STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235612	A. Building B. Wing	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freeman Nursing & Rehab Community	1805 Pyle Drive Kingsford, MI 49802

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35103 Based on interview and record review, the facility failed to provide respectful and dignified care and services to three Confidential Residents (#100, #200, and #300) of three residents reviewed for dignity. This deficient practice resulted in increased anxiety, fear, and apprehension with the provision of care by staff who were verbally aggressive and physically rough. Findings include: During an observation/interview on 5/2/22 at 8:00 a.m., Confidential Resident #C200 reported she had been waiting 45 minutes for a call light response. Resident #C200 said she had a bowel movement and had been sitting in feces while she waited for staff to respond to her call light. Resident #C200 stated, That hurt, and I had to lay like that. Resident #C200 said Registered Nurse (RN) E was so mean because RN E had instructed the CNA to remove pillows used for support and pain relief because Resident #C200 had pressed the call light too many times during night shift. Resident #C200 stated, RN E said I rang the light too much . She (RN E) was so mean. Resident #C200 said she had not told anyone else about how mean RN E was because .it is only going to get worse if I complain about her. During an interview on 5/2/22 at 8:35 a.m., the Director of Nursing (DON) was notified of Resident #C200's allegations of abuse. The DON accompanied this Surveyor into Resident #C200's room, and the Resident told the DON that [RN E], [CENA U] and [CENA V] were mean and/or rough with her. During a telephone interview on 5/2/22 at 12:47 p.m., Family Member (FM) S confirmed her mother (#C100) had talked about a night nurse that was mean. FM S said now they are supposed to have two people in the room during the provision of cares. During an interview on 5/3/22 at 11:20 a.m., Resident #C300 was asked if any staff were unkind or rough during cares. Resident #C300 stated, I am not going to say anything, because I don't want to get anyone in trouble. When told that other residents and staff had also been interviewed, Resident #C300 stated, Yes, there is a night nurse that was mean and disrespectful. Resident #C300 confirmed it was RN E but said she doesn't like to tattle on anyone because she doesn't want to get in trouble or get anyone else in trouble. During an interview on 5/4/22 at 9:40 a.m., LPN B confirmed she had reported concerns related to treatment of residents in the facility by RN E to the DON previously. LPN B said family members had reported concern with mean and inappropriate treatment by RN E to residents, and that the DON said she was going to handle things, but that is as far as it goes. (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	During a repeat telephone interview on 5/4/22 at 10:00 a.m., FM S said she had informed both the DON and the Social Services Designee (Staff) N of the concern with a staff member that was being mean. FM S said it was reported to the facility about 3-5 months ago, and she had never heard any result. FM S said this treatment by the staff has continued and is still ongoing with the mean staff person. Review of the facility Abuse Prevention Program Policy & Procedure, reviewed 1/2022, revealed the following, in part: All staff are expected to be in control of their own behavior, are to behave professionally, and should appropriately understand how to work with the nursing home population . Review of the booklet, Rights of Residents in [SA] Nursing Homes, dated 11/28/16, revealed, .Respect and Dignity You have a right to be treated with respect and dignity .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 35103 Based on interview and record review, the facility failed to fully investigate a fall with major injury, resulting in hospitalization and surgical repair for one Resident (R#8) of four residents reviewed for potential abuse investigation. This deficient practice resulted in the potential for continued abuse and/or mistreatment by facility staff. Findings include: Review of a 4/17/22 Fall Event Report for Resident #8 revealed the form was completed by the Director of Nursing (DON) on 5/2/22. The Event Report revealed Resident #8 was transferring from bed, right knee buckled and was lowered to floor with immediate post fall complaints of right