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	12/05/2022

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

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 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. 13791 All times reported in Eastern Standard time (EST). This citation pertains to intake: MI00129665 Based on observation and interview, the facility failed to provide a safe environment for residents as evidenced by the lack of functional night lighting in six of 15 observed resident rooms. This deficient practice has the potential to result in residents unable to safely navigate their rooms during the dark hours. Findings include: On 11/30/22 between 9:15 AM and 9:40 AM resident rooms were observed for the purpose of establishing the functioning of wall mounted recessed night light fixtures. It was determined a wall switch at the nurses' station was required to be turned on to activate all night lights in resident rooms. Once activated, the following rooms were observed without functional lights: 100, 111, 112, 113, 115, 118. Not all resident rooms were able to be observed due to privacy issues. An interview with Environmental services director (ESD) K was conducted on 11/30/22 at 9:55 AM. ESD K acknowledged knowing some of the lights were out, and stated they had just received a box of bulbs. ESD K was not aware of all rooms without functional night lights.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation pertains to Intake #MI00132859. All times are Eastern Standard Time (EST) unless otherwise noted. Based on observation, interview, and record review, the facility failed to prevent verbal abuse for two Residents (#21 and #25) of nine residents reviewed for abuse during resident to resident incidents. This deficient practice resulted in psychosocial harm for Resident #21, with feelings of fear, helplessness, and vulnerability. Findings include: Review of Resident #21's Minimum Data Set (MDS) assessment, dated 06/20/22, revealed Resident #21 was admitted to the facility on [DATE], with diagnoses including paraplegia (paralysis of lower extremities), pressure ulcer, kidney disease, anxiety, and depression. Resident #21 required extensive two-person assistance for bed mobility, and was dependent for transfers, toileting, and locomotion (bed dependent). The Brief Interview for Mental Status (BIMS) assessment revealed a score of 14/15, which showed Resident #21 had intact cognition. Review of the Resident #25's MDS assessment, dated 08/27/22, revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including heart failure, liver disease, dementia, bipolar disorder, psychotic disorder, delusional disorder, intellectual disability, and somatoform disorder (neurological symptoms without medical explanation). Resident #25 was independent with bed mobility, transfers, locomotion (wheelchair mobility), and toileting. The BIMS assessment revealed a score of 15/15, which showed Resident #25 had intact cognition. The Behavioral Assessment showed Resident #25 had physical behavioral symptoms directed at others four to six days during the assessment period, and verbal behavioral symptoms directed at others one to three days during the assessment period. Review of an investigation summary provided via email on 12/01/22, by the Nursing Home Administrator (NHA), revealed a Resident to Resident verbal altercation between Resident #21 and Resident #25, on 09/02/22. Resident #21 reported to her son, Family Member (FM) AA, Resident #25 was calling her negative names. The Social Services (SS) Director, Licensed Practical Nurse (LPN) Z, interviewed Resident #21, who reported Resident #25 had entered her room on 09/02/22 and called her something like old lady motor mouth. The Administrator (former) was notified, and when interviewed Resident #21 reported Resident #25 had called her a big lady motor mouth [expletive]. FM AA reported they observed Resident #25 backing out of Resident #25's room (upon their arrival to the facility), and heard Resident #21 yell for Resident #25 to leave their room. Registered Nurse (RN) P was walking towards Resident #21's room with FM AA, and reported they heard Resident #21 state, [Resident #25]; get out! Resident #25 was interviewed, and denied the incident, but reported she did not like Resident #21. Resident #21 reported Resident #25 left the room when asked, but did not understand why Resident #25 did not like her. The intervention was Resident #21 was reminded to use their call light when needed, and was provided with a wrist whistle additionally for assistance. The facility administration concluded Resident #25 did enter the doorway of Resident #21's room and called her names. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an observation on 11/30/22 at 1:58 p.m., Resident #25 was observed wheeling her wheelchair quickly down the hallway from the dining room, and reported she was headed to her room to get a sweater. During an observation on 12/01/22 at 9:08 a.m., Resident #21 was laying in their hospital bed. Review of LPN Zs interview/witness statement, dated 09/09/22, revealed the NHA (former) reported, [. Resident #21 reported feeling unsafe as she is bedbound [bed dependent] and cannot move if [Resident #25] were to ever lay hands on her . Review of Resident #21's interview/witness statement, dated 09/02/22 at approximatley 4:30 p.m., revealed, . [Resident #21] doesn't understand why [Resident #25] won't leave her alone, but [sic] doesn't know what [Resident #25] is capable of. [Resident #21] said she has heard stories of [Resident #25] hitting other people, and [Resident #25] makes her nervous. [Resident #21] told me that she did not like that [Resident #25] had called her a big lady motor mouth [expletive]. [Resident #21] said that [Resident #25] had done this on numerous occasions. [Resident #21] said she doesn't know why [Resident #25] is after her and won't leave her alone. [Resident #21] has the feeling that [Resident #25] may do something to her, and [Resident #21] is incapacitated and unable to defend herself . Review of the Electronic Medical Record (EMR) showed Resident #21 and Resident #25 had been roommates prior to this incident, which Resident #21 confirmed. Review of Resident #25's current Care Plan revealed, Problem: Resident is unable to make consistent daily decisions without cues/supervision for safety R/T [related to] DX [diagnoses] intellectual difficulties, bipolar disorder with restlessness and agitation at times .Approach: In new situation, provide support and reassure to reduce stress and potential agitation .Approach: Give feedback to resident when inappropriate decisions are made .Approach: Determine if decision made by the resident may be negative to the resident or others . Review of Resident #21's current Care Plan revealed no interventions to address Resident #21's reported feelings of fear, helplessness, and vulnerability from the verbal incidents perpetrated towards her by Resident #25, or interventions to provide support, monitoring, or prevention of these occurrences. During an interview on 11/28/22 at 1:58 p.m., Resident #25 was asked about her involvement in any resident to resident incidents. Resident #25 denied any incidents with other residents, and showed Surveyor her room, and how well she made her bed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/01/22 at 9:09 a.m., Resident #21 reported Resident #25 was a meanie (a mean person), Resident #21 reported when Resident #25 came to their room as a new roommate Resident #25 said, 'I don't like you .', and called her a motor mouth [expletive]. Resident #25 reported Resident #21 said this to her repeatedly and added, It was a daily thing [occurrence]. Resident #21 reported to management staff and Resident #25 was moved to the end of the hall. Since then Resident #25 still came to her door and repeatedly called her a motor mouth [expletive]. Resident #25 stated, It happened this week .They [staff] got me a whistle . Resident #25 showed Surveyor a whistle on her nightstand, but reported this still did not make her feel comfortable with Resident #25, as Resident #21 heard Resident #25 slapped one of the residents. Resident #21 added, [Resident #25] is only two doors down, and [the former NHA] said it was verbal abuse . Yes, that's what I would call it. Surveyor confirmed Resident #25 was two doors down, on the same side of the hall. During further interview (per Resident #21's request) on 12/01/22 at 9:25 a.m, Resident #21 reported Resident #25 also started holding up her middle finger [a rude gesture] to her in the last month, and was giving her the Sign of the Cross [a religious prayer gesture]. Resident #21 reported [LPN Z] said to her, Be very careful, as that woman [Resident #25] doesn't like you. Resident #21 stated, I am being targeted . Resident #21 reported more incidents [including a similar 11/24/22 verbal incident, and the gestures] occurred two days this past week. Resident #25 said she started to shake when the recent incidents occurred, and said, I was scared. Resident #21 further reported FM AA says, 'It's dangerous, and they [staff] don't watch her.' Resident #21 stated, What happens if [Resident #25] gets up at night? There is always a first time [clarified as a physical incident], and I don't sleep well at night [due to fear of Resident #25]. Resident #21 shared she was fearful of what Resident #25 could do to her, such as punching or a physical assault, and was fearful of an injury, given her health problems. Resident #21 reported FM AA was scared for her, and both had talked to management, yet