STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235217	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Bloomfield Hills	2975 N Adams Road Bloomfield Hills, MI 48304

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 30675 This citation pertains to intake #s MI00146078 and MI00147295. Based on observation, interview and record review, the facility failed to provide an environment that promoted and enhanced residents' dignity for one (R22) of five residents reviewed for dignity. Findings include: Review of complaints reported to the State Agency included allegations that residents were not being treated with dignity and respect. Review of the facility's policy titled, Dignity and Respect dated 7/11/2018: .It is the policy of this facility that all residents be treated with kindness, dignity and respect .The staff shall display respect for Resident's when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings .Violations of the Resident's right to dignity and respect should be promptly reported to the Director of Nursing Services and/or the Administrator. On 9/30/24 at 11:23 AM, R22 was observed seated behind the nursing station with several nursing staff also seated at the desk. During this time, resident repeatedly yelled out loudly. Despite staff attempting to redirect the resident with a magazine and telling them their daughter was out of town, the resident proceeded to yell loudly. Continued observations revealed two episodes when R22 yelled out, a resident in another room yelled back loudly for the resident to Shut-up. At the same time, multiple staff were observed laughing immediately following this other resident telling R22 to Shut-up. R22 was then observed to look at this surveyor, point to the room the other resident yelled Shut-up from and the resident then stated, What, what, say shut-up, what. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:28 AM, the resident in the other room near the nursing desk yelled out again for R22 to Shut-up. The staff seated at the nursing station where observed to lift their heads but did not respond verbally, or redirect the other resident that was yelling out to R22. Nurse 'P' (who was assigned to R22) was observed at 11:28 AM, walking by the room of the resident that yelled out and saying loudly just the resident's name and proceeded to go down the hallway, then announce to staff they were leaving to go on their break. At no point, were staff observed to respond to, or address R22 being told to Shut-up, nor respond to the resident that was yelling out to Shut-up. Review of the clinical record revealed R22 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: unspecified dementia, unspecified severity, with mood disturbance, altered mental status, epilepsy, unspecified, not intractable, without status epilepticus, generalized anxiety disorder, major depressive disorder recurrent, moderate, and vascular dementia, severe, with agitation. According to the significant change Minimum Data Set (MDS) assessment dated [DATE], R22 had no communication concerns, makes self-understood and understands others, had severe cognitive impairment, and had no mood/behavior concerns. On 9/30/24 at approximately 12:00 PM, the Administrator was asked about to provide the video surveillance via the camera observed on the ceiling nearing the nursing station on 2 east. At that time, the Administrator reported they did not have access and the person that did (Maintenance Director) was out sick. On 10/1/24 at 11:10 AM, an interview was conducted with the Administrator, Assistant Administrator and Regional Director of Operations (RDO). The Administrator reported they had attempted to replay the video surveillance from 9/30/24 but they were having difficulty getting the video to come back up. On 10/1/24 at approximately 12:45 PM, observation of the video surveillance revealed there was no sound and the images were difficult to see up close. The Director of Nursing (DON) was able to identify the staff seated at the nursing station. The Administrator and DON were informed of the concerns regarding what was observed by this surveyor and how staff responded with laughing and failed to respond to and/or address R22 being told repeatedly to Shut-up. The Administrator reported the Nurse had gone in to address it with the resident and they were informed that did not occur during the observations made with this surveyor and were informed of the exact observations and times.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview, and record review facility failed to provide an appropriate wheelchair/Geri-chair (a reclining chair with wheels) for one (R107) of two Residents reviewed for accommodation of needs. Findings include: Record review revealed R107 was originally admitted to the facility on [DATE] with diagnoses of respiratory failure, stroke with right hemiplegia (sided weakness), left craniectomy (is a surgical procedure in which a portion of the skull is removed), major depressive disorder, and anxiety. R107 had a tracheostomy tube (a surgical opening created through the neck into the trachea/windpipe to allow air to fill the lungs). Based on the Minimum Data Set (MDS) assessment dated [DATE], R107 had a Brief interview for Mental Status (BIMS) score of 00/15, indicative of significant cognitive impairment. R107 was dependent on staff assistance for their mobility in bed and transfers. R107 was receiving part of their nutrition through Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube surgically placed directly on the stomach to receive nutrition and hydration). An initial observation was completed on 9/30/24 at approximately 1:50 PM. R107 was observed in their bed with a facility provided gown and they had a helmet on. The lunch tray was on the bedside table next to the bed. R107 nodded their head when asked if they had their lunch. R107 was able to answer simple questions. There were two regular chairs in the room. R107 did not have any wheelchair/Geri-chair in their room. R107 was queried if they were able to get out of bed. They verbalized that they wanted to get out of bed and wanted to go out of their room. When queried if they had a chair to get out of bed and sit in, they said no and pointed to the two regular chairs and stated, Please check. There were no other chairs in the bathroom. Later in that day, R107 was observed in the bed. They were watching a show on their phone. When asked if they wanted to get out of bed, R107 stated, YES, PLEASE PLEASE. A follow up observation was completed on 10/1/24 at approximately 11:30 AM. R107 was observed in their bed with a gown on. When asked if they got out of bed, they said NO. Later that day at approximately 4:15 PM, R107 was observed in their bed with a gown and made a sad face when this surveyor walked in and stated WHY and when notified their concern was being followed up, R107 reported please. At approximately 4:50 PM, Licensed Practical Nurse (LPN) Q who was assigned to care for R107 (on 9/30/24 and 10/01/24) during that shift was interviewed. LPN Q reported that they regularly worked on R107's unit and they were familiar with the residents. They were queried why R107 had been staying in bed and reported that they checked with R107 one day and the resident did not want to get out of bed that day. LPN Q added that might have been a bad day and residents should be able to get out of bed if they wanted to. When queried if they offered R107 the assistance they needed to get out of bed every day, that R107 did not have any chair to get out of bed and sit in. LPN Q reported that they were not aware that R107 did not have a chair and walked into the room. R107 was in their bed and LPN Q asked if they wanted to get out of bed. R107 started saying, Yes .it's hard, it's hard. and became tearful. LPN Q reported that they would follow-up and confirmed that there was no Geri-chair in the room. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at approximately 10:15 AM, R107 had a Geri-chair in their room and when asked if they were getting up, R107 pointed the Geri-chair that was parked across their bed and said YES and were smiling. Review of R107's Electronic Medical Record (EMR) revealed multiple nursing progress notes that read alert and able to make needs known. R107's care plan revealed that they needed a Hoyer lift (a total body lift) to get in and out of bed. R107's CNA care plan (Kardex) did not have a plan to offer and assist them out of bed. An interview was completed with a Certified Nursing Assistant (CNA) S on 9/30/24 at approximately 2 PM. They were queried about R107's routine. They reported that R107 stayed in their bed in their room. They reported that they seldom had any visitors. They did not know why R107 did not have a chair. An interview was completed with a CNA T on 10/1/24 at approximately 4:45 PM. They reported that they were a float staff had been at the facility for over three months. They reported they know the residents and when queried if they had seen R107 out of their bed or assisted them to get of their bed, and they reported no. R107 did not have a care plan to be able to get out of bed and sit in Geri-chair. An interview was completed with Director of Rehabilitation (DOR) R on 10/2/24 at approximately 9:35 AM. They were queried about R107 why they stayed in bed all day and they did not have any chair. They reported that residents were able to get of bed as they chose and R107 used a Geri-chair. When queried if they had enough Geri-chairs, DOR R reported that the facility had limited Geri-chairs and they were able to follow up with administration and get one. An interview was completed with Director of Nursing (DON) on 10/2/24 at approximately 10:15 AM. They were queried about R107 and why they were in bed and did not have a Geri-chair to get out of bed. The DON reported that staff were to offer and assist residents to get out of bed as they chose. They were notified of multiple observations and they reported they would follow up. An e-mail request was sent on 10/2/24 at 8:44 AM to the facility Administrator to provide the facility policy on accommodation of needs and was not received prior to survey exit.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 30675 Based on observation, interview and record review, the facility failed to ensure residents and visitors had access to previous survey results, resulting in residents and visitors being uninformed of deficiencies identified in the facility. This had the potential to affect all residents who resided in the facility. Findings include: Review of the facility's policy titled, Resident Rights dated 7/11/2018: .The Resident has the right .To examine the results of the Nursing Center's most recent survey conducted by representative of the Department of Health and Human Services, and the plan of correction prepared by the Nursing Center in response to the survey . Review of the abbreviated surveys conducted since the facility's last recertification survey on 10/12/23 included surveys on 12/20/23, 5/8/24, 6/17/24, and 7/30/24. Review of the survey information binder revealed there was no documentation from any of these survey findings available for residents and/or visitors. On 10/1/24 at 12:40 PM, during environmental rounds with the Administration, when asked about the lack of surveys since the facility's last recertification survey, the Administrator confirmed the binder had not been updated. When queried about the lack of additional survey documentation available to the residents and/or visits since 10/2023, the Administrator reported they had recently hired an Assistant Administrator on 9/9/24 and that was part of their responsibility. When asked who was responsible for that prior to the recent hire, the Administrator offered no further explanation. On 10/2/24 at 3:00 PM, further review of the survey information binder revealed there was no further updates since the discussion with the Administrator on 10/1/24.