knee pain. The fall was witnessed by Certified Nurse Aide (CNA) H. Review of Resident #8's Radiology Reports revealed x-rays of the right femur, right knee, and right hip and pelvis revealed no fractures on 4/20/22, three days post fall (fall on 4/17/22). Radiology Reports of x-rays completed on 4/29/22 (12 days post fall) revealed Acute left femoral neck fracture. During a telephone interview on 5/3/22 at 8:00 p.m., CNA H confirmed she had been assisting Resident #8 with a transfer from bed to the wheelchair on 4/17/22 when he fell to the floor with an unidentified injury. CNA H confirmed she did not use a gait belt to assist Resident #8 with the transfer, was not standing within reach of the Resident, and did NOT lower the resident to the floor. Resident #8 fell to the floor when his legs buckled. CNA H said she repeated told nursing staff she had not lowered him to the floor, but it remained in the progress notes. During an interview on 5/4/22 at 10:14 a.m., RN T said she had heard CNA H calling for help on 4/17/22 when Resident #8 was on the floor. RN T said it was not a fall - because the CNA was behind him holding him. During an interview on 5/4/22 at 10:48 a.m., the DON and Regional Clinical Nurse K were asked about the nursing note that stated Resident #8 was lowered to the floor. The DON said that RN D had reported that to her (the DON) when she called and informed the DON of the situation. When the DON was asked what the definition of a fall was, she stated, Anytime it is an unintentional position change. Review of the facility Fall Prevention and Management Policy, revised 2/2020, revealed the following, in part: .Procedure: . 2. When a fall event occurs, a licensed nurse will: B. Complete a fall event/incident report. E. Interview or obtain staff statements to determine events surrounding the fall F. Document the occurrence and any follow-up in progress notes 4. The Director of Nursing of clinical leader will review the fall, events surrounding the fall, intervention, and post-fall documentation with the IDT during morning clinical meeting to elicit IDT input and recommendations and determine if additional investigation is needed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. The director of Nursing or clinical leader will complete an evaluation detail and investigation analysis summary . During an interview on 5/4/22 at 11:27 a.m., Regional Clinical Director K confirmed an incident report should have been completed timely, with statements from witnesses. The DON acknowledge a complete investigation of this fall with resulting fracture had not been completed to identify all details of Resident #8's fall and potential interventions to prevent future falls for the Resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 This deficiency is related to Intakee #MI00127036. Based on interview and record review, the facility failed to receive treatment and care in accordance with professional standards when physician prescribed antibiotics were discontinued for three Residents (#1, #2, & #3) out of three residents reviewed for quality of care. This deficient practice resulted in the potential for worsening of condition, antibiotic resistance, and resident apprehension with the quality of care provided in the facility. Findings include: Resident #1 Review of Resident #1's Minimum Data Set (MDS) assessment, dated 3/2/22, revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included: end-stage renal disease, hypokalemia (lower than normal potassium level in the blood), anxiety and depression. Resident #1 scored 14 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. During an interview on 5/2/22 at 11:00 a.m., Resident #1 was asked about any recent hospitalization s. Resident #1 confirmed she had been hospitalized for a bad UTI recently and commented that she had not felt well for about two weeks because she was sent to the hospital. Resident #1 stated, I kept telling them something was wrong, but nobody listened. Review of Urinalysis and Microbiology reports, collected 4/14/22, revealed Resident #1's urine culture showed >100,000 CFU/mL, with Streptococcus agalactiae (Group B). Review of Resident #1's April 2022 Medication Administration Record (MAR) revealed an order to: Obtain monthly vitals, once a Day on 1st Tue (Tuesday) of the Month, Start Date 8/31/21 was not documented as completed on Tuesday 4/5/22. The column entries were blank, and no other vitals were documented on the MAR for the month of April 2022. Obtain weekly blood pressure Other Test, once a Day on Monday, Start Date 5/25/21 had no blood pressures documented on the April MAR for any Monday in the month. Cephalexin (antibiotic) capsule; 250 mg, four times a day, Start Date 4/19/22, was administered beginning on 4/19/22. Review of Resident #1's nursing progress notes for April 2022, revealed the following, in part: 4/14/22 9:23 a.m. - New order via physician for U/A (urinalysis) with C&S (culture and sensitivity), wait for report to come back and treat as indicated. Daughter is aware. 