the incidents were still occurring. Resident #21 reported she had filed a grievance. During a phone interview on 12/01/22 at 09:41 a.m., FM AA stated there were several verbal incidents perpetrated towards his mother by Resident #25. FM AA reported Resident #25 would give Resident #21 inappropriate hand gestures, including the finger, and yelled at Resident #21, saying, I'm going to get you, motor mouth. FM AA clarified they had heard Resident #25 say this to Resident #21, and staff gave Resident #21 a whistle to alert staff, which Resident #21 did not use. FM AA reported Resident #21 was upset and fearful of Resident #25, including of a physical altercation. FM AA reported they had spoken to current and past administrators, nursing management staff, and social services staff, with no change in Resident #25's behaviors towards Resident #21. Staff told them Resident #25 was redirectable. FM AA reported they did not agree, as Resident #25's verbal behaviors towards his mother had continued. FM AA stated sometimes they [nursing management] have one aide working in the whole place, and cannot provide adequate supervision of Resident #25, especially when they are short staffed. FM AA reported they told a nursing staff person [who they declined to name] they were going to report the incidents (to the State Agency), and the staff asked them not to report, stating they would face retaliation. FM AA reported these incidents towards Resident #21 by Resident #25 had been going on for months, as well as towards other facility residents. FM AA reported they spoke to the NHA a few days ago with their concerns, and were again told Resident #25 was redirectable. Review of Resident #25's progress note, dated 08/12/22, revealed, .Asked resident [#25] if she called her roommate [Resident #21] 'motor mouth [expletive].' [Resident #25] replied 'Yes, but I won't do it again'. [Resident #25] also confirmed that she takes [Resident #21's] newspaper without asking 'but I give it back when I am done' Inquired what [Resident #25] should do differently in these instances. [Resident #25] replied, ' .I should ignore [Resident #21] instead of calling her names .' (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #21's Grievance Complaint Form, dated 08/12/22, revealed, .[Resident #21] upset; reported that her roommate [Resident #25] called her a 'motor mouthed [expletive]' several times. Per [Resident #21], 'That is the last straw.' Other complaints including her roommate taking her newspaper without asking. Keeping the bathroom door open when using the bathroom, and general rudeness.IDT [Interdisciplinary Team] met and decided to move the roommate [Resident #25] .[Resident #25] confirms each complaint did occur. [Resident #25] moved to room [#] . The grievance was signed by LPN Z on 08/12/22, and addressed by 08/14/22. Review of Resident #25's Behavioral Care provider summary, dated 02/15/22, revealed, XXX[AGE] year old female is seen for depression and delusions .staff agree [Resident #25] does better without a roommate . Previous history of aggression or violence: Yes . Review of Resident #25's Behavioral Care provider summary, dated 04/15/22, revealed, XXX[AGE] year old female is seen for bipolar and delusions .[Resident #25] fixates on her next door neighbor [unnamed roommate] repeating things throughout the day, this irritates her . Review of Resident #25's Behavioral Care provider summary, dated 06/30/22, revealed, .[Resident #25] had a recent altercation with another resident and had to move rooms. [Resident #25] fixates on her new roommate [Resident #21, per census], says [Resident #21] talks on the phone a lot and it frustrates [Resident #25] at times . Review of Resident #25's Behavioral Care provider summary, dated 09/02/22, revealed, .[Resident #25] continues to fixate on other residents and their noises and lights at night. Says they irritate [Resident #25] . Review of Resident #25's Behavioral Care provider summary, dated 10/17/22, revealed, .[Resident #25] has been bothering her old roommate [Resident #21], will purposely go into [Resident #21's] room down the hall however says [Resident #25] wants nothing to do with her . Review of Resident #25's Behavioral Care provider summary, dated 10/28/22, revealed, .Staff state [Resident #25] was seen spitting her medications into the toilet, they [staff] have been closely monitoring [Resident #25's] medication administration since . Review of Resident #25's progress notes revealed Resident #25 had physical altercations where she was the perpetrator with another facility resident on 05/19/22, 06/10/22, and 07/12/22. Review of Resident #25's progress note, dated 11/24/22 at 3:23 p.m., by RN P , revealed, .I was informed by [Resident #21] as soon as her son left, [Resident #25] came to [Resident #21's] doorway, and called her a 'motor mouth'. I approached [Resident #25], who was at the nurses station at this time, if [Resident #25] had gone past [Resident #21's] room and [Resident #25] said, 'Yes'. I then repeated what [Resident #21's room] said and [Resident #25] said, 'I apologize; I don't want to be in trouble. I won't do it again' .As I [RN P] am writing this, I heard [Resident #25] say to another resident, 'Get away from me,' and as I turned, [Resident #25] pushed the handle on the back of the resident's chair as she [Resident #25] made her way to her own room. Review of Resident #25's progress note, dated 06/09/22 at 7:08 a.m., revealed, [Resident #25] does have a hx [history] of verbal and physical behaviors particularly towards current and past roommates. Behaviors typically occur when she is upset with current and past roommates . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #25's progress note, dated 03/08/22, revealed, .[Resident #25] does have a hx of verbal and physical behaviors towards current and past roommates . Review of Resident #25's behavioral tracking logs (for 15 minute checks) showed no behavioral monitoring/tracking on 11/15/22 from 7:00 a.m. to 5:00 p.m., on 11/16/22 from 7:00 a.m. to midnight, and on 11/17/22 through 11/31/22. During an interview on 11/30/22 at 12:47 p.m., RN P confirmed Resident #25's behavioral management tracking logs should have been completed by staff on the missing dates, as behavioral incidents were occurring, including a resident to resident incident involving Resident #25 towards Resident #21 a week ago [on 11/24/22], when RN P was working. Review of Resident #25's behavioral tracking log, dated 11/24/22, was not completed, when a similar verbal abuse incident occurred perpetrated by Resident #25 towards Resident #21. During an interview on 11/30/22 at 12:47 p.m., the NHA confirmed the behavioral management tracking logs for Resident #25 were accurate, including the missing entries during November, 2022. During an interview on 12/01/22 at 10:37 a.m., the DON and LPN Z acknowledged verbal abuse had occurred to Resident #21, post review of the resident to resident incidents (which Resident #25 perpetrated towards Resident #21) . Both understood the need for increased supervision and effective interventions for Resident #25, as evidenced by the missing behavioral tracking logs and several resident to resident incidents towards Resident #21, which continued to recur. Both acknowledged Resident #21 would benefit from additional support and monitoring when they understood Resident #21 experienced psychosocial harm as a result of the repetitive, multiple resident to resident verbal abuse incidents. During an interview on 12/01/22 at 8:30 a.m., the Regional Operations Director, NHA S, and the NHA acknowledged the concerns with the multiple, ongoing resident to resident verbal altercations (which Resident #25 perpetrated towards Resident #21), the missing behavioral monitoring tracking during November, 2022, and Resident #21's adverse psychosocial outcomes of fearfulness and vulnerability, given the resident, family member, nursing staff, social services staff, and administration were reporting and documenting verbal abuse. Both reported they understood the deficient practice. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the policy, Abuse Prevention Program Policy and Procedure, reviewed 01/2022, revealed, Each resident has the right to be free from abuse, neglect, and corporal punishment of any type by staff or anyone. The facility will provide a safe resident environment and protect residents from abuse .[Facility Organization] has abuse prevention programs in which policies and procedures safeguard our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint .verbal, mental and sexual [abuse] . A resident to resident altercation should be reviewed as a potential situation of abuse .Investigations for potential abuse will not be dismissed in cases where either or both residents have a cognitive impairment or mental disorder. Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. During the investigation, it will be identified that the actions were willful were deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm .Mental or Verbal Abuse: Mental abuse is the use of verbal or nonverbal actions, which cause or has the potential to cause the resident to experience humiliation, intimidation, fear, agitation, or degradation .