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 30675 This citation pertains to intake # MI00146249. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, homelike environment, as evidenced by soiled floors, walls, trash/debris throughout the facility, and visible harborage of pests. This deficient practice has the potential to affect multiple residents throughout the facility, including R22 and R97. Findings include: Review of complaints reported to the State Agency included allegations that the facility's housekeeping staff were not keeping the facility clean, including resident rooms. According to the facility's policies regarding cleaning and homelike environment: Quality of Life - Homelike Environment dated 7/11/2018 read, .The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .Cleanliness and order .Pleasant, neutral scents .The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include .Institutional odors . Cleaning, Disinfection and Sterilization dated 7/11/2018 read, .It is the policy of this facility to provide supplies and equipment that are adequately cleaned, disinfected or sterilized .Supplies and equipment will be cleaned immediately after use . On 9/30/24 at 10:30 AM, R97's room was observed to have a resident laying in bed with tube feeding activity running via pump. The surrounding wall had a dried substance that appeared to be splattered across the wall along the back of the head of the bed. The tube feeding pole was observed soiled with dried brown colored substance along the pole and base. At approximately 10:35 AM, a nursing assistant was asked about the condition of R97's tube feeding pole and upon observation, confirmed the same findings. On 9/30/24 at 2:00 PM, an interview was conducted with R22's daughter at bedside who reported they had been on vacation for past two weeks and this was their first time coming back to the facility since. During this interview, the daughter reported multiple concerns with the cleanliness of the room and upon further observation there were many environmental concerns observed. These concerns included: The resident's c-pap machine (continuous positive airway pressure - a machine that uses mild air pressure to keep breathing airways open while sleeping) was observed upside down on the dresser and there was water leaking from the chamber and all over the bedside dresser. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The daughter then went to the side of the bedside dresser near the floor and asked what was down there. The daughter retrieved the item which was a used disposable wipe with fecal matter visible. The flooring underneath the bed and throughout the room was observed to have debris and trash scattered throughout. The daughter reported they frequently visited R22 multiple times a day for extended periods of time and did not see them come into the rooms, unless they asked them to. The edging of the overbed tray table was observed missing and the edging of the exposed particle board that was soiled was swollen from moisture damage. On 10/1/24 at 8:28 AM, observation of R97's room revealed a very strong foul, fecal odor that was present in the hallway before entering the room. Upon entering the shared bathroom, the toilet bowel was filled with fecal matter and paper towels. There was fecal matter smeared on the outer toilet bowl near the front. On 10/1/24 at 12:01 PM, another observation of R97's revealed the bathroom remained in the same soiled condition as observed earlier at 8:28 AM. On 10/1/24 at 12:19 PM, the Administrator was requested to observe several areas of the environment. Observations included: R97's room was observed in the same manner as earlier. When informed that had been like that since early this morning, and asked how soon that should've been taken care of, the Administrator reported Sooner rather than later. The 2 east dining room was observed to have cabinets that were broken with countertops that were pulled away on the edges. When asked about the poor condition of the contents of the room, the Administrator confirmed the same and reported there were some areas that needed to be replaced. When asked how they were made aware of furniture and items that needed to be replaced or repaired, the Administrator reported they were usually notified through morning meeting sand unit managers. When asked if they maintained any audits to provide for review, they reported they did not. The Administrator further reported they had started at the facility in June and the electronic reporting system was one of those things that all of our staff need to utilize. They were not sure if all staff had ability to use and deferred to their Maintenance Director but reported they were not available due to being out sick at this time. The Administrator further asked if this surveyor was aware they were under receivership. The Administrator was then asked if that meant residents weren't able to be provided with a clean, comfortable, homelike environment and offered no further response. R22's was observed to have soiled floors, the bed by the door did not have a mattress and only the metal bed frame was available. The overbed tray table was confirmed to be broken with missing edges that exposed swollen particle board that had expanded (from liquids) and the entire bottom metal holder had stains and debris on the surface. When asked how that could be properly sanitized in the current condition, the Administrator reported that needed to be replaced. At that time, the Administrator reported this was not up to standards and they had recently changed their housekeeping management and contacted the new supervisor by text message. The Administrator further reported their previous Housekeeping manager had not been working out and they had recently had a new manager for about two weeks now. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At approximately 12:30 PM, the Housekeeping Supervisor (Staff 'O') came to R22's room and confirmed the same observations. They reported they now had full staff and housekeeping should be in the resident rooms daily. When asked about the cleaning up of the soiled toilets, the Administrator reported nursing staff should be cleaning biohazards and bodily fluids. Housekeeping should then come in and sanitize and further stated, There is room for improvement there. When asked about the cleaning of resident care equipment such as tube feeding poles, Staff 'O' reported that was not their responsibility, nursing was responsible for that, but acknowledged they were responsible for the walls. When asked who was monitoring this to ensure these concerns were identified and addressed timely, the Administrator further reported each Unit Manager was responsible for their units and to make sure their units are up to snuff. 39592 On 10/1/24 at 8:33 AM, observation of the 2 [NAME] dining room revealed two residents, one with family members present, sitting at tables waiting for the breakfast trays to be served. A tray was observed on the counter along the East wall of the dining room. There was a ticket that was labeled dinner, along with a resident's name. On the tray was a bowl that had contained a salad, there was an open container of salad dressing in the bowl. There was an open foam container that appeared to be diced, canned pears. Observed around the tray and on the food were several small black flying insects. 49083 On 10/01/24 at 12:20 PM, an observation of the second-floor [NAME] dining room revealed four residents sitting at three different tables. The tabletops were dirty and appeared sticky. The entire carpeted floor was unkept with moderate amounts of crumbs and debris throughout. The kitchen counter displayed areas of brown colored, dried food substance, and debris. Two mirrors on the far wall in between the windows were smudged with fingerprints. Left window vertical blinds were observed broken and bent. Two blue colored fabric lounge chairs were observed with large stains on both seats and arm rests. The middle cabinet of a credenza containing board games was opened and revealed used white Kleenex tissue, a white sheet rolled up with yellow-colored stains and a dirty white bath towel. Lying on the floor next to the credenza, a dusty single black sock was observed.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 This citation pertains to Intake #MI00147295. Based on interview and record review facility failed to document and promptly resolve grievances reported to the facility staff for one (R104) of one Resident reviewed for grievances. Findings include: A complaint received by the State Agency revealed the facility failed to follow-up on a medication concern that was brought up to the attention of the facility administration and attending physician on multiple occasions by the R104 and family member(s). R104 was a long-term resident of the facility originally admitted on [DATE]. R104 had multiple hospitalization s in the recent past that included 12/14/23; 4/5/24; 8/28/24; and 9/6/24. R104's admitting diagnoses included chronic normocytic anemia (low hemoglobin level), CKD (chronic kidney disease), respiratory failure, dry gangrene right 5th toe, and diabetes. Based on the Minimum Data Set (MDS) assessment dated [DATE], R104 had a Brief Interview for Mental Status (BIMS) score of 14/15, indicative of intact cognition. Review of R104's resident profile document (face sheet) in Electronic Medical Record (EMR) revealed 3 family members 's name listed as emergency 1st, 2nd and 3rd contacts. An initial observation was completed on 9/30/24 at approximately11:10 AM. R104 was observed in the bed and was receiving oxygen via nasal cannula. R104 was queried about their care. R104 reported that they were not getting a medication to maintain their hemoglobin level that was prescribed the physician. They were ordered to get the medication weekly (every Friday) and they had not received it for several months. When questioned if they had brought up the concerns with the facility administration, R104 reported that they had addressed the concerns directly with the facility administrator and the attending physician, most recently two weeks ago. R104 added they also had a meeting with the facility administration that included their family members a few months ago and the concern was brought up during the meeting. R104 reported that facility administration had not resolved the medication concern that they had brought up and they had to involve their family. A follow-up e-mail was sent by their family members after that meeting as they were still not getting the medication. R104 reported that their family member had sent e-mail to the administrator and administrator came and asked what they wanted to report back to the family. R104 reported that they had given permission to follow up with family. The medication concern was not addressed with them or with their family; and it was still ongoing. R104 reported that they were notified the medication was expensive and facility would not cover the cost. An e-mail request was sent out to the administrator on 10/1/24 at 3:09 PM to provide any grievances that they may have for R104 from January-2024 to current date. The administrator reported that they did not have any grievances for R104. The administrator was requested to provide the letter/e-mail that was sent to the administrator by the family member, based on the information received from R104 and the complainant. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility provided one e-mail response that was sent by the facility administrator on 8/15/24 at 2:00 PM. The administrator did not provide any other e-mails communications. An interview was completed with the family member emergency contact on 10/1/24 at approximately 12:25 PM. This family who was listed as an emergency contact had reached out to the facility administrator on multiple occasions regarding their medication concern. The family member also reported that they had attended a meeting with the administrator and social worker on 7/25/24 and had brought up the concern. They added follow up e-mails were sent to the facility administrator on 7/28/24, 8/2/24 and 8/14/24. They received one reply from the facility administrator on 8/15/24 with no specifics/resolution for their concerns. Review of the e-mail communication provided by R104's family member revealed that an initial e-mail was sent to the facility administrator on 7/28/24, after their meeting with the facility administrator and social worker with R104. Review of the follow up letter that was sent to the facility administrator revealed multiple concerns that included R104 not receiving the medication that was ordered when they were hospitalized , questions about their insurance paperwork that was not completed timely, questions about their therapy etc. The family member and or the resident did not receive any response from the administrator regarding their concerns. A follow-up email was sent on 8/2/24 and did not receive any response from the administrator. Review of a second follow-up email that was sent to the administrator on 8/14/24 read in part, I have been waiting to hear back from you regarding my [R104]. I sent you an email with an attachment on the 28th of July 2024 and then I emailed you again on August 2nd, 2024, to see if you received the email and you responded that you found it in the spam folder and you would get back to me the following week after you talked to your team to expedite answers to my questions. Well, I haven't heard anything back from you or your staff and it's been two and a half weeks since I initially contacted you. What is going on? Did my (relationship omitted) ever receive the medication that was ordered from his doctor when he was released from the hospital? I spoke to him the other day and he told me he's still waiting and hasn't received the medication . You were very specific about the questions my sister and I asked and you stated that one of us should send you an email with an attachment with all of our questions because you were unable to address them at that time and would be able to do so later. My (relationship omitted) gave you permission to talk to me regarding everything we discussed including the questions we had at the meeting . Review of the administrator's response dated 8/15/24 revealed that they did not share the e-mail with R104 and they had mentioned it to them. The response also revealed that they were not in the facility when these events occurred and they were trying to get answers and get approval from R104. It must be noted that medication concern was ongoing during these e-mail communication and there was no resolution. There was no follow-up from the administrator after 8/15/24, and the medication concern was still ongoing. During an interview with the administrator on 10/1/24 at approximately 2:35 PM, they were queried if they were aware of medication concerns for R104 from the resident and the family. The administrator reported that they had a meeting with R104 and their family and they recalled the conversation about the medication. When queried if they had received concerns from R104 and emails from the family members of ongoing concerns and if they had addressed it. The administrator reported that family was meddling in R104's business and R104 was their own person. (continued on next page)

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	235217	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Bloomfield Hills	2975 N Adams Road Bloomfield Hills, MI 48304

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The administrator was queried about their grievance process during a follow up interview on 10/2/24 at approximately 3:00 PM. They reported that grievance forms can be initiated by any staff member if a resident/family member had a concern. The form was brought to the administrator's attention and they had assigned to the concern to the department leader to address the concerns. After the concerns were resolved they were returned to the administrator for follow up as needed. They added that their expectation is to follow up on any grievance within 24 hours and address within 3-7 days. The administrator did not provide why grievances from R104 or their family.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on interview and record review, the facility failed to complete an annual OBRA (Omnibus Budget Reconciliation Act) Level II Evaluation for one resident(R33) of one resident reviewed for PASARR (Preadmission Screen and Resident Review). Findings include: Clinical record review revealed R33 was admitted to the facility on [DATE] with hemiparesis following a stroke, heart failure, diabetes, and hypertension. Psychiatric history included vascular dementia and bipolar disorder. A Brief Interview for Mental Status (BIMS) evaluated on 07/03/24 score totaled 15/15 indicating R33 was cognitively intact. On 10/2/24, review of the available PASARR form revealed there were two 3877 forms, one was submitted on 7/27/24 and another on 9/12/24. There was no evidence of R33 having the 3878 (dementia exemption) completed for both dates, as well as evidence that there was a level II evaluation completed (given the resident's recent mental status exam which indicated intact cognition, R33 would likely require a level II evaluation and NOT a dementia exemption). On 10/02/24 at 9:44 AM, the facility was requested to provide documentation of R33's PASARR documentation (including if a level II evaluation was done, or a 3878-dementia exemption). The Assistant Administrator reported they were waiting on the physician's signature (which would be for a 3878-dementia exemption). On 10/2/24, an interview was conducted with Social Services Coordinator (SS B). When asked if R33's 3878 was completed, SS B reported the resident had dementia and indicated the 3878 form was in que (electronic portal) for a physician's signature. When inquired where the 3878 from 7/27/23 was documented, SS B was unable to locate within the R33's medical record or the electronic portal for the OBRA assessments. When inquired if they had reached out or could reach out to their local OBRA Coordinator, SS B reported they were unaware that was an available resource. When asked why the forms were not submitted timely for completion as the current 3877 and/or 3878 form was due to be completed by July 2024, SS B did not respond and acknowledged they were unable to provide documentation of an exemption or a Level II PASSAR. Review of a Social Service Job Description, revised 6/2/24 read, .Social Services Coordinator .Location: All MI (Michigan) Facilities .Reports to: Social Services Director/Administrator .Responsible for keeping up-to-date evaluation documentation on each Resident's activities at the facility which complies with Federal, State, and Local regulations .Coordinates services with OBRA (Omnibus Budget Reconciliation Act) .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review, the facility failed to develop resident-specific comprehensive care plans for one (R22) of three residents reviewed for care planning related to behavior-emotional needs and use of psychotropic medications. Findings include: On 9/30/24 at 11:23 AM, R22 was observed seated in a wheelchair behind the nursing desk reading a magazine with staff. The resident began to repeatedly yell out loudly, in which another resident was observed yelling out to the resident to shut up several times. Staff reported the resident's daughter was out of town and usually visited daily, but these behaviors were frequent and not new. Review of the clinical record revealed R22 was admitted into the facility on [DATE], discharged on [DATE] and readmitted on [DATE] with diagnoses that included: unspecified dementia, unspecified severity, with mood disturbance, altered mental status, generalized anxiety disorder, depression, adjustment disorder with mixed disturbance of emotions and conduct, major depressive disorder recurrent, moderate, and vascular dementia, severe, with agitation. According to the significant change Minimum Data Set (MDS) assessment dated [DATE], R22 had no hallucinations/delusions, mood/behavior concerns, and received antipsychotic, antidepressant and antianxiety medication. Review of R22's care plans revealed there were no care plans implemented for the resident's use of psychotropic medication prior to 8/15/24. Additionally, the care plans did not identify any resident-specific details of the resident's mood/behaviors, what to monitor for such as targeted behaviors or approaches that might help to de-escalate the resident. The care plans included: Resident uses anti-psychotic medications r/t (related to) Symptom Management, mood disorder. This was created and initiated on 8/15/24 by a Nurse Manager. Resident uses antidepressant medication r/t Depression. This was created and initiated on 8/15/24, with a revision on 9/11/24 by a Nurse Manager. Resident uses anti-anxiety medications r/t Anxiety disorder. This was created and initiated on 9/11/24 by a Nurse Manager. Resident has mood concern r/t cognitive impairment, Depression and anxiety. This was created on 2/16/24 by a Nurse Manager. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at approximately 11:00 AM, during an interview with the Corporate Clinical Nurse, when asked who was responsible to ensure care plans were implemented and specific to the resident's needs, including identified target mood and behaviors to monitor for, or approaches on how to handle the resident in certain situations, they reported that should be an interdisciplinary team effort. According to the facility's policy titled, Care Planning dated 1/15/2020: .The care plan is developed by the IDT which includes, but is not limited to .Social Services staff member responsible for the resident .To the extent possible, the resident, the resident's family and/or responsible party should participate in the development of the care plan . This policy did not mention ensuring it was resident specific.