4/15/22 2:32 p.m. - Resident continues with urgency, frequency, and increased pain with urination, urine is dark and foul, and she is only able to void scant amounts. C&S is pending. 4/17/22 12:40 p.m. - Nursing faxed UA results to [Physician W's] office awaiting orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/19/22 9:33 a.m. - New order: Cephalexin 250 mg qid (four times daily) for UTI (urinary tract infection), Resident aware, DPOA (Durable Power of Attorney) to be updated. 4/19/22 1:22 p.m. - Antibiotic (sic) DC/d (discontinued - condition does not meet facility requirements to treat. 4/19/22 1:26 p.m. - DPOA updated related to ABX (antibiotic) being DC'd. 4/19/22 3:40 p.m. - Per [Physician W] Cephalexin 250 mg qid order in place for 10 days .He says resident does meet criteria to be treated and he wants her to be treated. DPOA updated. During a telephone interview on 5/2/22 at 12:47 p.m., Family Member (FM) S said her family member had problems with UTI's prior to coming to the facility and when she got a UTI, she was kind of crazy. FM S said two weeks ago [Resident #1] started getting crazy. The doctor ordered the urinalysis and when it came back, they called and said they were going to treat her with Keflex. The nurse called back later that day and said they were not treating her for the UTI because she didn't meet the criteria. FM S stated, She did get the antibiotic because I was pretty ticked. During an interview on 5/4/22 at 9:40 a.m., Licensed Practical Nurse (LPN) B said the Director of Nursing (DON) told her (LPN B) that there was no criteria to treat [Resident #1] for a UTI in the facility, and it went against McGeers criteria. LPN B said she informed the DON that Physician W ordered the antibiotic for Resident #1. LPN B said the DON directly told her to D/C the antibiotics. LPN B said she spoke with the physician later that day, and the order was started again. LPN B stated, She (DON) tries to cancel physician orders on us all day. Resident #2 Review of Resident #2's MDS assessment, dated 4/22/22, revealed Resident #2 had active diagnoses that included: urinary tract infection, heart failure, renal insufficiency, septicemia, diabetes mellitus, anxiety, and depression. Resident #2 required extensive to dependent 1-2 personal assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #2 scored 15 of 15 on the BIMS reflective of intact cognition and was able to make her needs known. Review of Resident #2's hospital discharge summary dated 4/18/22 (date of discharge) revealed Resident #2 was admitted to the hospital on 4/15/22 with discharge diagnoses that included Septic Shock, present on admission and UTI, present on admission. Resident #2's History of Present Illness included the following, in part: Patient states she has been feeling sick for a couple of days now .Patient was apparently treated for bacterial vaginosis with Augmentin, she only received on dose of it .Urine and blood cultures show no growth, possibly due to recently starting Augmentin . Medications ordered upon discharge from the hospital included Cephalexin 500 mg capsule, orally 3 times per day, for 7 days. Review of Resident #2's progress notes revealed the following, in part: 4/14/22 4:36 p.m. - .new orders as follows: 1. Augmentin one gram PO (orally) BID (twice daily) after meals x 7 days for diverticulitis . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/15/22 9:15 a.m. - Blood noted to urine, urine is foul with strong smell . pain with urination, nausea, lower abdominal pain and cramping, frequency, and urgency with scant amount of voiding .Fax made to physician. LPN B 4/15/22 1:01 p.m. - Chunky bloody sediment to urine, odor is excessively four, resident in discomfort. [Physician W] Called, LPN B 4/15/22 1:05 p.m. - new order to send to ED for evaluation. LPN B 4/15/22 7:18 p.m. - Resident admitted .with UTI and Sepsis . LPN B 4/18/22 - 9:50 p.m. - .Resident returned . following inpatient stay for the following: Septic shock secondary to UTI . Has new order for Keflex, but after consultation with DON will contact house physician in AM to verify that he agrees with Keflex order . 