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 All times are Eastern Standard Time (EST) unless otherwise noted. Based on observation, interview, and record review, the facility failed to provide adequate ADL (activities of daily living) care for one Resident (#23) of two residents reviewed for ADL care. This deficient practice resulted in increased pain during functional transfers for Resident #23, and the risk of injury to the resident and caregivers. Findings include: Review of Resident #23's Minimum Data Set (MDS) assessment, dated 10/14/22, revealed Resident #23 was admitted to the facility on [DATE], with diagnoses including cancer (unspecified), Parkinson's disease (a progressive neurological disorder), traumatic brain injury, left hip fracture, stroke, polymyalgia rheumatica (an inflammatory disorder causing stiffness), dementia, anxiety, and depression. Resident #23 required extensive two-person assistance with transfers, and extensive one-person assistance with bed mobility, dressing, toileting, and hygiene. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 6/15, which indicated Resident #23 had severe cognitive impairment. The pain assessment revealed Resident #23 received scheduled pain medication, and had not had pain during the look-back period (prior 5 days). During an interview on 11/29/22 at 12:33 p.m., Resident #23 was observed laying down in her bed. Resident #23 was interviewable, and reported she would like range of motion therapy due to stiffness. No contractures were evident per observation. During an observation on 11/30/22 at 08:44 a.m., Resident #23 was observed seated upright in a manual wheelchair. She was smiling and holding a large stuffed animal. No contractures were evident. During an interview on 11/30/22 at 01:48 p.m., the Activity Director, Staff L, reported they frequently offered Resident #23 participation in the group exercise class however Resident #23 refused much of the time. During an interview on 11/30/22 at 08:46 a.m., the Rehabilitation Director, Physical Therapy Assistant (PTA) DD, reported Resident #23 was discharged from therapy a couple months ago due to lack of participation, and a plateau in progress. PTA DD indicated Resident #23 was discharged at the level of using a mechanical standing lift for transfers, due to bilateral leg/knee pain which remained at the time of therapy discharge. PTA DD reported Resident #23's knees would twist during transfers (as she struggled to pick up her legs), so a two-person stand pivot transfer was unsafe. PTA DD reported they had educated nursing staff regarding Resident #23's level of assistance at discharge, per their usual process. PTA DD clarified they provided Resident #23 with an Exercise Program at discharge, which she completely independently, and referred her to the facility exercise group. Review of Resident #23's current ADL Care Plan revealed Resident #23 was designated to use a mechanical sit to stand lift with two-person assistance, was non-ambulatory, and used a wheelchair for locomotion in the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/30/22 at 10:39 a.m., Certified Nurse Aide (CNA) Y was asked about Resident #23's range of motion and any functional decline for Resident #23. CNA Y reported they completed some range of motion with Resident #23 during cares, as it was tasked for Resident #23. CNA Y reported Resident #23 was a two-person stand pivot transfer assist and stated, We [two staff] do a pivot transfer. We have [Resident #23] hold onto the chair and help turn herself. CNA Y clarified [Resident #23's] left side (her weak side from a stroke) was the side she struggled to transfer towards, since her bed was against the wall, which Surveyor observed. CNA Y denied any contractures. During an observation on 11/30/22 at 10:52 a.m., the CNA tasks were viewed with CNA Y. CNA Y reviewed the task care designations, and stated, [Resident #23] is supposed to be a two-person transfer with a Mechanical Stand lift. CNA Y acknowledged they were not aware this was Resident #23's transfer status, and would need to clarify. The Director of Nursing (DON) walked by and was told about the discrepancy, and reported they would clarify Resident #23's transfer status. Review of the Electronic Medical Record (EMR) including Resident #23's falls revealed no falls occurred during staff transfers with Resident #23. The EMR was reviewed for any new injuries to Resident #23, and none were found. During an interview on 11/30/22 at 11:00 a.m., Resident #23 was asked about their transfers with nursing staff. Resident #23 responded she had no pain during the interview, however experienced leg/knee pain during the transfers, reporting a lot of pain. Resident #23 reported she had quit therapy due to the leg pain, and reported she was having trouble sleeping with the pain. Resident #23 clarified, I sure as heck didn't complain about it when they used the [standing] lift. Resident #23 stated she would prefer (CNA) staff would use the standing lift, but they had stopped using it, and she did not know why. When asked about her pain level during transfers, Resident #23 reported, It's a good '8' [with 10 being the highest and 0 being the lowest] when they transfer me. During a second interview on 11/30/22 at 11:09 a.m., CNA Y was asked if Resident #23 was having pain when they [two staff] were completing stand pivot transfers, per their earlier report. CNA Y responded, Yes, [Resident #23] does have pain, when they [CNA staff] completed two-person stand pivot transfers. CNA Y reported they tried to transfer Resident #23 away from her weak left side during the transfers. CNA Y reported the pain was at least moderate. CNA Y confirmed they had already received a reeducation today from the DON to transfer Resident #23 with the mechanical sit to stand lift, with two-person assistance, per tasks, Care Plan, and therapy recommendations at time of discharge from therapies in October, 2022. During an interview on 11/30/22 at 11:29 a.m., CNA CC was asked how they transferred Resident #23. CNA CC responded, I usually do extensive two-person assistance. I find another aide to help me. CNA CC reported Resident #23 was sometimes very weak, and needed extensive assistance to do a stand pivot transfer. CNA CC denied Resident #23 had pain during the transfers, and reported they did complete range of motion with cares. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/30/22 at 02:55 p.m., CNA Y and CNA CC were planning to transfer Resident #23 back to bed per Resident #23's request after lunch. Resident #23 agreed to Surveyor observation. CNA Y and CNA CC used the mechanical sit to stand lift to transfer Resident #23 back to bed, as both reported they had been educated to use the sit to stand lift by the DON on 11/30/22, after the discrepancy was noted by Surveyor. Resident #23 vocalized no pain during the transfer, and after the transfer denied any pain. Resident #23 reported she liked being transferred with the sit to stand lift, and wanted to transfer with the sit to stand lift going forward. During an interview on 11/30/22 at approximatley 3:05 p.m., Resident #23's nurse, Registered Nurse (RN) P, reported she had not been aware Resident #23 was having pain during the stand pivot transfers. RN P understood Resident #23 would be using the mechanical sit to stand lift with nursing staff going forward, per the DON. RN P clarified Resident #23 had scheduled Tramadol for pain, and had not needed any additional pain medication, as she was typically Resident #23's nurse during the day shift. During an interview on 11/30/22 at approximately 3:15 p.m., the DON reported they understood the concern, and had educated nursing staff to only use the mechanical sit to stand lift for Resident #23's transfers, per their own review of the Care Plan, CNA tasks, and therapy's most recent discharge recommendations from October, 2022. During an interview on 12/01/22 at 8:40 a.m., the Regional Operating Director, NHA S, and the current NHA were apprised of the concern with Resident #23 not being transferred correctly. Both understood the concern, and reported a staff education would be completed. Review of the policy, Activities of Daily Living, ADLs/Maintain Abilities, dated 11/20/21, revealed, Intent: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values, and beliefs. Procedure: 1. Based on the comprehensive assessment of a resident, and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. 3. The facility will provide care and services for the following activities of daily living: b. Mobility - transfer and ambulation .