EE crushed all medications that were given to R82 including the extended release metoprolol which is not meant to be crushed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/24 at 9:51 AM nurse EE was observed preparing morning medications for R62, which included aspirin 81 mg enteric coated. Review of R62's MAR showed that they should have received aspirin 81mg in chewable form and not the enteric coated version. On 2/13/24 at 12:06 PM a copy of the facilities medication administration policy was requested via email. The facility failed to provide a copy of the policy prior to the end of the survey.

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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. 48680 Based on observation and interview the facility failed to ensure appropriate medication storage for one of three medication rooms and one of six medication carts resulting in the potential for unauthorized access to medication storage areas. Findings include: On 2/13/24 at 10:11 AM, the 1 north medication cart was left unlocked. Unit Manger I walked passed the cart and locked it. Unit Manger I was then interviewed and asked if the cart should be locked. She indicated it should. At that time, an observation of the contents of the cart was conducted and revealed an unopened vial of insulin. At that time, Unit Manager 'I' was asked how the insulin should be stored and said it should have been in the refrigerator. On 2/13/24 at 10:39 AM, the 2nd floor medication room was observed unlocked and Nurse EE was observed to enter the room without having to unlock the door. Nurse EE was interviewed and asked should the medication room be locked and Nurse EE replied, Yes, it should be. On 2/13/24 at 11:00 AM, an interview with the Director of Nursing (DON) was conducted and she was asked how unopened insulin should be stored and should medication rooms be locked, the DON replied yes and explained that the doors to medication rooms should be locked and the unopened insulin should be in refrigerator. On 2/13/24 policy was requested but never received by the exit of the survey. 49083 On 2/13/2024 at 10:21 AM, An observation was made with Licensed Practical Nurse (LPN) AA of the Unit One South medication cart. The first drawer was opened and a vial of Refresh (lubricant for dry eyes) eye drops was sitting on top of a tissue, with no resident name. LPN AA said the medication should not be here.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview and record review, the facility failed to provide timely laboratory services as ordered by the physician for one (R18) of one resident reviewed for laboratory services. Findings include: R18 was originally admitted to the facility after hospitalization on [DATE]. R18's admitting diagnoses included heart failure, lymphedema, morbid obesity, spinal stenosis, chronic respiratory failure, adjustment disorder with depressed mood, and osteoarthritis of bilateral knee. Based on the Minimum Data Set (MDS) assessment dated [DATE], R18 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicative of an intact cognition. An initial observation was completed on 2/12/24 at approximately 9:40 AM. R18 was observed sitting in their wheelchair next to their bed. During this observation an interview with R18 was completed. During the interview R18 reported that they were not getting the care they needed at the facility. When queried further on their concerns R18 reported that the physician ordered labs/tests and they were not done, and they had asked the facility nursing staff and they had not received any clear explanation. Later that day, during a follow up observation at approximately 1:30 PM, R18 had expressed the same concerns with the tests that were ordered by their doctor, and they were not getting done. A review of R18's Electronic Medical Record (EMR) revealed the following physician orders. An order dated 12/3/23 read, U/A (Urinalysis) one time only to rule out infection and the order status read completed; an order dated 1/9/24 that read U/A C&S (culture and sensitivity) with order status discontinued; and an order dated 1/19/24 read, CMP (Comprehensive Metabolic Panel)/Complete Blood Count, lipid panel . and the status read discontinued. Further review of R18's EMR did not reveal any laboratory test results. A review of R18's nursing progress revealed a note dated 12/3/23 at 10:55 that read, Resident was seen physician in the building 12/3/23. New order for UA, CBC, and CMP has been placed. Order for Bactrim will start 12/4/23. Care is ongoing. Another progress note dated 12/6/23 at 18:59 read, Antibiotic in effect . A physician progress note dated 12/21/23 at 15:06 read in part, Patient was scheduled to get labs drawn but did not. Will need rescheduling for lab draw patient discussed with nursing staff. A physician progress note dated 1/9/24 at 16:00 read in part, Patient reports burning with urination .urine culture ordered. An interview with Unit Manager I was completed on 2/13/24, at approximately 12:30 PM. Unit Manager I was queried on their lab results and where they were placed in the EMR. Unit manager I reported that they had a recent change in their lab provider's documentation system, and they had to log on to a different software that the facility's lab provider used to pull the test results. Unit Manager I reported that this change had happened a few weeks ago and prior to the change test results were uploaded under results tab of the facility's EMR system. Unit manager I was queried on the lab results for R18 that were ordered on 12/3/23, 1/9/23 and 1/19/23. Unit manager I reviewed the lab provider's software and reported that R18 had only one lab results from 2/1/24 and shared a copy of the results. Unit Manager I reviewed R18's EMR and confirmed there were no other test results available for R18. When queried why the order status on multiple orders read discontinued when the physician documentation reported pending labs, no further explanation was provided. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Director of Nursing (DON) on 2/13/24 at approximately 5:30 PM. The DON was queried about the lab process and the concerns with R18's lab orders that were not done. The DON reported that there was an issue with their lab provider not sending the phlebotomists; facility staff had to complete the draws and they had challenges completing labs. The DON reported they were probably not done and that they understood the concern and did not have any further explanation. A request for facility policy on laboratory services was sent via e-mail to the facility Administrator on 2/14/24 at 12:28 PM. Facility did not provide the policy prior to survey exit.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 22960 This citation pertains to intake #MI00138924, MI00140002, and MI00140828. Based on observation, interview, and record review, the facility failed to provide meals that were palatable and attractive, resulting in resident food complaints and dissatisfaction with the meals provided. Findings include: On 2/12/24 at approximately 8:45 AM, there was a covered pan of cooked zucchini observed on the stove top. When queried, Dietary Manager (DM) U stated that the cooked zucchini was for the lunch meal. On 2/12/24 at 11:30 AM, the same pan of cooked zucchini was observed on the steam table for the lunch meal service. The texture of the zucchini was soft and mushy, and pale in color. On 2/12/24 at 12:30 PM, a lunch test tray was obtained. The cooked zucchini was watery, mushy and bland in taste. In addition, the pureed zucchini was sampled. The texture of the puree was gelatinous, slimy, and was a pale yellowish green color. The pureed zucchini was tasted and was quite bland and flavorless. When plated, the dollop of pureed zucchini spread out onto the plate, and did not hold any shape. It was sticky, and when a spoon-full of the puree was tilted, the substance stretched off the spoon in a gelatinous strand. On 2/12/24 at 12:45 PM, DM U was queried about the consistency of the regular and pureed zucchini, but provided no explanation. On 2/13/24 at 10:42 AM, a confidential interview was conducted with seven residents, some of whom attend the resident council meetings. When queried about any concerns with the care and services in the facility, seven of seven residents who wished to remain anonymous reported the food served in the facility was not good. One resident stated, Food is a work in progress, but it never seems to get better. Another resident reported the food did not taste good. Another resident reported the vegetables were not cooked right. All seven residents reported food was not served hot. One resident stated, It's luke warm at best. Two residents reported the food was not appetizing and you did not know what you were served. According to the International Dysphagia Diet Standardization Initiative (IDDSI), Level 4 Pureed consistency: Description/Characteristics: Falls off the spoon in a single spoonful when tilted and continues to hold shape on a plate. Not sticky .

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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. 22960 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 2/12/24 between 8:45 AM-9:15 AM, during an initial tour of the kitchen with Dietary Manager (DM) U, the following items were observed: The paper towel dispenser at the handwashing sink was empty. According to the 2017 FDA Food Code section 6-301.12 Hand Drying Provision, Each handwashing sink or group of adjacent handwashing sinks shall be provided with: (A) Individual, disposable towels;. The filter for the ice machine had a date of installation of 1/6/23. The filter noted replace 6 months after install. In addition, there was an accumulation of dust on the side vents of the ice machine. DM U was queried about the ice machine filter and cleaning, and stated that Maintenance was responsible for both. On 2/12/24 at 10:30 AM, Maintenance Supervisor V was queried about the cleaning of the ice machines and the filter replacements. Maintenance Supervisor V stated there was no documentation of the ice machine cleaning or filter replacement. This documentation was also requested from the Administrator, but was not provided by the end of the survey. In the walk-in cooler, there was an opened, undated package of deli turkey, and debris on the floor underneath the racks. According to the 2017 FDA Food Code section 3-501.17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. There was peeling paint on the ceiling tile tracking above the dish machine area. According to the 2017 FDA Food Code section 6-501.11 Repairing, Physical facilities shall be maintained in good repair. There was black debris on the inside bottom surface of the ice scoop holder, and the tip of the ice scooper was resting on the black debris. DM U confirmed the debris and proceeded to clean the scoop and holder in the dish machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the Food & Drug administration (FDA) 2017 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: .(E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous (time/temperature control for safety food) .