4/19/22 9:23 a.m. - Call made to [Physician W] to clarify orders, message left for him to call back facility, fax sent to his office. LPN B 4/19/22 9:36 a.m. - New order: Cephalexin 500 mg tic (three times daily) 7 days for UTI, resident is aware. LPN B 4/19/22 1:29 p.m. - Antibiotic DC'd - does not meet criteria to receive treatment at the facility. LPN B 4/19/22 3:29 p.m. - [LPN C] clarified orders with [Physician W], He does want resident (#2) on Cephalexin 500 mg tic times 7 days. He states she meets criteria to be treated based on diagnosis of septic shock secondary to TUI and reports labs now show post IV ABX treatment not how she presented to ED. 4/21/22 10:42 a.m. - MD in facility, new order rec'd to d/c the ABT Keflex due to resident has no supporting data of UTI and has no c/o pain, itching, swelling to vaginal area. Authored by DON. 4/23/22 10:02 a.m. - Resident is receiving skilled nursing care related to septic shock secondary to UTI. Abx discontinued related to resident no meeting facility criteria to be treated. She presents with moderate amount of lower abdominal pain this morning and nausea .Her urine is amber with mildly foul order . Fax made to physician with update on condition including VS (vital signs) and pain. Resident #3 Review of Resident #3's MDS assessment, dated 3/20/22, revealed Resident #3 had the following active diagnoses: renal insufficiency, neurogenic bladder, diabetes mellitus, paraplegia, anxiety, and depression. Resident #3 required extensive one to two person assist with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #3 scored 15 of 15 on the BIMS reflective of intact cognition and was able to make her needs known. Review of Resident #3's progress notes revealed the following, in part: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/18/22 11:54 a.m. - Resident sent out to hospital via ambulance at 11:55 a.m. Resident returned from an ultrasound appointment, lethargic, grey, hanging forward in wheelchair, confused . Don aware and [Physician W] said to ship her (to hospital). 4/19/22 5:53 a.m. - Resident returned via facility van and companion at 4:30. Resident appeared more alert. Continues with confusion as prior to transport to hospital, awaiting urine culture. 4/19/22 2:27 a.m. - . N.O. (new order) for Cephalexin 500 mg one tab twice a day for 7 days. Will follow up in AM regarding Keflex with house MD. 4/19/22 9:37 a.m. - New order: Cephalexin 500 mg tid for 7 days for bladder infection (per Physician W). 4/19.22 2:46 p.m. - Talked to [Physician W] at this time. Discontinue Keflex. During a telephone interview on 5/3/22 at 8:30 p.m., [Physician W] confirmed he had not discontinued prescribed antibiotics for Residents #1, #2, or #3, but they were discontinued by the DON, who said they did not meet (McGeers) criteria. Physician W confirmed he was also the Medical Director of the facility. When asked about Resident #2's diagnosis of diverticulitis with Augmentin treatment on 4/14/22, Physician W said that he needed to use a diagnosis that would allow him to treat the resident with antibiotics without having them discontinued for not meeting criteria. When asked if it was appropriate for a nurse to discontinue prescribed physician orders, Physician W said he did not feel that was appropriate, and he thought the facility was wrong for doing such. Physician W stated, Perhaps I have not pushed back hard enough (against discontinuation of his physician orders for antibiotics). Physician W said he did feel pressure from the Director of Nursing to discontinue antibiotics that he felt were necessary for the resident's medical treatment. During an interview on 5/4/22 at 11:04 a.m., the DON was asked about the absence of completed McGeer's criteria sheets related to urinary tract infections for Resident #1, #2, and #3. The DON confirmed she had not fully completely the McGeer's criteria so could not truly determine if those residents did or did not meet the McGeer's criteria. When asked to identify what the McGeer's criteria were for a urinary tract infection, the DON was unable to provide the correct information, and acknowledged she had been doing the McGeer's criteria incorrectly.