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 All times are Eastern Standard Time (EST) unless otherwise noted. This deficiency pertains to Intakes #MI00129665 and #MI00129273. Based on observation, interview, and record review, the facility failed to ensure sufficient staff to provide for resident's care needs, based on acuity and the Facility Assessment. This deficient practice resulted in Resident dissatisfaction with the timeliness of care provided and unmet care needs. This deficiency has the potential to affect all facility residents. Findings include: During an interview on 11/28/22 at 2:43 p.m., with Resident #5 stated, The nurses rush and they don't talk to me. I can see that is because there are a half dozen (call) lights on . days (day shift CNAs) are short (staffed) . Last week I could not get a shower because the girl was working by herself down here . with all these heavy (care needs) people, and it was the same on the [NAME] (hall). Wednesday and Saturday are my shower days, and I didn't get one. During an interview on 11/29/22 at 7:10 a.m., Registered Nurse (RN)B was asked about documentation of which staff worked on the nursing schedule. RN B stated, Well I don't think the Director of Nursing (DON] or any of the administrative nurses that worked the floor are on the schedule. We don't put that on the nursing schedule. RN B said the DON, Social Services Designee/LPN Z' or RN/MDS B filled in as floor nursing staff. When asked how this Surveyor would know who worked, as those administrative staff members were not identified on the nursing staff list, RN B stated, Well, I suppose you wouldn't (know). During an interview on 11/29/22 at 9:43 a.m., Resident #21 stated, (There are} not enough CNA's. Two weeks or (maybe) a week ago there was a nurse and one CNA during the day. I don't want to be called a liar. Saturday (there were three nurses) and they had no CNAs. In the last six months there have been nights where there were no CNAs. We get the short end of the stick . [CNA Y] is the only one working on this side. The office help are running around here making like CNAs. They have done this to me - if I complain too much then they totally ignore me period and then what do you do. They don't walk past - they just don't show up . I got called on the carpet yesterday . every morning when I go to therapy, they are supposed to give me a Xanax and two Tylenol so I can get through therapy. [Therapy Staff] came in and I told [them] that I had not had my pills yet. There wasn't a blessed soul around except three residents . I was yelling for the nurse. I waited by that desk for one hour and I did not see one fricken nurse for one hour . During a telephone interview on 11/30/22 at 7:01 p.m., CNA GG said she began work at the facility in March of 2022. CNA GG said the first night she was training in as a CNA, the day shift nurse aides both called in and she had to work the floor alone as a CNA without even really knowing the residents. CNA GG said that there were multiple times when she was the only CNA working the floor during shifts and would be the only one when carried over to other shifts. CNA GG stated, It was like that all the time. CNA GG confirmed that resident showers would not get completed because there was not enough staff to do all the showers on the schedule. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility Daily Staffing Sheets (postings) on 11/29/22 at 12:45 p.m., revealed administrative staff, including the Director of Nursing (DON), MDS (Minimum Data Set) assessment/Registered Nurse (RN) B, and Licensed Practical Nurse/Social Services Designee Z worked multiple shifts to cover for the unavailability of a floor nurse. The Daily Staffing Sheets also documented the following shifts, where staffing appeared insufficient to meet resident needs, based on the Facility Assessment between 10/4/22 and 11/28/22: 11/28/22 Day Shift One LPN, one RN, and 2 CNAs (Certified Nurse Aides). 11/13/22 One RN and 2 CNAs Day Shift; Night Shift one LPN Night shift and 1.5 CNAs. 11/9/22 One LPN and one CNA on night shift. 10/30/22 Night shift one LPN and one CNA. 10/26/22 Night Shift one LPN and one CNA. 10/24/22 Night Shift one LPN, and CNA. 10/23/22 Night Shift one RN and one CNA. 10/7/22 Night Shift one LPN and one CNA. 10/4/22 Afternoon shift 1 RN 8 hours, no CNAs. Night shift one RN 12 hours no CNAs documented. Review of the Facility Assessment, dated 9/6/22, revealed the following staffing information: [The Facility] is licensed to provide care for :35 . Staffing Plan: 3.2. Based on the resident population and their identified needs for care and support, we have determined the following approach to staffing to ensure that facility has sufficient staff to meet the needs of the residents at any given time . Position: Licensed Nurses (Direct Care Staff) 2-3 FTE/12-hour shifts (Total Number of FTE's Needed on Daily Basis) .Certified Nursing Assistants 6-8 FTE/7.5/12-hour shifts . Other Nursing Personnel (e.g., those with administrative duties) 2FTE/8-hour shifts . State of Michigan criteria for minimum staff requirements found in the Facility Assessment from 1980 (old information) that did not include the acuity of facility residents in determination of required staffing levels. 11/29/22 2:45 PM [NAME] provided copies of the requested Staffing sheets for July, although three pages were missing for the dates reported when there were no CNA's present in the building. No evidence was provided to show evidence of adequate staffing in the building on 7/22/22 night shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 11/30/22 at 11:15 a.m., upon entry into the business office manager's (Staff) T's office this Surveyor observed Staff T quickly move her pen from a stack of papers that she was filling out. Nursing Assignment Sheets with July 2022's date were in clear sight. Staff T was asked about documentation on the almost blank July 2022 Nursing Assignment sheets. Staff T said she was filling them out, because they did not have the originals, so they were being recreated. Recreated documentation has not been requested, but rather payroll documentation for hours worked on the days where the Nursing Assignment sheets, and the Nurse Staffing Postings were missing in the documentation required for review. Regional Operations Director S entered the room and stated that she had previously received permission to recreate documents from the previous and current section manager. This Surveyor again requested the payroll information for the specified days as previously requested, and Regional Operations Director S said they (payroll documentation) would not be accurate because the administrative nursing staff that worked would not necessarily be documented on the payroll sheets because they were salaried. Regional Operations Director S added the payroll would not be accurate because she had brought up several staff from the facility where she was the Nursing Home Administrator (NHA). Payroll documentation was provided for one CNA from another corporate facility; however, review Assignment Sheets and Staff postings for days provided no documentation of the identified CNA being in the facility during the dates in July when the Nursing Assignment sheets were missing (July 18, 22 through July 22, 22). On 11/30/22 at 1:03 p.m., telephone contact with the identified CNA from another corporation facility was attempted. The telephone call was not answered, and the message stated, Not available at this time, please try your call again. A repeat attempt that same day resulted in the same message. During an interview on 11/30/22 at 2:35 p.m., CNA Y confirmed she had worked in the facility on Friday 7/22/22 with RN P and CNA FF on Day shift. CNA Y said both afternoon shift CNAs had called off (not worked) for the day. CNA U had walked off the floor during day shift and there was only one aide on each hall during Day shift. CNA Y confirmed she had worked alone, as the only aide on both halls during afternoon shift and was relieved by a night CNA. One CNA worked the whole night. When specifically asked if any other corporate facility CNA staff had worked as a CNA on days, afternoons, or nights, on that Friday 7/22/22. CNA Y said she was sure there were no staff from any other facility working in the building as a CNA that day. During a telephone interview on 11/30/22 at 2:47 p.m., RN EE stated, Yes, I do recall having to work with no CNA's while we were waiting for somebody to come in. I had one CNA at the start of the night - I got called in for night shift, and the CNAs that were on afternoons all called off. Somebody from day shift stayed over, then she left, and the midnight shift came in. When asked if she had worked without any CNAs on night shift, RN EE stated, I could have - I just am not sure. Depending on what is going on - even having two (CNAs) can be challenging at times. When I was in the [administrative] role they struggled to have coverage - because they only had two CNAs scheduled for night shift. There was one that stayed over for day shift - she left and there was nobody. RN EE confirmed there was no other corporation CNAs that worked that specific night. RN EE stated, (It is) absolutely not adequate to have 2 CNAs on day shift, nor on afternoons. The two on nights will do the wet checks together. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Facility Assessment, dated 10/28/22, revealed the following staffing levels identified by the facility for sufficient based on the facility census: [Facility Name] is licensed to provide care for: 35 (Residents). 1.2 [Facility name] has a daily average census June-August 31st. Total Avg. (average) Residents = 26. 1.2a. In an effort to help our facility determine staff needs we also took into account the average number of residents admitted /discharged on weekdays & weekends. Weekdays: 2 . Assistance with Activities of Daily Living - As of September 6, 2022, included: 1-2 residents were independent in dressing, transfers, toileting, and mobility. 