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 This citation pertains to Intake #MI00147295. Based on observation, interview, and record review the facility failed to administer an erythropoietin stimulating agent (ESA-medication that stimulates the bone marrow to produce more red blood cells) as ordered by physician(s) for one (R104) of one Resident reviewed for quality of care resulting resulted in avoidable hospitalization s (due to critically low hemoglobin levels), blood transfusions, with feelings of frustration, helplessness, and diminished quality of life. Findings include: A complaint received by the State Agency revealed that R104 did not receive a medication that was ordered by the physician to be administered regularly resulting in hospitalization s due to low hemoglobin. The complaint also revealed that the facility failed to follow-up on the concern despite the concern was brought to the facility's administration's attention on multiple occasions by R104 and family members. Review of the clinical record revealed R104 was originally admitted on [DATE]. R104 had multiple hospitalization s in the recent past that included 12/14/23; 4/5/24; 8/28/24; and 9/6/24. R104's admitting diagnoses included chronic normocytic anemia (low hemoglobin level), CKD (chronic kidney disease), respiratory failure, dry gangrene right 5th toe, and diabetes. Based on the Minimum Data Set (MDS) assessment dated [DATE], R104 had a Brief Interview for Mental Status (BIMS) score of 14/15, indicative of intact cognition. Review of R104's resident profile document (face sheet) in the Electronic Medical Record (EMR) revealed three family member names listed as emergency contacts. An initial observation was completed on 9/30/24 at approximately 11:10 AM. R104 was observed in the bed and was receiving oxygen via nasal cannula. R104 was queried about their care. R104 reported that they were not getting a medication to maintain their hemoglobin level that was prescribed by the physician. They were ordered to get the medication weekly (every Friday) and they had not received it for several months. When questioned if they had brought up the concerns with the facility administration, R104 reported that they had addressed the concerns directly with the facility administrator and the Physician, most recently two weeks ago. R104 added they also had a meeting with the facility administration that included their family members a few months ago and the concern was brought up during that meeting. R104 reported that facility administration had not resolved the medication concern that that they had brought up and they had to involve their family. A follow-up e-mail was sent by their family members after the meeting as they were still not receiving the medication. R104 confirmed that they had not received the medication to date. When queried if they had received any response for not receiving the ordered medication, R104 added that they were notified by the Administrator that the medication was expensive and it was not covered by their insurance and the facility would not cover the cost. R104 added that they did not have the funds and said they did not understand how it was cost effective for the facility to keep sending them out to hospital every few months to get the medication and blood transfusions. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A follow-up observation was completed on 10/1/24 at approximately 11:55 AM. R104 was observed in their bed with their oxygen on. R104 reported they recently went out to the hospital due to low hemoglobin. They added they received a blood transfusion and received the medication (Aranesp) needed during their hospital stay. They also saw a hematologist during their recent hospital stay and they recommended to continue the medication weekly. They added that the specialists at the hospital were trying to figure out why their hemoglobin levels were dropping and they recommended getting the medication to maintain the levels. R104 added they can feel when their hemoglobin levels drop. They added that they were very upset and frustrated with the medication that they were not receiving and the lack of follow-up from the facility administration for several months that resulted in multiple hospitalization s and blood transfusions. Review of R104's electronic medical record (EMR) included a nursing progress dated 9/30/24 at 15:51 (after the concern was brought to the facility's attention during survey) read, Physician gave order to start Retacrit 40000 units weekly (medication used to treat anemia) until resident follow up with hematologist for any changes. A practitioner progress note dated 9/26/24 at 11:38 AM read in part, patient has been hospitalized several times due to low blood levels. No GIB (gastro-intestinal bleed i.e. bleeding in stomach). Ferrous sulphate and Aranesp (medication for anemia) ordered. Aranesp DCd (discontinued) due to insurance non-coverage . Further review of EMR revealed that R104 had a hospitalization on [DATE] and had returned to the facility on [DATE]. Review of hospital records dated 9/9/24 revealed that R104 had called the EMS on 9/6/24 due to complaints of chest pain. Hospital records revealed a lab report dated 9/9/24 that revealed a low hemoglobin level of 8.4 g/dl (gram/dilution) (normal level 11-12 g/dl). R104 was administered Aranesp on 9/8/24. A physician progress notes dated 9/9/24 read under plan that read in part Chronic normocytic anemia - extensive workup on previous admission including colonoscopy (procedure examine the colon), EGD (esophagogastroduodenoscopy - a procedure to examine the upper gastrointestinal tract including the food pipe and stomach); attributed to CKD (chronic kidney disease) .Receives weekly darbepoetin-alfa (Aranesp) injections - continue on this. Monitor regular CBC (complete blood count). Review of hematology oncologist consult during hospitalization (dated 9/4/24) read in part, Principal problem: Anemia - unspecified .plan: patient will benefit from Retacrit 40,000 units weekly. Review of discharge medications order from hospital included Aranesp and read inject 300 mcg (microgram) into skin every 7 days for 360 days on Fridays. Further review of R104 EMR revealed Aranesp was not ordered after they were readmitted to the facility on [DATE] and did not receive the medication. Further review of the EMR revealed the facility staff and providers were aware that that the R104 was ordered to receive this medication weekly. There was no evidence in R104's EMR that the facility made any attempts to obtain the medication and/or communicated and followed up with the resident. Review of EMR revealed a practitioner notes dated 9/24/24, that read in part patient has been hospitalized several times due to low blood levels. No GIB (gastro-intestinal bleed i.e. bleeding in stomach). Ferrous sulphate and Aranesp (medication for anemia) ordered. Aranesp DC (discontinued) due to insurance non-coverage .Plan: chronic anemia of CKD- labile .request a substitute for Aranesp. There was no evidence in EMR on any follow-up after and no substitute was ordered. R104 was unaware of any follow up regarding a substitute. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A practitioner note dated 9/20/24 at 13:26 read, this is a --[age and gender omitted]-- on ferrous sulphate for chronic low blood levels associated with CKD. Patient was hospitalized 3 weeks ago for low hemoglobin and CHF (congestive heart failure) exacerbation .Plan: Chronic anemia of CKD labile-No labs found since readmission .continue Aranesp and ferrous sulphate . It must be noted that R104 did not receive Aranesp since they were readmitted from the hospital on 9/4/24. Review of discontinued orders on EMR revealed that Aranesp was ordered on 9/6/24 and was discontinued on 9/9/24 after they were readmitted the hospital on 9/7/24. Review of R104's discontinued physician orders revealed an order for Aranesp dated 4/19/24 (after readmission from hospital on 4/17/24) that read Aranesp (albumin free) injection solution prefilled syringe 200 MCG/0.4 ML (Darbepoetin Alfa) - inject subcutaneously one time a day every Friday for Anemia. Review of Medication Administration Record (MAR) revealed that R104 did not receive the medication from 4/19/24 through 7/15/24. The medication was discontinued on 7/15/24 and it was not re-ordered and R104 was transferred out to hospital on 8/28/24 with a critically low hemoglobin of 6.9 g/dl. Further review of EMR revealed a physician progress note dated 9/5/24 that revealed that R104 was seen by the provider after readmission from hospital. The note read, this is a [age and gender omitted] with pertinent medical history of GIB, anemia of CKD and CHF who was sent out for low hemoglobin of 6.6. Upon arrival to ED (emergency department patient was transfused 2 units capital PRBCs (packed red blood cells) for hemoglobin of 6.9 .O2 (oxygen) need increased due to hypoxia (decreased oxygen in blood) hematology oncologist (doctor who specializes in blood related diseases) recommended Procrit (medicine similar to Aranesp) .plan: chronic anemia of CKD-labile .continue Aranesp. A nursing progress note dated 8/28/24 read, patient transferred to hospital r/t low hemoglobin per physician order. A practitioner note dated 7/15/24 read, Plan: chronic anemia-labile -last hemoglobin 9.5 from 10.8. Continue ferrous sulphate. Aranesp has been on hold for several months due to insurance discrepancy . but did not address alternatives for the medication and or any attempts to receive the medication at any off-site locations. A nursing progress note dated 7/15/24 read, Discussed with physician. Aranesp will be dc (discontinued). HGB will continue to be monitored. A physician note dated 6/18/24 revealed that R104 was seen for regulatory visit and medication reconciliation. The section Diagnosis/status/Plan read in part, Acute blood loss anemia - labile last hemoglobin 9.3 .continue Aranesp. Practitioner notes dated 5/22/24, 5/20/24, 5/7/24, and 4/20/24 read that R104 was currently on ferrous sulfate and Aranesp for chronically low blood levels/anemia. It must be noted that R104 was not receiving this medication during this time (since 4/19/24). R104 had not received their medication prior to their hospitalization s. A nephrology (kidney specialist) consult dated 4/5/24 (during hospitalization) read, recurrent acute on chronic anemia- previous extensive workup done - admission hemoglobin-6.4 .plan: will give Aranesp 300 mcg once a day and needs to continue weekly Aranesp 200 mcg at discharge. He thinks he did not receive the Aranesp dose for last 3 weeks . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was completed with R104's family member on 10/1/24 at approximately 12:25 PM. This family member reported they had reached out to the facility Administrator on multiple occasions regarding their medication concern. The family member also reported that they had attended a meeting with the facility administrator and social worker on 7/25/24 and had brought up the concern. They added follow up e-mails were sent to the facility administrator on 7/28/24, 8/2/24 and 8/15/24. An interview was completed with Nurse Practitioner (NP) M on 10/2/24 at approximately 7:55 AM. NP M confirmed they were following the care of R104 under supervision of the attending physician. The attending physician/Medical Director was on vacation and was unavailable for interview. During this interview NP M was queried why R104 was not receiving Aranesp and what was their expectation if a resident was not receiving a medication that was ordered. They reported that they were aware that R104 was not receiving the medication a few months ago. During this initial interview NP M did not have computer access and they provided information based on what they could remember. They reported that their expectation is for the facility staff to notify them timely if a resident did not receive any of their medications. They added that R104 had multiple causes of anemia and they were trying to get a follow-up hematology oncologist appointment. They were queried about multiple hospitalization s related to low hemoglobin levels and recommendations from the specialists to continue the medication at the facility; and why it was not addressed. It was shared that R104 had an order to receive the medication for over three months and did receive any doses. They reported that it was a valid concern and they should have looked for an alternative medication/treatment and addressed it. They reported that they will review the chart and call back with any additional information. Later that day at approximately 10:55 AM, NP M called back and reported that R104 had extensive work up during hospitalization . They added that the medication was not indicated if the hemoglobin is a level below 10 per pharmacy based on the recent discussion. There was no further explanation of why R104's hemoglobin was monitored closely and not administer the medication as indicated/recommended by the specialists to maintain their hemoglobin levels. They reported that they were on vacation when R104 was hospitalized in September. They were notified of the concerns and they reported that they understood the concerns. An interview with Unit Manager (UM) N was completed on 10/1/24 at approximately 12:15 PM. UM N was queried about the medication (Aranesp) for R104. They reported that R104 was on this medication and the physician discontinued the medication in July as R104's hemoglobin was stable. When queried about R104's low hemoglobin in April and in August when they needed hospitalization s and transfusions and why Aranesp that was ordered, but were not administered. UM N reviewed the EMR and reported that R104 was on the 2nd floor and had moved to 1st floor (on 5/29/24) and they had identified on 7/15/24 that R104 had missed this medication (since 4/17/24) and they had followed up with the provider (NP M) and notified that R104 had not been getting the medication and they had written a note. They added that the NP M discontinued the order for Aranesp. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) was completed on 10/01/24 at approximately 2:55 PM. Regional Nurse Consultant was present during the interview. The DON was queried about the facility's process to ensure that that residents received the medications that were ordered by the physician upon admission/readmission. They reported that the admitting nurses reconciled the orders and unit managers followed up after to ensure that residents received their medications. If there was any missed medication that nurses notified the physician and followed up with their unit manager. The DON was queried if they were aware of R104 not receiving their Aranesp since 4/17/24 due insurance discrepancy and had hospitalization s due to low hemoglobin. They reported that they were unaware that they did not receive the medication in July over an extended period of time. The DON reported they understood the concern and the medication should have been ordered and administered and did not provide any further explanation. During an interview was completed with the administrator on 10/1/24 at approximately 2:35 PM. They were queried if they were aware of medication concerns for R104 from the resident and the family. The administrator reported that they had a meeting with R104 and their family and they recalled the conversation about the medication. When queried why R104 was not receiving the medication that was ordered for several months and was hospitalized multiple times and needed transfusions, the administrator reported that they were not clinical and they had to check with the clinical team. They were queried if the DON was part of their meeting and they were not sure. When queried about the insurance discrepancy/coverage that was reported by R104, evidenced by the documentation in the EMR, the administrator reported that they were not aware of any insurance concerns and they should be getting the medications as ordered by their physician. A review of the facility provided document titled Medication Administration with a revision of 12/19/19, read in part, It is the policy of this facility that medications shall be administered as prescribed by the attending physician. PROCEDURE: 1. Only licensed medical and nursing personnel or other lawfully authorized staff members may prepare, administer and record medications. 2. Medications must be administered in accordance with the written orders of the ordering/prescribing physician. NOTE: If a dose seems excessive considering the resident's age and condition, or a drug order seems to be unrelated to the resident's current diagnosis or condition, the nurse should contact the physician. 3. All current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR) 12. Should a drug be withheld, refused, or given other than the scheduled time, the nurse must enter an explanatory note. NOTE: The Director of Nursing and attending Physician must be notified when two (2) doses of a medication are refused or withheld. 13. Medications ordered for a particular resident may not be administered to another resident .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 This citations pertains to intake: MI00146611 Based on observation, interview, and record review, the facility failed to secure the smoking materials for one (R15) of one Resident reviewed for smoking resulting in the potential to cause burns from smoking/smoking materials that were unsecured. Findings include: During the entrance conference with the facility administrator on 9/30/24 at 9:58 AM, the administrator reported that the facility was a non-smoking facility and they did not have any current smokers at the facility. Record review revealed R15 was originally admitted to the facility on [DATE] with diagnoses of cancer of the urinary bladder, peripheral vascular disease, nicotine dependence, Chronic Obstructive Pulmonary Disease (COPD), diabetes, and heart disease. Based on the Minimum Data Set (MDS) assessment dated [DATE], R15 had a Brief Interview for Mental Status (BIMS) score 14/15, indicative of intact cognition. An initial observation was completed on 10/1/24 at approximately 9 AM. R15 was observed in their bed. They had a power wheelchair in their room. R15 had a roommate. R15 reported that they used their power wheelchair to go out of the facility. When queried further about the process they reported that there was none and they would just let the staff know that they were leaving. A follow-up observation was completed on 10/2/24. During this observation R15 was observed sitting in their power wheelchair across from the nurse's station. When queried if they were ready to do anything, R15 reported that they were going to go smoke. When queried where did they get the smoking supplies from R15 reported that they kept all their smoking supplies in their room, hidden. When asked, R15 showed a pack of cigarettes and a lighter in their coat pocket. When queried if staff monitored or assisted them, R15 reported that they did not have any assistance and they could do it on their own. They added that they had been smoking for a while. They also reported that facility staff were aware that they smoke. Review of Physician progress notes dated 9/25/24 read, Patient is a current some day smoker. He smokes (name omitted) cigarettes per day. Another practitioner note dated 9/24/24 read Tobacco: current everyday smoker. A social worker progress note dated 8/27/24 read Social worker met with (R15 name omitted) on 8/27/24 in common area (internet cafe) to discuss the non-smoking policy at the facility. (R15 name omitted) confirmed that he understands the policy of no smoking on the entire campus . (continued on next page)

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Skld Bloomfield Hills	2975 N Adams Road Bloomfield Hills, MI 48304

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Certified Nursing Assistant (CNA) U on 10/2/24 at approximately 1:05 PM. They reported that they had usually worked on the unit and they knew the residents. CNA U was queried if they had residents who smoked on the unit. CNA U pointed to R15 (who was sitting in the hallway, outside of the dining room door) and reported that they were a smoker. They were queried if staff assisted or monitored R15, and they reported that R15 did their own thing usually and sometimes staff went outside with them to monitor. An interview was completed with unit manager (UM) V on 10/2/24 at approximately 1:15 PM. They were queried if they had residents who were current smokers and they reported that they were a smoke free facility and did not have any residents who smoked. UM V was notified that R15 had smoking materials, they had been smoking for a while and their staff were aware. They reported that R15 was not allowed to keep smoking materials and they would follow-up. An interview was completed with the administrator on 10/2/24 at approximately 1:25 PM. When notified of the observations and concerns, the administrator reported that they were a non-smoking facility and they were going to secure his smoking materials and follow up with their corporate. They reported that they understood the concern. The Director of Nursing (DON) was notified of the observations and the concern on 10/2/24 at approximately 4 PM. The DON reported that they understood the concern. They added that they would complete a smoking assessment and follow up with their team.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to ensure medically-related social services and follow-up to address psychosocial and mental health needs including mood/behavior management, patient advocacy/guardianship, and coordination of PASARR (Preadmission Screening and Annual Resident Review) for three (R22, R25 and R117) of four residents reviewed for social services. Findings include: The facility was previously determined to be out of compliance for concerns with providing medically related social services to address psychosocial needs, including guardianship during an abbreviated survey conducted on 7/30/24 with an alleged compliance date of 8/19/24. Review of the facility's documentation provided for Social Work job descriptions included: Revised 6/1/24, Job Title: Social Services Director .Location: All MI (Michigan) Facilities .Reports to: Administrator & RDO (Regional Director of Operations) .Responsible for keeping up-to-date evaluation documentation on each resident's activities at the facility which complies with Federal, State, and Local regulations . Revised 6/2/24, Job Title: Social Services Coordinator .Location: All MI Facilities .Reports to: Social Services Director/Administrator .Responsible for keeping up-to-date evaluation documentation on each Resident's activities at the facility which complies with Federal, State, and Local regulations .Ensure completion of any required components of DPOA (Durable Power of Attorney) or guardianship paperwork .Coordinates services with OBRA (Omnibus Budget Reconciliation Act) . R22 On 9/30/24 at 2:00 PM, an interview was conducted with R22's daughter in the resident's room. At that time, when asked about the resident's behaviors of yelling out, the daughter reported they felt that was due to concerns with back and butt pain from sitting in the chair. They further reported the resident was not able to verbalize this to staff (pain) and so they will yell out disruptively and this had been discussed with the facility staff multiple times (this was not reflected in any of the resident's documentation for potential behavior causes). Review of the clinical record revealed R22 was admitted into the facility on [DATE], discharged on [DATE] and readmitted on [DATE] with diagnoses that included: unspecified dementia, unspecified severity, with mood disturbance, altered mental status, epilepsy, unspecified, not intractable, without status epilepticus, paroxysmal atrial fibrillation, generalized anxiety disorder, depression, adjustment disorder with mixed disturbance of emotions and conduct, major depressive disorder recurrent, moderate, and vascular dementia, severe, with agitation. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the significant change Minimum Data Set (MDS) assessment dated [DATE], R22 had no communication concerns, had severe cognitive impairment (scored 1/15 on Brief Interview for Mental Status/BIMS exam), had no hallucinations/delusions, had no mood/behavior concerns, received antipsychotic, antianxiety, and antidepressant medication, had no gradual dose reduction (GDR) attempted, and deferred to the physician documentation which stated, .a GDR was clinically contraindicated on 7/24/24. Review of the physician orders revealed R22 had been admitted with and received antipsychotic and antianxiety medication since admission and were prescribed for dementia and agitation. Review of the care plans revealed there were none implemented for R22's use of antipsychotic and antidepressant medication until 8/15/24, and the antianxiety medication was not implemented until 9/11/24. None of these care plans identified any resident-specific targeted behaviors/symptoms to monitor for, or interventions that might be attempted to redirect specific behaviors when/if those instances occur. The care plan initiated on 2/16/24 for mood concern did not identify any specific details of what signs/symptoms the resident exhibited, or what to monitor for specifically. There was no documentation from social services regarding R22's behaviors, or reviews with the interdisciplinary team that they identified resident-specific targeted behaviors for their use of multiple psychotropic medications, including antipsychotic, antidepressant, and antianxiety medication. Review of the EMR for what specific targeted behaviors revealed there were no detailed/resident-specific identified. The Medication Administration Records (MARs) included: ANTIPSYCHOTIC BEHAVIOR TRACKING: Document # of delusions each shift. ANTIANXIETY BEHAVIOR TRACKING: Document # of s/sx (signs/symptoms) of anxiety exhibited each shift. Monitor for side effects of PSYCHOTROPIC medication(s) of any medication classification; including, but not limited to increased sedation, drowsiness, lightheadedness, syncope, abnormal movements (TD), dry mouth, etc. My initials indicate absence of signs and symptoms of side effects. Review of R22's behavior documentation on the MARs revealed some months were all documented as 0, a few had one or two entries of anxiety and delusions, and some were left blank. The few documented entries did not have any specific details for R22. There were no corresponding progress notes as well. On 10/2/24 at 8:24 AM, the Administrator was requested via email to provide any mood/behavior documentation since admission. Review of the documentation provided revealed the same progress notes that were reviewed, which did not include any documentation from social services regarding R22's behaviors or use of psychotropic medications. There were no behavior management quarterly reviews provided for review (as per policy below). According to the facility's policy titled, BEST PRACTICE BEHAVIOR & PSYCHOTROPIC MEDICATION MONITORING dated 7/30/2020: (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Patients utilizing psychotropic medication, whether scheduled or PRN, will be monitored for symptoms with documentation within medical record when observed .Each shift, Licensed Nurse, will document via eMAR # of episodes of specific behavior were exhibited, either by personal observation or via communication with other team members, including but not limited to, CNA (Certified Nursing Assistant), Houesekeeping, etc . Front-line staff members (CNA, Activity Assistants, etc.) Documentation will be completed via Point of Care (POC) .When a behavior or symptom is observed by front-line staff member, they will log into POC and document the type of behavior observed, intervention(s) attempted with behavior, and response to intervention per POC documentation requirements, either by Q (every) shift (allows multiple entries) or PRN (as needed) .Documentation may be completed via either: Point of Care (POC), or Progress Note(s) with utilization of 'Mood/Behavior' progress note type for 'exception' documentation; i.e., episodes that require additional documentation of intervention, response to intervention, etc .Nursing Management, or designee, will monitor [Electronic Medical Record/EMR] Clinical Dashboard option 'Psychotropic Medication Ordered in last 7 days' daily on business days to ensure the following .Psychotropic medications have appropriate diagnosis or indications for use, Appropriate behavior documentation and monitoring for potential side effect orders and POC tasks have been created within medical record, Plan of Care is in place to address patient utilization of medication, symptoms and/or specific behaviors, non-pharmacological interventions, etc . Behavior Management Reviews will be completed per facility schedule based on patient needs, but no less than quarterly . R117 Review of the clinical record revealed R117 was admitted into the facility on [DATE], discharged on [DATE], and readmitted on [DATE] with diagnoses that included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The profile information in the clinical record indicated R117 was their own representative, and identified three other family members (granddaughter, son, and daughter) as contacts. According to the MDS assessment dated [DATE], R117 had long and short term memory impairment with severely impaired cognitive skills for daily decision making. Further review of the clinical record revealed there was no designated power or attorney, or legal guardian in place, despite R117's severe cognitive impairment. Review of the most recent social service progress note for R117 was on 8/26/24 at 2:26 PM from Social Services Staff (SS 'B') that read, Social Worker left voicemail message for [R117's granddaughter] on 08/26/24 regarding guardianship. Social Worker will follow up as needed. There was no further follow documented in the clinical record. On 10/1/24 at 3:17 PM, an interview was conducted with SS 'B'. When asked if there was any follow-up to their discussion with R117's granddaughter from 8/26/24 regarding guardianship, SS 'B' reported they had not heard back from the family yet and the granddaughter was supposed to follow up with her parents. When asked when should the facility follow-up be done, especially if they have not heard back yet (since 8/26/24), SS 'B' reported they will have to find out and get back. (SS 'B' had no further follow-up by the end of the survey). (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at approximately 10:30 AM, the Administrator and Assistant Administrator were informed of the concerns regarding lack of social work coordination for mood/behaviors/psychotropic medications, including care plan development and lack of guardianship follow-through. Neither were able to offer any further explanation. 49083 R25 On 10/2/24, clinical record review revealed R25 was admitted to the facility on [DATE] with a medical history of Parkinson's disease, heart disease, and diabetes. Psychiatric diagnoses included dementia, and schizophrenia. R25 had a BIMS score 9/15 indicating moderate cognitive impairment. Record review revealed on 8/20/24, R25 was evaluated determined unable to make medical treatment or financial decisions and guardianship was recommended. Progress note dated 8/16/24 revealed social services contacted R25's daughter and recommended guardianship. The progress note dated 8/21/24 documented social services informed R25's daughter about the results of the capacity evaluation and the determination of inability to participate in complex decision making. The family expressed they will proceed with guardianship. The progress note dated 8/30/24 documented that social services met with R25's daughter and provided the letter of decision-making capacity and the daughter would be filing for guardianship soon. Social Worker will follow up as needed . On 10/2/24, further review of the clinical record revealed there was no further progress notes from social services since 8/30/24 and no documentation of follow-up from social services with R25's daughter regarding guardianship status.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to ensure a resident prescribed psychotropic medication had adequate documentation to support continued use, as well as identify and monitor resident specific targeted behaviors and approaches for one (R22) of five residents reviewed for unnecessary medication, resulting in prolonged unnecessary use of psychotropic medication and the inability to monitor the effectiveness of the prescribed treatment due to lack of supporting documentation. Findings include: On 9/30/24 at 11:23 AM, R22 was observed seated in a wheelchair behind the nursing desk reading a magazine with staff. The resident began to repeatedly yell out loudly, in which another resident was observed yelling out to the resident to shut up several times. On 9/30/24 at 2:00 PM, an interview was conducted with R22's daughter in the resident's room. At that time, when asked about the resident's behaviors of yelling out, the daughter reported they felt that was due to concerns with back and butt pain from sitting in the chair. They further reported the resident was not able to verbalize this to staff (pain) and so they will yell out disruptively and this had been discussed with the facility staff multiple times (this was not reflected in any of the resident's documentation for potential behavior causes). Review of the clinical record revealed R22 was admitted into the facility on [DATE], discharged on [DATE] and readmitted on [DATE] with diagnoses that included: unspecified dementia, unspecified severity, with mood disturbance, altered mental status, epilepsy, unspecified, not intractable, without status epilepticus, paroxysmal atrial fibrillation, generalized anxiety disorder, depression, adjustment disorder with mixed disturbance of emotions and conduct, major depressive disorder recurrent, moderate, and vascular dementia, severe, with agitation. According to the significant change Minimum Data Set (MDS) assessment dated [DATE], R22 had no communication concerns, had severe cognitive impairment (scored 1/15 on Brief Interview for Mental Status exam), had no hallucinations/delusions, had no mood/behavior concerns, received antipsychotic, antianxiety, and antidepressant medication, had no gradual dose reduction (GDR) attempted, and deferred to the physician documentation a GDR was clinically contraindicated on 7/24/24. Review of the physician orders revealed R22 had been admitted with and received antipsychotic and antianxiety medication since admission and were prescribed for dementia and agitation. Review of the care plans revealed there were none implemented for R22's use of antipsychotic and antidepressant medication until 8/15/24, and the antianxiety medication was not implemented until 9/11/24. None of these care plans identified any resident-specific targeted behaviors/symptoms to monitor for, or interventions that might be attempted to redirect specific behaviors when/if those instances occur. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan initiated on 2/16/24 for mood concern did not identify any specific details of what signs/symptoms the resident exhibited, or what to monitor for specifically. Further review of the electronic medical record (EMR) revealed documentation of R22 having behaviors of yelling out at times. There were no documented concerns with psychosis such as distressing delusions or hallucinations. Review of R22's physician orders for psychotropic medication revealed the resident had been admitted with multiple psychotropic medication. R22's current psychotropic medications included: Quetiapine Fumarate (an antipsychotic medication) Oral Tablet 25 MG (Milligrams) Give 1 tablet by mouth two times a day for Antipsychotic related to UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH MOOD DISTURBANCE (total dose of 50 MG every day). This order had been started on 7/29/24. The previous dose of 50 MG every eight hours (total dose of 150 MG every day). Lorazepam (an antianxiety medication) 0.5mg/1ml (Milliliters) Gel APPLY TO WRIST TOPICALLY EVERY 12 HOURS FOR ANXIETY (BEYOND USE DATE=14 DAYS) (HANDLE WITH GLOVES). This medication had been started on 8/15/24. Mirtazepine (an antidepressant medication) Tablet 15 MG Give 1 tablet by mouth at bedtime related to GENERALIZED ANXIETY DISORDER. This medication had been ordered on 5/29/24. Citalopram Hydrobromide (an antidepressant medication) Tablet 10 MG Give 1 tablet by mouth one time a day for depression give with 20mg to =30mg. This medication had been ordered on 2/15/24. Citalopram Hydrobromide Oral Tablet 20 MG Give 20 mg by mouth one time a day for treats depression. This medication had been ordered on 1/29/24 (upon admission). Review of the EMR for what specific targeted behaviors revealed there were no detailed/resident-specific identified. The Medication Administration Records (MARs) included: ANTIPSYCHOTIC BEHAVIOR TRACKING: Document # of delusions each shift. ANTIANXIETY BEHAVIOR TRACKING: Document # of s/sx (signs/symptoms) of anxiety exhibited each shift. Monitor for side effects of PSYCHOTROPIC medication(s) of any medication classification; including, but not limited to increased sedation, drowsiness, lightheadedness, syncope, abnormal movements (TD), dry mouth, etc. My initials indicate absence of signs and symptoms of side effects. Review of R22's behavior documentation on the MARs revealed some months were all documented as 0, a few had one or two entries of anxiety and delusions, and some were left blank. The few documented entries did not have any specific details for R22. There were no corresponding progress notes as well. On 10/2/24 at 8:24 AM, the Administrator was requested via email to provide any mood/behavior documentation since admission. Review of the documentation provided revealed the same progress notes that were reviewed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 12:04 PM, review of the documentation provided by the facility for R22's mood/behavior documentation included the same progress notes in the EMR. Review of the psych evaluations since admission on 2/7/24, 2/25/24, 2/28/24, 3/13/24, 4/4/24, 5/29/24, 7/24/24, and 9/18/24 all identified R22's behaviors of yelling out/screaming, restless and delusions, however there were no specific details of what the delusions were. Review of the task Behavior documentation for the past 30 days (max look back period) revealed staff documented yelling/screaming behaviors on 9/18/24 at 6:11 AM, 9/21/24 at 6:51 AM, and on 9/22/24 at 6:44 AM. On 10/2/24 at 12:36 PM, a phone interview was conducted with Psych Nurse Practitioner (NP 'I'). NP 'I' confirmed they had been following R22 since admission and further reported as of a week ago, they were no longer coming to the facility. When asked about R22's behaviors and reason why on antipsychotic, antianxiety, and multiple antidepressant medication, NP 'I' reported they felt R22 had gotten a lot better, felt their behaviors had improved. When asked what specific behaviors, NP 'I' reported behaviors of yelling out. NP 'I' confirmed there were no concerns with hallucinations, but the resident would yell out, be very disoriented, and more delusional. When asked what specific delusions as this was not reflected in any of the documentation reviewed, NP 'I' reported the family reports she'll say things to them, and was unable to give any specific details. NP 'I' reported the antipsychotic was decreased recently and had made some progress. When asked to confirm specifically their rationale to continue the multiple psychotropic medications in the absence of any specific targeted behaviors that warranted use of these medications, NP 'I' reported the yelling out and what family reported. When asked to confirm what they reviewed during their evaluations of R22, NP 'I' confirmed the documentation reviewed was the behavior log that's only for 14 day look back in the POC (Point of Care) the CNAs documented but was not always accurate, and they spoke to staff. NP 'I' was not aware of the Nurse's documentation on the MAR. NP 'I' reported they had recently seen R22 on 9/18/24 and at that time, there were only two episodes of yelling/screaming in the last 14 days. NP 'I' was informed of the concerns regarding lack of resident-specific targeted behaviors for all classes of psychotropic medications, lack of care plans/interventions and continued use of these medications and they acknowledged improvements were needed. Review of a pharmacy recommendation completed by R22's Attending Physician (Physician 'J') on 7/31/24 read, Note to Attending Physician/Prescriber .This resident is receiving Quetiapine but lacks an allowable diagnosis to support its use (listed on MAR). Please circle the accurate indication for use below for nursing to update: -Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder -Delusional Disorder, Psychosis NOS, Atypical Psychosis, Brief Psychosis -Mania, Bipolar Disorder, -Depression with Psychotic Features, Treatment Refractory Major Depression OR (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Behavioral or Psychological Symptoms of Dementia (BPSD) Targeted Symptom: agitation. Physician 'J' circled the above option and wrote in targeted symptom as agitation. Only the diagnosis what updated. On 10/2/24 at approximately 1:30 PM, an interview was conducted in person with R22's Attending Physician (Physician 'J'). When asked about their response to the pharmacy recommendation from 7/31/24 and R22's use of multiple psychotropic medication, Physician 'J' reported the medications were not touched due to resident's continued behaviors of yelling out and then becomes anxious. (This was conflicting since there were medication adjustments, but the resident remained on these medications in absence of appropriate and identified targeted behaviors in accordance with regulatory requirements). They were informed of the discussion with Psych NP 'I' and lack of supporting documentation and was unable to offer any further explanation. On 10/2/24 at approximately 11:00 AM, during an interview with the Corporate Clinical Nurse, the above concerns were reviewed regarding the lack of supporting documentation and continuation of psychotropic medications in absence of appropriate diagnoses and identified behaviors. According to the facility's policy titled, BEST PRACTICE BEHAVIOR & PSYCHOTROPIC MEDICATION MONITORING dated 7/30/2020: .Patients utilizing psychotropic medication, whether scheduled or PRN, will be monitored for symptoms with documentation within medical record when observed .Each shift, Licensed Nurse, will document via eMAR # of episodes of specific behavior were exhibited, either by personal observation or via communication with other team members, including but not limited to, CNA (Certified Nursing Assistant), Houesekeeping, etc . Front-line staff members (CNA, Activity Assistants, etc.) Documentation will be completed via Point of Care (POC) .When a behavior or symptom is observed by front-line staff member, they will log into POC and document the type of behavior observed, intervention(s) attempted with behavior, and response to intervention per POC documentation requirements, either by Q shift (allows multiple entries) or PRN . Documentation may be completed via either: Point of Care (POC), or Progress Note(s) with utilization of 'Mood/Behavior' progress note type for 'exception' documentation; i.e., episodes that require additional documentation of intervention, response to intervention, etc .Nursing Management, or designee, will monitor [electronic medical record] Clinical Dashboard option 'Psychotropic Medication Ordered in last 7 days' daily on business days to ensure the following .Psychotropic medications have appropriate diagnosis or indications for use, Appropriate behavior documentation and monitoring for potential side effect orders and POC tasks have been created within medical record, Plan of Care is in place to address patient utilization of medication, symptoms and/or specific behaviors, non-pharmacological interventions, etc .Behavior Management Reviews will be completed per facility schedule based on patient needs, but no less than quarterly .

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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 This citation pertains to intake #s MI00146249 and MI00147295. Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than five percent. Three medication errors were observed from a total of 36 opportunities for three out of three residents (R19, R03, R83) resulting in an error rate of 8.33%. Findings include: Review of a complaints filed with the State Agency included allegations that medications were not being properly administered. On 10/01/24 at 8:28 AM, a medication administration observation was conducted with Licensed Practical Nurse (LPN) L. R19 R19 had an order for one tablet of chewable Aspirin 81 milligrams (mg). LPN L was observed preparing an enteric coated aspirin 81 mg and crushed the medication for administration. R03 R03 had an order for one tablet of chewable Aspirin 81 milligrams (mg). LPN L was observed preparing an enteric coated aspirin 81 mg, crushed the medication, then administered it. R83 On 10/01/24 at 9:38 AM, LPN L obtained an order for one tablet chewable aspirin 81 mg. LPN L was observed preparing an enteric coated aspirin 81 mg and administered to R83. On 10/01/24 at 4:35 PM, an interview was conducted with the Director of Nursing (DON) and acknowledged LPN L should have given the correct medication as ordered by the Physician and that enteric coated medications are not to be crushed for administration. Review of the facilities policy titled; Medication Administration dated 12/2019 documented .Medications must be administered in accordance with the written orders of the ordering/prescribing physician .