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35103 This deficiency is related to Intake #MI00127036. Based on interview and record review, the facility failed to provide adequate supervision during transfer from bed to wheelchair which resulted in harm with a fractured femoral head (hip fracture) for one Resident (#8) of four residents reviewed for falls. This deficient practice resulted in harm as evidenced by an unassisted fall to the floor, left femoral head (hip) fracture, lack of a complete post-fall assessment, delayed diagnostic x-ray evaluation of Resident #8's left leg/hip, and a significant increase in pain. Findings include: Review of Resident #8's Minimum Data Set (MDS) assessment, dated 2/22/22, revealed Resident #8 had been a long-term resident in the facility and had active diagnoses that included: mild intellectual disabilities, cerebral palsy, and non-Alzheimer's dementia. Resident #8 required extensive, one-person physical assistance with bed mobility and transfers between surfaces and scored 8 of 15 on the Brief Interview for Mental Status (BIMS) reflective of moderately impaired cognition. Pain assessment on the MDS assessment documented no pain in the last five days. Review of a 4/17/22 Fall Event Report for Resident #8 revealed the form was completed by the Director of Nursing (DON) on 5/2/22. The Event Report revealed Resident #8 was transferring from bed, right knee buckled and was lowered to floor with immediate post fall complaints of right knee pain. The fall was witnessed by Certified Nurse Aide (CNA) H. During an interview on 5/2/22 at 12:24 p.m., Licensed Practical Nurse (LPN) C was asked about Resident #8's fall in the facility. LPN C said Resident #8 had cried in pain for days until a second order for an Xray of the left hip/leg was obtained by a facility nurse. LPN C said his left leg/hip was broken for a week before the x-ray on the left side was completed. Review of Resident #8's nursing progress notes revealed the following: 4/18/22 5:45 a.m. [Central Daylight Time (CDT)]- Resident had complaints of right knee pain. 4/17/22 he was being transferred from bed to w/c (wheelchair) when his right knee buckled, and he was lowered to the ground. No c/o (complaint of) pain at the time. This am resident had c/o right knee pain nursing gave resident Tylenol. Right knee palpated and resident did not c/o (complain of) pain. Right knee is free of visible injury no redness no bruising no edema . 4/20/22 8:10 a.m. (CDT) - Resident having increased pain to both left and right thighs from knees to hips related to recent fall .fax sent . to (physician) office requesting increase in pain medication and x-rays ., written by Licensed Practical Nurse (LPN) B. 4/20/22 9:13 a.m. (CDT) - New order for Xray to right femur, knee, and hip . No orders for Xray to left knee, femur, hip at this time ., written by LPN B. 4/20/22 5:33 p.m. (CDT) - Xray's completed at facility, all views are negative (of right hip/leg/knee) . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4/22/22 12:54 p.m. (CDT) - Resident continues to receive PT (physical therapy) services . Therapy reports decreased in tolerance d/t (due to) pain of BLE (bilateral lower extremities) . 4/23/22 9:50 a.m. (CDT) - Resident (#8) continues to have pain down both thighs. Greater pain noted to left thigh, hip, and knee. Lidocaine patch in place, bio freeze applied, Tramadol given . 4/24/22 10:22 a.m. - [Resident #8] continues to have pain down left thigh this morning . 4/27/22 8:58 a.m. - Pain noted to lower back and left thigh this AM . 4/28/22 1:37 p.m. - New order received . X ray left hip, thigh, and knee. Xray lumbar back related to increased pain post being lowered to the floor incident . 4/30/22 5:21 a.m. - Resident x-rays sent 5am. The results are: X-ray of Femur = (equals) Acute Left Femoral Neck FX (fracture). X-Ray of Hip and Pelvis show femur FX . 4/30/22 7:09 a.m. - New order to send to . ED (Emergency Department) to have pinned (surgical repair of left hip) . Resident continues to have increased pain. Ambulance called for transfer . 