22 to 31 residents required Assist of 1-2 staff for those same ADLs. 2-7 residents were totally dependent upon staff for those same ADLs. The Facility Assessment Staffing Plan included: 3.2 Based on the resident population and their identified needs for care and support, we have determined the following approach to staffing to ensure that facility has sufficient staff to meet the needs of the residents at any given time. Staffing Tool 1: Evaluation of overall number of facility staff needed to ensure a sufficient number of qualified staff is available to meet each resident's needs. Refer to the guidance in the various tags that have requirements for staffing to be based on/in according with the facility assessment .Enter number of staff needed or an average or range: Licensed Nurses (Direct Care Staff), Total Number of FTE's (full time equivalents) Needed on Daily Basis: 2-3/12-hour shifts. Certified Nursing Assistants, 6-8 FTE/7.5/12 hr. (hour) shift. The facility also included the [State Name} Staff Requirements, dated January 1, 1980 in their facility that detailed patient ratios and the number of patients to nursing care that included: The ratio of patients to nursing care personnel during a morning shift shall not exceed 8 patients to 1 nursing care personnel; the ratio of patients to nursing care personnel during an afternoon shift shall not exceed 12 patients to 1 nursing care personnel, and the ratio of patients to nursing care personnel during a nighttime shift shall not exceed 15 patients to 1 nursing care personnel, and there shall be sufficient nursing care personnel available on duty to assure coverage for patients at all times during the shift . No reference to acuity consideration was noted in this portion of the Facility Assessment. During an interview on 12/01/22 at 1:48 p.m., the NHA and Regional Operations Director S agreed the Facility Assessment CNA levels did not provide adequate staffing levels to meet resident care needs based on the lowest level identified in the Facility Assessment document. Both the NHA and Regional Operations Director S agreed the facility had been struggling with short staffing. 40330 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a phone interview on 12/01/22 at 09:41 a.m., FM AA stated there were several verbal incidents towards his mother by Resident #25. FM AA reported Resident #25 would give Resident #21 inappropriate hand gestures, including the finger, and yelled at Resident #21, saying, I'm going to get you, motor mouth. FM AA clarified they had heard Resident #25 say this to Resident #21, and staff gave Resident #21 a whistle to alert staff, which Resident #21 declined to use. FM AA reported this caused Resident #21 to be upset and fearful of Resident #25, including of a physical altercation. FM AA reported they had spoken to current and past administrators, nursing management staff, and social services staff, with no change in Resident #25's behaviors, as staff told them Resident #25 was redirectable. FM AA reported they did not agree, as Resident #25's verbal behaviors towards his mother had continued. FM AA stated sometimes they [nursing management] have one aide working in the whole place, and cannot provide adequate supervision of Resident #25, when they are short staffed. FM AA reported they told an unnamed staff [who they declined to name] they were going to file a report them (to the State Agency), and the staff asked them not to report, stating they would face retaliation. FM AA reported these incidents towards Resident #21 by Resident #25 had been going on for months, as well as towards other facility residents. FM AA reported they spoke to the NHA a few days ago with their concerns, and were told Resident #25 was redirectable. FM AA asked to continue the interview to discuss Resident #21's care needs not being met, and related it was hit or miss. FM AA reported sometimes Resident #21 laid in wet urine for up to 14 hours (until the next shift), more than once. FM AA reported recently when they were present Resident #21 waited from 2:00 p.m. until 6:30 p.m. to be changed, despite their requests. FM AA reported they told the nurse who said, The aides can do it. It's not my job. FM AA reported this upset both him and Resident #21. FM AA reported their biggest concern was Resident #25 approaching and upsetting Resident #21. FM AA stated All I can tell [Resident #21] is to blow the whistle, and said they didn't think that was an adequate intervention to stop Resident #25's behaviors, and the potential for verbal and physical altercations. FM AA clarified they had discussed their concerns with facility administration. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/01/22 at 10:08 a.m., Resident #21 was asked about nursing care. Resident #21 reported she had been frequently left in a wet brief, and stated, I'm afraid to say anything as I want to stay here [at the facility]. Resident #21 reported this had occurred in the past two weeks. Resident #21 reported she and her roommate had both been left in their wet briefs for six hours, and stated, They [nursing staff] shut the door on us, and didn't come back. Both of us were in there with COVID [an infectious viral illness]. We both pushed the call light, and it was not answered for six hours. Resident #21 reported they had waited for hours to be changed on other occasions, and stated, That's why my sore [pressure sore] didn't heal; these last couple months have been terrible [with long call light wait times]. Resident #21 stated the longest she has had to wait was from 6 p.m. at night until 4:00 to 5:00 a.m. in morning, and it was a month ago. Resident #21 reported they [nursing staff] had to change the bed [which was wet]. Resident #21 reported they typically wait one to two hours to be changed, on all shifts, and stated, There is nobody here. [FM AA] came in one day and said, 'Where are the staff?' Resident #21 stated, My rear end starts to sizzle. When asked if their pressure ulcer was healing, Resident #21 reported it had healed, however their back was sore and stated, Another sore may have started. Resident #21 reported they were going to the wound clinic on 12/02/22 for follow-up. Resident #21 confirmed the verbal incidents perpetrated towards her by Resident #25 were ongoing, causing her to feel scared and afraid of a physical incident, as she was vulnerable and helpless being in her bed. Resident #21 confirmed she considered them verbally abusive, and did not know why Resident #25 continued to call her names and make inappropriate gestures towards her, as she and her son had told staff including administration and nursing staff on multiple occasions, yet the incidents recurred.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation pertains to Intake #MI00132859. All times are Eastern Standard Time (EST), unless otherwise noted. Based on observation, interview, and record review, the facility failed to provide adequate behavioral monitoring for one Resident (#25) of one resident reviewed for behavioral monitoring, related to completion of behavioral tracking logs. This deficient practice resulted in Resident #25's behavioral care logs not being completed, and the potential for resident to resident altercations, and abuse. Findings include: Review of the Resident #25's MDS assessment, dated 08/27/22, revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including heart failure, liver disease, dementia, bipolar disorder, psychotic disorder, delusional disorder, intellectual disability, and somatoform disorder (neurological symptoms without medical explanation). Resident #25 was independent with bed mobility, transfers, locomotion (wheelchair mobility), and toileting. The BIMS assessment revealed a score of 15/15, which showed Resident #25 had intact cognition. The Behavioral Assessment showed Resident #25 had physical behavioral symptoms directed at others four to six days during the assessment period, and verbal behavioral symptoms directed at others one to three days during the assessment period. Review of Resident #25's behavioral tracking logs (for 15 minute checks) showed no behavioral monitoring/tracking on 11/15/22 from 7:00 a.m. to 5:00 p.m., on 11/16/22 from 7:00 a.m. to midnight, and on 11/17/22 through 11/31/22. Review of Resident #25's current Care Plan and Care planning showed Resident #25 was care planned to have 15 minute checks completed, related to behavioral monitoring/tracking, beginning 5/19/22. During an interview on 11/30/22 at 12:43 p.m., Certified Nurse Aide (CNA) Y confirmed they typically completed Resident #25's behavioral tracking logs, and showed Surveyor a behavioral monitoring logbook, and reported she was unsure why there were no entries for Resident #25 for the past month, during November, 2022. During an interview on 11/30/22 at 12:47 p.m., RN P confirmed Resident #25's behavioral management tracking logs should have been completed by staff on the missing dates, as behavioral incidents were occurring, including a resident to resident verbal incident involving Resident #25, perpetrated towards Resident #21, a week ago [on 11/24/22], when RN P was working. Review of Resident #25's 11/24/22 behavioral tracking log was not completed. Review of Resident #25's progress notes confirmed a resident to resident verbal altercation had occurred on 11/24/22, perpetrated by Resident #25 to Resident #21. During an interview on 11/30/22 at 12:47 p.m., the NHA confirmed the behavioral management tracking logs for Resident #25 were accurate, including the missing entries during November, 2022. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/01/22 at 8:30 a.m., the Regional Operations Director, NHA S, and the NHA acknowledged the concern with the missing behavioral monitoring tracking during November, 2022. NHA S also confirmed Resident #25 was currently care planned to have 15 minute behavioral checks. Review of the policy, Behavior Intervention Program Management Process, revised 01/2022, revealed, It is the policy of the facility that residents who exhibit episodes of inappropriate behavior be reviewed by the facility's interdisciplinary team for contributing factors, underlying causes, and develop an individualized, person-centered plan of care .6. Behavior symptom tracking logs will be available for care staff to document observations of behaviors. Tracking logs will be reviewed by Social Services or designee .Any critical behaviors will be reported immediately to Director of Nursing and Administration.