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 34208 Based on interview, and record review, the facility failed to ensure the facility was administered in a manner that maintains the safety and care of residents so residents may reach their highest practicable physical, mental, and psychosocial well-being for all 99 residents who reside at the facility, resulting in quality care not being provided to residents, an un-homelike environment, no ongoing program of meaningful activities, inadequate staffing to meet resident's needs, palatable food being not being served, food not served under sanitary conditions, and ineffective infection control and antibiotic stewardship programs. Findings include: On 2/15/24 at 10:34 AM, an interview was conducted with the facility's Administrator regarding systemic failures identified during the survey. The Administrator was asked who was responsible for identifying and addressing systemic failures and indicated the Quality Assurance team and the Administrator were responsible. They were then asked why systemic failures were identified and said it was probably attributed to the building having three different administrators over the past six months. The Administrator indicated they were aware of concerns with facility's physical environment, and the infection control and antibiotic stewardship programs. On 1/11/24 a facility document pertaining to the job duties of the facility Administrator was reviewed and revealed the following: Position Summary: The Nursing Home Administrator (NHA) assumes authority, responsibility, and accountability for their facility. The Administrator manages the facility operations within established guidelines and provides effective supervision of staff for all departments. The NHA develops and implements the annual plans for the facility and provides proper management of the financial and/or business affairs of the facility Manage Facility Operations Within Established Guidelines: Oversee operation of each Facility department to assure compliance with operating policies and procedures. Oversee the operation of a licensed Nursing Home. Provide for compliance with local, state and federal laws and policies of the Personnel Handbook in all personnel actions. Provide for adequate protection of the assets of the Facility. Provide for and maintain appropriate systems and procedures to administer the Facility. Provide for the maintenance of appropriate records such as personnel and patient records .Provide for compliance of all Corporate policies and procedures for the operation of a licensed nursing home. Periodically review compliance with industry standards and all applicable regulations through quality assurance reviews . Maintain Quality Lifestyle and Health Care for Facility Patients. Oversee preparations for regulatory surveys, and maintain standards and procedures, which comply with licensure and accreditation requirements. Take corrective action required as a result of survey findings or as a result of administrative review .Provide for adequate staffing and for regular training of staff in areas appropriate to their needs .Provide for regular leisure activities to promote quality of life .Provide for Effective Supervision of Staff for all Departments . Cross-reference F584, F679, F725, F804, F812, F880, and F881.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34208 Based on interview and record review the facility failed to establish an effective Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) plan that identified system issues that resulted in sub-standard quality of care. This deficient practice had the potential to affect all 99 residents in the facility. A review of a facility provided policy titled, Quality Assurance and Performance Improvement revised 10/2022 was conducted and read, Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive data driven Quality Assurance Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life . On 2/15/24 at 10:34 AM, an interview was conducted with the facility's Administrator regarding various systemic failures identified during the survey. The Administrator was asked who was responsible for identifying and identifying systemic failures, developing improvement plans, and reviewing and revising the plans and they said said the Quality Assurance team that consisted of department heads responsible. They were then asked why systemic failures were identified and said it was probably attributed to the building having three different administrators over the past six months. The Administrator further indicated that prior to their employment as the Administrator of the building they believed the facility had not had an effective QAPI program. Cross-reference F584, F679, F725, F804, F812, F880, and F881.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 22960 This citation has two deficient practices. Deficient Practice #1 Based on interview and record review, the facility failed to have an active plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all of the 99 residents in the facility. Findings include: On 2/13/24 at 12:45 PM, review of the facility's Water Safety Plan dated 4/10/23 noted the following deficiencies: 1. There was no water safety team designated in the water safety plan. The plan noted The Water Safety Team shall consider environmental testing for Legionella to validate that the growth and spread of Legionella is controlled within the building water systems, however no team had been designated. 