5/3/22 9:08 a.m. - .resident (#8) had surgery yesterday (5/2/22) to left femur fracture, area pinned . Review of Resident #8's Physical Therapy Treatment Encounter Notes, dated 4/14/22 through 4/29/22, revealed the following physical therapy documentation: Date of Service 4/21/22 - Clinical approached Patient twice to participate in skilled therapy services, w/Patient agreeing second attempt. Patient reported he was in (sic) experiencing pain in L (left) hip/thigh area and was in tears. Clinical assisted Patient in static stands at parallel bars x 2 w/Moderate physical assist and consistent verbal cueing for sequencing. Patient was visibly in pain. Clinical reported findings to DON and is going to look future into pain. Patient had Xray on RLE (right lower extremity - came back negative - Patient is telling clinician L side . Date of Service 4/27/22 - Patient reported pain in L hip/thigh/knee area - CENA staff reporting Patient c/o of only L sided pain. DON was informed and contributes it to being arthritis or possible sciatica . Date of Service 4/28/22 - Patient performed static stands at parallel bars x 2 w/Patient complaining of slight discomfort of L hip/thigh area .Patient reported pain in L hip/thigh/knee area in which Clinician has been talking with nursing about this ongoing pain. Today nursing reached out to Physician to investigate further Xrays. During an interview on 5/3/22 at 11:16 a.m., Physical Therapist (PT) O and Physical Therapy Assistant (PTA) N confirmed Resident #8 had continued to participate in physical therapy following the fall with fracture on 4/17/22. Both staff confirmed they were aware of his increased pain, and reported it to the DON and nursing staff, until an x-ray was finally obtained of Resident #8's left leg/knee/hip on 4/29/22 (12 days post fall), identifying the left femur fracture. (continued on next page)

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	235612	A. Building B. Wing	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freeman Nursing & Rehab Community	1805 Pyle Drive Kingsford, MI 49802

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #8's April 2022 Medication Administration Records (MARs) revealed the following pain documentation: Lidoderm (lidocaine adhesive patch for pain) was added to Resident #8's MAR on 4/23/22 - for increased complaints of pain. Tramadol, as needed for pain was started on 4/19/22, with doses administered on 10 of 12 days between 4/19/22 and 4/30/22. Acetaminophen 325 mg, 2 PO (by mouth) for mild discomfort was initiated 7/1/16, but in April of 2022, doses were administered on 4/17 through 4/30/22. On 4/17 the Pain Location was documented on the MAR as l (left) leg. Bio freeze topical gel 0.5% was started on 4/22/22 to apply to bilateral knees for pain. Pain Assessments for Resident #8 between 4/1/22 ant 4/16/22 revealed assessments were completed three times daily with a pain rating of 2 out of 10, on four individual assessments. Beginning on 4/17/22 (day of fall) through 4/20/22, Resident #8's pain was documented between 2 to 5 out of a scale of 10, on 25 separate pain assessments. Review of Resident #8's Radiology Reports revealed x-rays of the right femur, right knee, and right hip and pelvis revealed no fractures on 4/20/22, three days post fall (fall on 4/17/22). Radiology Reports of x-rays completed on 4/29/22 (12 days post fall) revealed Acute left femoral neck fracture. During a telephone interview on 5/3/22 at 8:00 p.m., CNA H confirmed she had been assisting Resident #8 with a transfer from bed to the wheelchair on 4/17/22 when he fell to the floor with an unidentified injury. CNA H confirmed she did not use a gait belt to assist Resident #8 with the transfer, was not standing within reach of the Resident, and did NOT lower the resident to the floor. Resident #8 fell to the floor when his legs buckled. CNA H said she repeatedly told nursing staff she had not lowered him to the floor, but it remained in the progress notes. When asked about a post fall physical assessment, CNA H said Registered Nurses (RNs) T and D did not complete a head-to-toe assessment, compare leg lengths, or assess for internal/external rotation of the legs prior to moving the Resident from the floor back into bed. CNA H said by Friday, 4/22/22, Resident #8 was screaming and crying in pain. He could not get out of bed and when he was rolled in bed he was crying out in pain. During an interview on 5/4/22 at 10:14 a.m., RN T said she had heard CNA H calling for help on 4/17/22 when Resident #8 was on the floor. RN T said it was not a fall - because the CNA was behind him holding him. RN T said when RN D returned from a break the post fall assessment had been completed by RN D. RN D denied having completed a post fall assessment, because she thought it had been done by RN T. RN T said they did not apply a gait belt prior to lifting Resident #8 from the floor back into the bed, and she did not check for any injuries. During an interview on 5/4/22 at 10:48 a.m., the DON and Regional Clinical Nurse K were asked about the nursing note that stated Resident #8 was lowered to the floor. The DON said that RN D had reported that when she called and informed the DON of the situation. When the DON was asked what the definition of a fall was, she stated, Anytime it is an unintentional position change. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility Fall Prevention and Management Policy, revised 2/2020, revealed the following, in part: .Procedure: . 2. When a fall event occurs, a licensed nurse will: A. complete an immediate physical assessment of the resident . B. Complete a fall event/incident report. C. Notify the physician and responsible party. D. Initiate orders from the physician, if indicated E. Interview or obtain staff statements to determine events surrounding the fall E. (SIC) Implement an appropriate intervention/preventive measure F. Document the occurrence and any follow-up in progress notes G. Communicate the fall on the 24-hour report H. Monitor the resident and follow-up if indicated . 4. The Director of Nursing of clinical leader will review the fall, events surrounding the fall, intervention, and post-fall documentation with the IDT during morning clinical meeting to elicit IDT input and recommendations, and determine if additional investigation is needed. 5. The director of Nursing or clinical leader will complete an evaluation detail and investigation analysis summary . During an interview on 5/4/22 at 11:27 a.m., Regional Clinical Director K, in the presence of the DON was asked about the lack of supervision and failure to follow the facility fall policy regarding Resident #8's fall with major injury (femur fracture) on 4/17/22. Regional Clinical Director K acknowledged staff education would be provided to timely report to the nurse, assess the resident for injury before removing from the floor, completion of notification to the responsible party, follow up with any physician order, and implement interventions based on the cause of the fall. Regional Clinical Director K confirmed an incident report should have been completed timely, with statements from witnesses, and a gait belt or Hoyer lift should have been used to remove Resident #8 from the floor.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35103 This deficiency is related to Intake #MI00127036. Based on interview and record review, the facility failed to ensure a complete and accurate medical record for one Resident (#6) of four residents reviewed for medical records. This deficient practice resulted in an unauthorized change to a nursing progress note by unlicensed non-clinical staff, and the potential for incorrect alteration of the medication record. Findings include: During a telephone interview on 4/21/22 at 2:39 p.m., anonymous Complainant Z reported the facility Nursing Home Administrator (NHA), who was not a licensed clinician, deleted a nursing progress note authored by a facility nurse, and put improper data as the rationale for the deletion. During an interview on 5/2/22 at 12:24 p.m., Licensed Practical Nurse (LPN) C confirmed she had seen nursing progress notes that were edited by the NHA for Resident #6. Review of Resident #6's Progress Notes, dated 4/3/2022, found the following entries deleted (grayed out as not valid) from the Residents medical record: 1. 4/3/22 4:51 p.m., CNA (Certified Nurse Aide) noted resident medications to be on bedside table by RN (Registered Nurse) on duty, DON (Director of Nursing) notified by CNA related to recent education on notifications for improper distribution of medications, RN spoke with DON as well as writer at that time. CNA and writer informed by resident (#6) at 2:50 pm that RN had come down to room after phone conversation with DON and reprimanded resident. Resident reports RN to have said 'Next time I'll wake you up out of a dead sleep to give you your medications then.' MDS (Minimum Data Set) nurse covering for DON notified. MDS nurse notified administrator. Administrator instructed MDS nurse to inform writer to make a note of incident and put a copy under his door. Administrator to look into the issue tomorrow. Authored by RN B 2. 