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	12/05/2022

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40330 This citation pertains to Intake #MI00132859. All times are Eastern Standard Time (EST) unless otherwise noted. Based on observation, interview, and record review, the facility failed to provide adequate Social Services care for two Residents (#21, #25) of nine residents reviewed for medically related social services. This deficient practice resulted in the lack of social services supportive visits and effective interventions to prevent the verbal abuse of Resident #21 by Resident #25. Findings include. Review of Resident #21's Minimum Data Set (MDS) assessment, dated 06/20/22, revealed Resident #21 was admitted to the facility on [DATE], with diagnoses including paraplegia (paralysis of lower extremities), pressure ulcer, kidney disease, anxiety, and depression. Resident #21 required extensive two-person assistance for bed mobility, and was dependent for transfers, toileting, and locomotion (bed dependent). The Brief Interview for Mental Status (BIMS) assessment revealed a score of 14/15, which showed Resident #21 had intact cognition. Review of the Resident #25's MDS assessment, dated 08/27/22, revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including heart failure, liver disease, dementia, bipolar disorder, psychotic disorder, delusional disorder, intellectual disability, and somatoform disorder (neurological symptoms without medical explanation). Resident #25 was independent with bed mobility, transfers, locomotion (wheelchair mobility), and toileting. The BIMS assessment revealed a score of 15/15, which showed Resident #25 had intact cognition. The Behavioral Assessment showed Resident #25 had physical behavioral symptoms directed at others four to six days during the assessment period, and verbal behavioral symptoms directed at others one to three days during the assessment period. Review of an investigation summary provided via email on 12/01/22, by the Nursing Home Administrator (NHA), revealed a Resident to Resident verbal altercation between Resident #21 and Resident #25, on 09/02/22. Resident #21 reported Resident #25 called her a derogatory name, which the facility administation confirmed occurred. Review of the Social Services Director, Licensed Practical Nurse (LPN) Zs interview/witness statement, dated 09/09/22, revealed the (former) NHA reported, [.Resident #21] reported feeling unsafe as [Resident #21] is bedbound [bed dependent] and cannot move if [Resident #25] were to ever lay hands on her. [Resident #21] provided with a whistle she can keep at bedside to blow to alert staff if [Resident #25] were to enter [Resident #21's] room. On 09/03/22, [LPN Z] provided [Resident #21] with a whistle that is on a bracelet to wear on her wrist. There was no mention of psychosocial support provided during these social services visits, given Resident #21's report of feeling unsafe (fearful). Review of Resident #21's Electronic Medical Record (EMR) including nursing progress notes, and the 09/02/22 investigation summary revealed there were incidents of verbal aggression/abuse by Resident #25, to Resident #21, which occurred 11/24/22, 09/02/22, and 08/12/22. Per Resident #21's grievance form dated 08/12/22, there were several similar verbal incidents, on and prior to 08/12/22. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #21's interview/witness statement, dated 09/02/22 at approximatley 4:30 p.m., revealed, . [Resident #21] doesn't understand why [Resident #25] won't leave her alone, but [sic] doesn't know what [Resident #25] is capable of. [Resident #25] said she has heard stories of [Resident #25] hitting other people, and [Resident #25] makes her nervous. [Resident #21] told me that she did not like that [Resident #25] had called her a big lady motor mouth [expletive]. [Resident #21] said that [Resident #25] had done this on numerous occasions. [Resident #21] said she doesn't know why [Resident #25] is after her and won't leave her alone. [Resident #21] has the feeling that [Resident #25] may do something to her, and [Resident #21] is incapacitated and unable to defend herself . During an interview on 12/01/22 at 9:09 a.m., Resident #21 reported Resident #25 had called her derogatory names when they were roommates, and had continued to call her a motor mouth [expletive] since Resident #25 moved down the hall, with two more incidents in the past week. Resident #21 reported Resident #25 had also used inappropriate gestures towards her, and she was afraid of a physical incident. She reported the whistle provided by LPN Z to use when Resident #25 approached her room did not make her comfortable with Resident #25, as she did not believe it would prevent a physical altercation. Resident #21 reported she remained fearful of Resident #25, which caused her to not sleep well, as Resident #25's room was two doors down from her, which Surveyor confirmed. Resident #21 reported she talked to facility management, the social services director, nursing staff, and her family, yet the incidents continued to recur, which caused her to feel upset and scared. During a phone interview on 12/01/22 at 09:41 a.m., FM AA reported they were concerned about Resident #25's behaviors towards Resident #21, which they had witnessed, which included giving her the finger and saying, I'm going to get you, motor mouth. FM AA stated Resident #21 was afraid Resident #25 would use a weapon, and that she couldn't defend herself. FM AA reported they had discussed these ongoing verbal incidents with administration, nursing, social services, yet the verbal incidents/behaviors continued to recur. FM AA' reported they did not believe the whistle was an effective intervention, as Resident #21 would not use the whistle, and they did not believe Resident #25 was redirectable, as the administration staff had told him, including this past week. FM AA reported they felt Resident #21 was being singled out by Resident #25, and were concerned for Resident #21's safety and well-being. Review of Resident #25's progress note, dated 08/12/22, revealed, .Asked resident [#25] if she called her roommate [Resident #21] 'motor mouth [expletive].' [Resident #25 replied 'Yes, but I won't do it again'. [Resident #25] also confirmed that she takes [Resident #21's] newspaper without asking 'but I give it back when I am done' .Inquired what [Resident #25] should do differently in these instances. [Resident #25] replied, ' .I should ignore [Resident #21] instead of calling her names .' Review of Resident #21's Grievance Complaint Form, dated 08/12/22, revealed, .[Resident #21] upset; reported that her roommate [Resident #25] called her a 'motor mouthed [expletive]' several times. Per [Resident #21], that is the last straw. Other complaints including her roommate taking her newspaper without asking. Keeping the bathroom door open when using the bathroom, and general rudeness.IDT [Interdisciplinary Team] met and decided to move the roommate [Resident #25] .[Resident #25] confirmed each complaint did occur. [Resident #5] moved to room [#] . The grievance was signed by LPN Z on 08/12/22, and addressed by 08/14/22. Review of the Electronic Medical Record (EMR) showed Resident #21 and Resident #25 had been roommates prior to this incident, which Resident #21 confirmed. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #25's current Care Plan revealed, Problem: Resident is unable to make consistent daily decisions without cues/supervision for safety R/T [related to] DX [diagnoses] intellectual difficulties, bipolar disorder with restlessness and agitation at times .Approach: In new situation, provide support and reassure to reduce stress and potential agitation .Approach: Give feedback to resident when inappropriate decisions are made .Approach: Determine if decision made by the resident may be negative to the resident or others . Review of Resident #21's current Care Plan including the behavioral care plan revealed no interventions to address Resident #21's reported feelings of fear, helplessness, and vulnerability from the verbal incidents perpetrated towards her by Resident #25, or interventions to provide support, monitoring, or prevention of these occurrences. Review of Resident #25's Behavioral Care provider summary, dated 06/30/22, revealed, .[Resident #25] had a recent altercation with another resident and had to move rooms. [Resident #25] fixates on her new roommate [Resident #21, per census], says [Resident #21] talks on the phone a lot and it frustrates [Resident #25] at times . Review of Resident #25's Behavioral Care provider summary, dated 09/02/22, revealed, .[Resident #25] continues to fixate on other residents and their noises and lights at night. Says they irritate [Resident #25] . Review of Resident #25's Behavioral Care provider summary, dated 10/17/22, revealed, .