2. The water safety plan noted, Routinely clean/disinfect or inspect the following system components: Backflow prevention- Annually, Ice Machine- Monthly. Review of the backflow prevention assembly test report, noted that the last testing had been completed 5/10/22, not annually in accordance with their water safety plan. Documentation of the ice machine cleaning and the filter replacements was requested from Maintenance Supervisor V on 2/12/24 at 10:30 AM. Maintenance Supervisor V stated there was no documentation of the ice machine cleaning or filter replacement. This documentation was also requested from the Administrator, but was not provided by the end of the survey. 3. The water safety plan noted, Monitor the hot water system to verify temperatures are being maintained within the established control limits. Documentation of water temperature monitoring was requested on 2/12/24 at 10:40 AM from Maintenance Supervisor V, and from the Administrator on 2/13/24 at 10:30 AM and 2/14/24 at 8:46 AM, but was not provided by the end of the survey. 49083 Based on interview and record review, the facility failed to maintain a comprehensive infection control program which included consistent identification and tracking of infection and complete adequate hand hygiene during medication pass. This deficient practice had the potential to affect all residents at the facility, resulting in the potential for the spread of infection and undetected infections. Findings include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/24 at 9:28 AM, A review of the facility's infection control program was conducted with Registered Nurse (RN) DD, who has performed as the facility's designated infection control leader since October 2023. Review of the infection control books provided by the facility revealed no documentation of an infection control program. RN DD confirmed prior to her running the infection control program, it was overseen by the Director of Nursing (DON). On 2/14/24 at 9:55AM, an interview with the DON and the Administrator was conducted and they indicated from March 2023 to September 2023 there was no documentation to support an infection control program for the facility. On 2/15/24 at 10:34 AM an interview was conducted with the facility's Administrator regarding the Quality Assurance Program's role with the infection control program. The Administrator said prior to their role as the Administrator it was their understanding that the Infection Control program had not been looked at during the Quality Assurance meetings. They further indicated they were told there was a person in place in the past, but when they left employment the facility did not replace them. Review of the facility's Infection Prevention and Control Program Policy Implemented: 4/2017 Revised: 5/2023 read .The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . 49272 On 2/13/24 nurse EE was observed preparing and passing morning medications for three residents. Nurse EE had access to hand sanitizer both on the medication cart and mounted on the wall in close proximity but failed to perform hand hygiene prior to entering the each resident's rooms at approximately 9:32 AM, 9:43 AM and 9:51 AM. Alcohol-based hand sanitizer was used by nurse EE upon exit of each resident's room only. The facilities Hand Hygiene policy stated, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors., additionally it stated, Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. According to the Centers for Disease Control and Prevention (CDC) website Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 49083 Based on interview and record review, the facility failed to maintain an effective Antibiotic Stewardship program that included consistent implementation of protocols to ensure that an antibiotic is prescribed for the correct indication, dose, and duration to appropriately treat infection for one resident (R21) of one resident reviewed for antibiotic medications. Findings include: On 2/14/24 at 10:04 AM, a record review of the facility Infection Control Antibiotic Line List from January 2024 revealed R21 was ordered: Bactrim DS Tab 800-160 milligram (mg) 1 tab every 12 hours for a bacterial infection for 7 days start 1/13/24. Record review of the Medical Administration Record (MAR) documented the following: 1/13/24 medication not adminstered, 1/14/24 one of two doses scheduled administered, 1/20/24 one of two doses scheduled admisitered. This documentation revealed the resident did not receive two doses daily for seven days as ordered. Further record review confirmed R21 did not receive the total amount of prescribed antibiotic and there was no documentation to justify the type of bacterial infection R31 was being treated. On 2/14/24 at 10:28 AM, a review of the facilities infection control program was conducted with Registered Nurse (RN) DD, who functions part-time as the facilities Infection Control Nurse. RN DD confirmed there was no documentation of communication between the ordering RN FF and the physician of the indication for the antibiotic and DD also confirmed R21 did not receive the total doses ordered. Upon further record review and interview, RN DD stated R21 was not listed within the facilities Infection Report which triggers a personalized care plan for infection. On 2/14/24 at 1:17 PM, RN DD Identified the facilities Infection Control Program was deficient and confirmed with this surveyor that other residents were not on antibiotic line list and should have been. On 2/20/2022 at 4:23 PM, a record review of the facilities Infection Prevention and Control Program Implemented: 4/17 Revised: 5/23 states: . The facility has established and maintains an infection control program . Paragraph 5 .antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program .