5/3/22 4:51 p.m., --INVALID--CNA noted resident medication to be on bedside table by RN on duty, DON notified by CNA related to recent education on notifications for improper distribution of medications, RN spoke with DON as well as writer at that time. e-Signed BY [Administrator's Name]. Noted in Electronic Medical Record as Marked Invalid BY: [Administrator's Name] Admin on 04/04/2022 07:51 a.m. Reason: Incorrect Data. During an interview on 5/3/22 at 9:18 a.m., the NHA confirmed he had edited RN B's 4/3/22 nursing progress note on 4/4/22 at 7:51 a.m. When asked if the unlicensed non-clinical NHA had the authorization to edit clinical nursing documentation, the NHA acknowledged that he should not have edited the nursing progress note. During an interview on 5/3/22 at 9:31 a.m., Regional Clinical Director K was asked if it was appropriate for non-clinical staff to edit another nurse's progress note. Regional Clinical Director K said that this Surveyor already knew the answer to that question, and then stated, It is certainly not commonplace for the administrator to edit the nursing note. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/4/22 at 9:40 a.m., LPN B confirmed she had written the progress note related to Resident #6 and the NHA had deleted it. LPN B said she would not have deleted anything in the nursing progress note and felt it accurately describe the situation and properly documented such in the medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35102 Based on interview and record review, the facility failed to perform adequate infection control surveillance per facility policy. This deficient practice had the potential to result in spread of infectious disease. Findings include: During an interview on 5/3/22 at 2:02 p.m., with Staff K, the DON/IP acknowledged not fully understanding the process for identifying residents' infections using Mc Geer's criteria (Infection surveillance definitions for long-term care to identify true infections). The DON/IP said she had not started nor completed the tool in the electronic medical record (EMR) for Resident #1, Resident #2, and Resident #3. It was the DON/IP's misunderstanding the tool was only used after the residents' infection had resolved to determine if the infection met criteria. The DON/IP confirmed residents suspected/actual infections were not monitored continually (daily) on a line-listing. The DON/IP was asked to provide resident infection surveillance for March 2022 through May 2022. No data was provided for May 2022; the DON/IP said the surveillance data was compiled at the end of the month and not monitored daily for potential/actual infections. When asked how Resident #1, Resident #2, and Resident #3 were determined to have met criteria for infections since the McGeer's was not utilized, the DON/IP said they were counted since they received antibiotics. During an interview on 5/3/22 at 3:42 p.m., Staff K confirmed no resident COVID-19 screenings and vital signs had been completed on any residents throughout the facility since 2/11/22. Staff K indicated the COVID-19 screenings should have been completed at least daily. Staff K confirmed the DON/IP should have been reviewing the logs routinely and been aware the logs were not completed by both Certified Nurse Aides and nurses. Staff K confirmed the following: no active resident infections were tracked, McGeer's Criteria was not properly utilized to identify resident infections, no staff monitoring for infection control compliance was completed i.e., appropriate hand hygiene, Personal Protective Equipment (PPE) use, observations of invasive procedures for aseptic technique, proper isolation precautions, etc. During an interview on 5/4/22 at 10:48 a.m., the DON/IP said she now knows that McGeer's form within the EMR should be initiated when a potential infection concern is identified, and data entered by nurses each day. When asked if any staff monitoring for infection control was completed, the DON responded, No, none. After review of 24-hour Report of Pt. (Patient)Conditions and Nursing Unit Activities was reviewed for May 2022, the DON confirmed no residents were identified and tracked for potential infections that should have been. Review of the facility's policy for Infection Control Program Introduction reviewed 01/2022, read in part, The duties of an Infection Preventionist may include: .*Distinguish healthcare-associated from community-acquired infections *Surveillance activities *Monitoring tracking systems, collecting and analyzing data *Helping to ensure that procedures and protocols are followed properly .All infections are tracked and to be logged regularly .(facility) will utilize McGeer's criteria to assist in the recognition of infections and ensure antibiotic usage is appropriate .