[Resident #25] has been bothering her old roommate [Resident #21], will purposely go into [Resident #21's] room down the hall however says [Resident #25] wants nothing to do with her . Review of Resident #25's progress notes revealed Resident #25 had physical altercations where she was the perpetrator with another facility resident on 05/19/22, 06/10/22, and 07/12/22. Review of Resident #25's progress note, dated 11/24/22 at 3:23 p.m., by RN P , revealed, .I was informed by [Resident #21] as soon as her son left, [Resident #25] came to [Resident #21's] doorway, and called her a 'motor mouth'. I approached [Resident #25], who was at the nurses station at this time, if [Resident #25] had gone past [Resident #21's] room and [Resident #25] said, 'Yes'. I then repeated what [Resident #21's room] said and [Resident #25] said, I apologize; I don't want to be in trouble. I won't do it again .As I [RN P] am writing this, I heard [Resident #25] say to another resident, 'Get away from me', and as I turned, [Resident #25] pushed the handle on the back of the resident's chair as she [resident #25] made her way to her own room. Review of Resident #25's progress note, dated 06/09/22 at 7:08 a.m., revealed, [Resident #25] does have a hx [history] of verbal and physical behaviors particularly towards current and past roommates. Behaviors typically occur when she is upset with current and past roommates . Review of Resident #25's progress note, dated 03/08/22, revealed, .[Resident #25] does have a hx of verbal and physical behaviors towards current and past roommates . Review of Resident #25's behavioral tracking logs (for 15 minute checks) showed no behavioral monitoring/tracking on 11/15/22 from 7:00 a.m. to 5:00 p.m., on 11/16/22 from 7:00 a.m. to midnight, and on 11/17/22 through 11/31/22. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/30/22 at 12:47 p.m., RN P confirmed Resident #25's behavioral management tracking logs should have been completed by staff on the missing dates, as behavioral incidents were occurring, including a resident to resident incident involving Resident #25 towards Resident #21 a week ago [on 11/24/22], when RN P was working. Review of Resident #25's 11/24/22 behavioral tracking log showed it was not completed. During an interview on 11/30/22 at 12:47 p.m., the behavioral management tracking logs for Resident #25 were confirmed as accurate by the NHA, including the missing entries during November, 2022. Review of Resident #21's social services and nursing progress notes including interdisciplinary notes revealed no psychosocial support was provided to Resident #21 following the ongoing verbal abuse incidents perpetrated towards her by Resident #25. There was no mention of these incidents in Resident #21's progress notes, only in Resident #25's progress notes. During an interview on 12/01/22 at 10:37 a.m., the DON and LPN Z acknowledged verbal abuse had occurred to Resident #21, post review of the resident to resident incidents (which Resident #25 perpetrated towards Resident #21) . Both understood the need for increased supervision and effective interventions for Resident #25, as evidenced by the missing behavioral tracking logs and several resident to resident incidents towards Resident #21, which continued to recur. LPN Z reported she had discussed the incidents with Resident #21 when they occurred, stating, [Resident #21] has two whistles and she said to [Resident #21], 'You have to use them'. LPN Z reported Resident #21 was cognizant, and didn't understand why Resident #21 was not using the whistle when the events occurred. Both acknowledged Resident #21 would benefit from additional psychosocial support and monitoring when they understood Resident #21 experienced psychosocial harm as a result of the repetitive, multiple resident to resident verbal abuse incidents, and the whistle was not an effective intervention. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During this same interview, the Social Services Director, LPN Z, was asked further about the lack of psychosocial support/visits for Resident #21 after these incidents, and appropriate interventions to prevent the multiple incidents of verbal abuse towards her by Resident #25, as reported during interview and review of the EMR and investigation summary dated 09/02/22. LPN Z confirmed Resident #21's Care Plan was not updated to include supportive interventions to address her feelings of fear, helplessness, and vulnerability. LPN Z reported they had not offered supportive visits post the incidents to address Resident #21's concerns, and understood the concern. LPN Z reported they believed the main intervention was to redirect Resident #25 to her room for a break, and for Resident #21 to use the whistle when Resident #25 was in her vicinity. Surveyor asked if Resident #25 had the mental capacity to understand her actions, and the cognitive capacity to carryover their instructions. LPN Z responded, No, I don't think [Resident #25] does. LPN Z explained Resident #25 scored 4/30 on the SLUMS assessment (a dementia assessment), which was in the dementia scoring range. LPN Z reported Resident #25 denied doing everything (towards Resident #21) but the incidents had been witnessed, and reported Resident #25 needed more to do, such as activities. LPN Z added, I need someone [to give guidance] who is familiar with nursing home rules for behaviors, and acknowledged they had reached out to another nursing home social worker for suggestions. LPN Z reported Resident #25' diagnoses (mental and intellectual) doesn't qualify with us, however other alternative placement options had been turned down, due to dementia was now the primary diagnosis, per the outside/community mental health assessments. LPN Z further clarified Resident #25's dementia diagnosis limited her ability to qualify for other programs and settings, and stated, [Resident #25] being here is a detriment to her in my opinion. LPN Z added they were not a social worker, but a nurse, and had done all the interventions they knew to do. During an interview on 12/01/22 at approximately 11:00 a.m., the DON confirmed Resident #21 would benefit from additional social services for support and visits, and to address Resident #21's psychosocial outcome of feeling scared and vulnerable from Resident #25's repetitive, ongoing verbally abusive behaviors towards her. The DON acknowledged the building was developing staff, as they were a newer team, and hiring additional staff including activities staff, which they believed would help staff to address these concerns. The DON reported they understood the concerns. During an interview on 12/01/22 at approximatley 12:25 p.m., the Regional Operations Director, NHA S, and the NHA acknowledged the concern with the multiple resident to resident verbal abusive altercations (which Resident #25 perpetrated towards Resident #21), and the lack of supportive visits, Care Plan updates, and follow up by Social Services related to Resident #21's adverse psychosocial outcome. Both understood LPN Z would benefit from additional training related to the behavioral management of facility residents. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, Social Services Department, revised 01/2022, revealed, Social Services department will ensure the resident has medically related social services needs are continually met. Social services will assure to meet the physical, mental, and psychosocial well-being of teach resident, and to assist in attaining or maintaining the highest practicable level of functioning .Medically-related social services means services provided by the facility's staff to assist residents maintaining or improving their ability manage their everyday physical, mental, and psychosocial needs. The social service department is responsible for services or participation in the following: .Identifying individual social and emotional needs. Assisting to providing corrective action for the resident's needs by developing and maintaining individualized social services care plans, maintaining regular progress and follow-up notes indicating the resident's response to the plan and adjustment to the institutional setting .Making supportive visits to residents and performing needed services (.i.e. services to meet the resident's needs .Finding options to most meet the physical and emotional needs of each resident . Review of the document, [Facility Organization] Job Description, undated, revealed, Position Title: Social Services Director .General Purpose: Responsible for developing, planning, implementing, and evaluating social services programs and services in accordance with state and federal regulations. To identify and provide for residents. social, emotional, and psychological needs. To aid in the development of the resident is [sic] full potential .to provide family counseling as needed .Performs all duties using independent judgment and discretion to implement regulations and policy .Licensed Social Worker preferred. Qualifications: Must, at a minimum, have a bachelor's degree in a human services field and one year of supervised social work experience in a health care setting .Social Work Functions: Duties .Provide or arrange for needed counseling services . Find options that most meet the physical and emotional needs of each resident .