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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 the kitchen and the 1st and 2nd floor pantry refrigerators in a sanitary manner. This deficient practice had the potential to affect all residents in the facility that consume food. Findings include: On 9/30/24 between 8:50 AM-9:20 AM, during an initial tour of the kitchen with Dietary Manager (DM) K, the following items were observed: In the walk-in cooler, there was pooled milk on the floor near the milk crates. DM K stated that staff would get the spilled milk cleaned up when they began putting stock away. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean. The shelving rack used to store spices and various food items, was observed with a heavy buildup of grease, food debris and dust. DM K confirmed the soiled rack and stated staff would clean it right away. According to the 2017 FDA Food Code section 4-602.13 Nonfood-Contact Surface, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 9/30/24 at 9:25 AM, the 1st floor pantry refrigerator utilized for the storage of resident food items, was observed to be heavily soiled with dried on food spills. In addition, the microwave located in the 1st floor pantry, was heavily soiled on the inside surface with splattered food debris. On 9/30/24 at 9:30 AM, the 2nd floor pantry refrigerator utilized for the storage of resident food items, was observed to be soiled with food and liquid spills. In addition, the following items were observed inside the refrigerator: a container of potato salad dated 9/9, an undated container of an unknown food item, a Greek salad dated 9/7, an undated container of pizza and vegetable, a container of garlic spread dated 8/25, an undated container of an unknown food item, an undated container of moldy meat and rice, an undated pork chop, and a moldy bag of fruit dated 9/6. Review of the facility's policy Food Brought by Family/Visitors Adopted 7/11/18 noted: 6. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the use by date. 7. The nursing staff is responsible for discarding perishable foods on or before the use by date. 8. The nursing and/or food service staff must discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). On 9/30/24 at 11:45 AM, 3 male kitchen staff employees were observed with beards, but were not wearing beard restraints. The 3 kitchen staff employees were observed prepping food items, serving food from the steam table, and assembling trays for lunch service. On 9/30/24 at 2:45 PM, DM K confirmed that all kitchen staff with beards should wear a beard restraint. (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 2017 FDA Food Code section 2-402.11 Effectiveness, (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to employ a qualified social worker on a full-time basis to meet the psychosocial, mental, and behavioral health care needs of the residents. This deficient practice had the potential to affect all residents that reside within the facility. Findings include: During the recertification survey conducted [DATE] to [DATE], substandard quality of care was identified regarding the facility not having a qualified social worker to provide medically related social services full-time to the 122 residents who resided in the facility. The facility was certified for 159 beds. Deficient practices were identified during the survey related to social services, specifically concerns with lack of assessment and monitoring for resident's psychosocial, mood and behavioral needs, and coordination of guardianship. Review of the facility's documentation provided for Social Work job description included: Revised [DATE], Job Title: Social Services Director .Location: All MI (Michigan) Facilities .Reports to: Administrator & RDO (Regional Director of Operations) .Responsible for keeping up-to-date evaluation documentation on each resident's activities at the facility which complies with Federal, State, and Local regulations .If the facility has 120 beds or more, this position requires a minimum of a bachelor's degree in social work or another human services field, and One year of supervised social work experience in a health care setting working directly with individuals . Revised [DATE], Job Title: Social Services Coordinator .Location: All MI Facilities .Reports to: Social Services Director/Administrator .Responsible for keeping up-to-date evaluation documentation on each Resident's activities at the facility which complies with Federal, State, and Local regulations .Ensure completion of any required components of DPOA (Durable Power of Attorney) or guardianship paperwork . Coordinates services with OBRA (Omnibus Budget Reconciliation Act) .Education, Training, and Experience . Strongly prefer a degree in gerontology or a related field and at least one year of experience in a social services program for the elderly or related field . These job descriptions did not identify license requirements for a full-time social worker in a facility that was certified/licensed over 120 beds. This facility is certified for 159 beds. On [DATE] at 12:40 PM, an interview was conducted with the Administrator in the presence of the Assistant Administrator and the Regional Director of Operations (RDO). When asked about the facility's Social Work staff and who was employed as their full-time licensed Social Worker since their facility was over 120 beds, the Administrator reported that was Social Service Staff (SS 'B') but their license expired in [DATE] and confirmed that had been identified during an abbreviated survey. They further reported the facility had recently hired a licensed Social Worker (SW 'F') who started on [DATE]. (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Administrator was asked who was employed as their full-time licensed SW following their knowledge that SS 'B's license expired and they reported they had a Social Worker (SW 'C') who was contingent, on their employee roster, and was at the facility every other weekend. They further reported Social Worker (SW 'D') who was a licensed SW came to help from their sister facility and confirmed there was no full-time licensed SW from [DATE] (when SS 'B's license expired) until [DATE]. The Administrator reported they were interviewing for full-time coverage and tried to cover from their four other buildings but was not able to until [DATE]. The Administrator was requested to provide documentation of their licensed SW's and who was full-time and part-time since from their last recertification survey on [DATE] to present. On [DATE] at 5:25 PM, the Assistant Administrator responded by email that SW 'C 's license expired [DATE]. On [DATE] at 8:32 AM, the Administrator was informed that Substandard Quality of Care had been identified regarding the facility not having full-time licensed social worker. The Administrator confirmed he just found out last night that the part-time person (SW 'C') they had coming every other weekend, their license expired [DATE] and SW 'D' had been helping out part-time from their sister facility, but aware was not full-time. When asked how the facility failed to identify SW 'C's expired SW license as the concerns were brought to the facility's attention during the abbreviated survey on [DATE], the Administrator reported HR (Human Resources) should've been on top of that and it fell through the cracks. Review of the documentation provided by the facility regarding SW staff timeline since their last recertification survey to present confirmed there was no full-time social worker employed at the facility from [DATE] to [DATE].

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 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 systemic issues that resulted in sub-standard quality of care from failure to employ a qualified full time social worker and failure to provide medically related social services. This deficient practice had the potential to affect all 120 residents of the facility. Findings include: Facility failed to employ a qualified social worker on a full-time basis and failed to identify the ongoing concern. Facility was unaware of this concern until the concern was brought to the attention of the Administrator. The facility was previously determined to be out of compliance for concerns with providing medically related social services to address psychosocial needs, including guardianship during an abbreviated survey conducted on [DATE] with an alleged compliance date of [DATE]. On [DATE] at 8:32 AM, the Administrator was informed that Substandard Quality of Care had been identified regarding the facility not having a full-time licensed social worker. The Administrator confirmed he just found out last night that the part-time person (SW 'C') had been coming every other weekend, their license expired [DATE] and SW 'D' had been helping out part-time from their sister facility, but aware was not full-time. When asked how the facility failed to identify SW 'C's expired SW license as the concerns were brought to the facility's attention during the abbreviated survey on [DATE], the Administrator reported HR (Human Resources) should've been on top of that and it fell through the cracks. On [DATE] at approximately 10:30 AM, the Administrator and Assistant Administrator were informed of the concerns regarding lack of social work coordination for mood/behaviors/psychotropic medications, including care plan development and lack of guardianship follow-through. Neither were able to offer any further explanation. A facility provided document titled Quality Improvement - Quality Assessment and Assurance Program with a revision date [DATE] read in part, Quality Assurance is a continuous process towards quality management. Improving services begins with the realization that higher levels of quality are achieved through every interaction between employees, residents, families and caregivers. Each person's effort contributes to improving resident outcomes and satisfying service expectations. In the [NAME] for continuous improvement, team members bring together multidisciplinary expertise from all levels of the organization in approaching problems and finding solutions. Interventions are analyzed and targeted key performance improvement steps identified. PERCEPTIONS OF QUALITY Quality Assurance and Performance Improvement (QAPI) builds upon traditional quality assurance methods by emphasizing the organization and systems. QAPI incorporates systems, programs, clinical practice, and clinical development driving system integrations and inter-program coordination through organized leadership oversight. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Some characteristics of Quality Assurance and Performance Improvement include: o Focuses on the resident needs and service o Directs exploration of systems rather than identifying individual weaknesses o Empowers employees o Involves leadership o Integrates analysis of data o Finds opportunities to improve o Provides participation, communication and team spirit o Changes outcomes through process implementation o Evaluates customer service and satisfaction o Develops service quality o Promotes a continuous closed loop process o Encourages self-development and organizational interests The Quality Assessment and Assurance (QAA) Committee provides leadership and guidance for ongoing continuous quality and performance improvement. The central tenet of management is to provide motivating forces of engagement and empowerment rather than police errors or find fault. The following six steps are an adaptation of the scientific problem-solving process and nursing process. The process provides a structured methodology to analyze the problem, strategize possible solutions, determine actions required, develop plans, implement approaches, and evaluate effectiveness .