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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** 49083 Based on interview and record review, the facility failed to implement their policy and ensure accurate education, tracking and administration of the pneumococcal vaccine for one (R38) of five residents reviewed for the pneumococcal vaccination. Findings include: On 2/14/24, A review of the clinical record revealed R38 was admitted to the facility in September 2023, and most recently readmitted [DATE] with diagnoses that included: diabetes, hypertension, alcoholism, and right leg amputation. Minimum Data Set (MDS) dated [DATE] 4 revealed a Brief Interview for Mental Status (BIMS) of 15/15, indicating intact cognition. R38's Vaccination status was reviewed in the medical record and documentation indicated R38 did not receive the pneumonia vaccine. A record review of vaccination consent for R38 was provided by Registered Nurse DD, the facilities infection control lead. The consent for R38 revealed R38 consented to receive the pneumococcal vaccine on 9/25/23. Further review of the consent showed handwritten documentation within the right margin of the consent . 1/11/24 Declined . When questioned why there was handwritten documentation that this resident declined on 1/11/2024, RN DD replied she was not at the facility and could not attest to the note. On 02/14/2024 at 10:58 AM, R38 was questioned if the facility had offered and had he elected to receive the pneumonia vaccine. R38 replied he never heard of the pneumonia vaccine and didn't know that it existed. The facilities Pneumococcal Vaccine Policy Implemented: 04/2012 Revised: 09/2022 Policy Explanation and Compliance Guidelines specified: .It is our policy to offer our residents immunization against pneumococcal disease in accordance with current CDC guidelines and recommendation .Prior to offering the pneumococcal immunization, each resident's representative will receive education regarding the benefits and side effects of the immunization .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 22960 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program, resulting in gnats in R87's room and throughout the facility. Findings include: On 2/12/24 at 9:00 AM, numerous gnats were observed flying around in the main kitchen. There were 2 red, apple shaped plastic containers observed on the shelf behind the coffee machine. When queried, Dietary Manager (DM) U stated they were (non-professional) traps for the gnats. When queried about whether or not a professional pest control company had been out recently to provide services to eradicate the gnats, DM U stated he was unsure of the date they were last there. On 2/12/24 at 11:00 AM Maintenance Director V was queried about their pest control program, and stated he would have to look for any service reports they may have. On 2/12/24 at 1:00 PM, review of the pest control service reports provided, revealed the date of the last pest control service was 8/28/23. When queried at that time if there were any more current visits from the pest control company, Maintenance Supervisor V stated he did not have any more current service reports. 38271 On 2/12/24 at approximately 9:52 a.m., R87 was observed ambulating in the day room. R87 was queried if any concerns about their stay in the facility and they reported there was a problem with gnat's being everywhere and have seen gnats on the facility food trays and indicated they felt there was an infestation in the kitchen.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47283 Based upon interview and record review, the facility failed to complete/document the 12-hour annual in-service training requirement for eight of eight Certified Nurse Assistant's (CNA) (CNAs N, Q, T, LL, MM, OO, PP and RR) reviewed for required training resulting in the potential for staff being unaware of best practice guidelines when caring for residents and provision of inadequate resident care. Findings include: On 2/14/24 a request was sent via e-mail for 5 staff members and on 2/15/24 surveyor provided a request in person to the facility Administrator for the staff members (CNAs) to provide the annual 12-hour training completion and transcripts. The facility provided transcripts for only 5 staff members that did not meet the annual 12 hrs. training requirement for all the staff. Facility provided transcript hours for the five staff members did not meet the 12-hour per year training requirement. The completed transcript hours for staff ranged from 0.75 hours to 6.5 hours. An interview was completed with the facility Administrator on 2/15/24, at approximately 9:15 AM. Administrator was queried on who was responsible to complete the annual competency training for the staff. Administrator reported that department managers were responsible for staff training and annual competencies for staff were completed as online training. On 2/15/24 at approximately 10:35 AM, during the Quality Assurance and Performance Improvement (QAPI) program review Survey Team Coordinator, Administrator was queried on who was responsible in the facility to ensure to train and track the annual required training for the CNAs. The Administrator reported that the facility did not have any designated staff member at this time. An interview was completed with the Director of Nursing (DON) on 2/14/24, at approximately 4:20 PM. DON was queried if the facility had a designated staff member to train and track the required training for the CNAs. DON reported that they did not have any designated staff member to train and or track the required training since the facility's last annual survey and they were doing some training for the nurses. DON reported that CNAs were completing the online trainings.