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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. 13791 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety as evidenced by: 1. Failing to ensure frozen food, removed from its original packaging and placed in plastic zippered bags, was properly labeled. 2. Failing to replace a torn, damaged and ill fitting gasket on an upright refrigerator. 3. Failed to maintain the steamer cooking appliance in a sanitary manner. This deficient practice has the potential to result in food borne illness among any or all 39 residents in the facility. Findings include: (All reported times are in EST) 1. On 11/28/22 at 4:30 PM, two plastic zippered bags were observed in the upright freezer in the rear adjacent storeroom. Both plastic bags were absent of any labeling which identified the product, the date it had been removed from the original packaging, or an expiration date. On 11/29/22 at 12:30 PM, this same observation was made. on 11/30/22 at 8:15 AM, an interview was conducted with Kitchen Manager (KM) F, who acknowledged that the bags should have been labeled with the above information. The FDA Food Code 2017 states: 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method APPROVED by the REGULATORY AUTHORITY for refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. 2. On 11/28/22 at 12:45 PM, the upright single door Delfield refrigerator, located in the food preparation area, was observed to have a door gasket which was torn on the lateral edge, and an installation which prevented the door from sealing. The upper and lower corners of the gasket were twisted and did not provide a seal, and was further supported by cold air exiting the unit when the door was closed. At this time, an interview with Dietary Aide (DA) J was conducted who stated the unit has a difficult time maintaining temperatures. 3. On 11/29/22 at 8:40 AM, Dietary Cook (DC) G was observed using the mechanical steamer. Excessive steam was exiting through the door when it was closed. Further observations of the cooking equipment revealed the door handle was corroded. DC G stated the steamer door is supposed to be closed and prevent the exit of steam until the door is opened, and the unit had been in this condition for a few months. The FDA Food Code 2017 states: 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to ensure all professional staff were licensed, certified, or registered in accordance with applicable State laws for one Licensed Practical Nurse (LPN) out of six licensed nurses whose qualifications were reviewed. This deficient practice resulted in the provision of skilled nursing care by an unlicensed LPN, and the potential for the provision of skilled care services that did not meet standard of practice requirements for all facility residents. Findings include: This deficiency pertains to Intakes MI00129273 and MI00132598. Multiple complaint allegations were investigated that alleged the facility allowed a nurse to work with a suspended nursing license. During a telephone interview on [DATE] at 4:40 p.m., regarding the employment of a nurse with a suspended nursing license, confidential Complainant E stated, . For [LPN C] the 12 hour midnight shifts went without a nurse (a licensed nurse) when she was suspended. I want to know if families were informed that their loved one was provided care by a nurse with a suspended license. Complainant E said the information had been provided to the facility, LPN C had been terminated in July of 2022, but had recently been rehired by the facility. Review of a copy of a Licensing and Regulatory Affairs ([NAME]) online review of [LPN C's] disciplinary actions revealed the following: Suspended Applied [DATE] Fine Imposed Applied [DATE] Limited/Restricted Applied [DATE] Probation Applied [DATE] Review of the facility Past Noncompliance/Action Plan, developed [DATE], revealed the following, Description of deficient Practice: The facility administrator was notified by an outside source that a nurse who works the night shift at [the facility] had a suspended license. The administrator validated that the nurse's license had been suspended. The Administrator subsequently notified and suspended the nurse, on [DATE], from employment pending investigation. Review of an Employee Memorandum revealed [LPN C] was Suspended Pending Investigation beginning [DATE], Violation No. HR-,d+[DATE].4, Description of Violation: Failure to follow the Company's Professional Standards of Conduct . Discharge Effective [DATE] . Upon completion of investigation, [LPN C] was terminate. She received the notification by phone . (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 6:58 a.m., the Director of Nursing (DON) confirmed she was aware of the [State Name} Bureau of Professional licensing Board of Nursing disciplinary action that placed LPN C on nursing license probation as of [DATE]. The DON said that the former facility nursing home administrator was responsible for submitting quarterly reports to the State Board of Nursing. The DON stated, We found out that the quarterly reports (detailing LPN C's nursing competency in the position) were not being done once we called the State of . The DON also confirmed [LPN C] was clearly noted in the Board of Nursing Disciplinary documents as responsible for ensuring the submission of the quarterly reports, payment of a $250.00 fine within 90 days of the effective date of the disciplinary order, signed [DATE] (effective 30 days later), and multiple other conditions of employment. The DON and LPN C have a familial relationship, and both were terminated in [DATE] related to supervision and continued employment of a licensed nurse with a suspended license. LPN C worked from [DATE] through [DATE] as an unlicensed nurse, often working the night shift as the only nurse in the building. The facility self-identified the deficiency on [DATE], and implemented the following detailed interventions delineated in their Past Noncompliance Action Plan, dated [DATE], How and why deficient practice occurred: The nurse had actions taken against her nursing licensure that resulted in probationary nurse licensure. The nurse reported the probationary status to the previous facility administrator. The previous Administrator did not follow up with the terms of the nurses' probation or notify Atrium Centers of a nurse who had probationary licensure. The terms of probation were not met, and the nurse's license was subsequently suspended for not meeting the terms of probation. Upon investigation it was identified that the actions taken against the nurse were due to the lack of inaction (sic: action) by the nurse to notify a physician when a resident had a change of condition . Plan of Correction/Plan to Address: Action for Nurse Involved: The nurse was suspended on [DATE]. The [State Name] Consent Order and Stipulation for disciplinary action was reviewed and indicates the nurse cannot work in home health care. The nurse was placed on probation. The nurse was instructed to contact the licensing agency to obtain any change of licensure status in writing. Per the nurse, she was told that no changes will be made to the status of her license until the monetary fine as required as a condition of her probation is received. The nurse reports that she has submitted the payment for fees. The nurse's personnel file, fingerprints, background check, and references were reviewed. Identification of residents/Facility Actions: Residents in the facility are identified as being at potential risk. The following actions were taken on [DATE]: (continued on next page)

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	235612	A. Building B. Wing	12/05/2022

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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The progress notes for residents who expired in the facility from [DATE] - current were reviewed to determine any concerns with physicians not being contacted timely with resident changes of condition. - Resident incident reports generated by the suspended nurse were reviewed from [DATE] - current to determine if actions taken by the nurse were appropriate and physicians were notified of the incidents. - Medication Error reports from [DATE] - current were reviewed to determine if the suspended nurse was involved and to ensure appropriate actions were taken in response to the errors, including physician notification. - The nursing licenses of all nurses employed at {Nursing Facility] were audited to ensure active licensure. During the audit it was identified that one nurse has her license under a different last name than the name on her social security card. The nurse has been asked to submit a request to the licensing board to amend the last name on her licensure to match the name she has on her social security card. - The certifications of CENAs (Certified Nurse Aides) were reviewed to ensure active CENA certification. There was 1 PRN (as needed) CENA identified whose certification presents as lapsed. The CNA was informed and will not be allowed to work until valid, active certification is presented. The CENA was also instructed to notify her current full-time employer of the lapsed certification. {Medical Association] was notified to determine a potential delay in transition of information from [the CENA licensure source]. - The electronic health record was reviewed to ensure employee licensed names are the same name that is in the electronic health record for documentation purposes. - Review of CENA certification identified 1 CENA whose last name on her certification is different than the last name on her social security card. The CENA has been asked to submit a request to {the CENA licensure source] to change the last name on her certification to match the last name on her social security card. - Contracted employees and employees of [Facility Corporation] who visit [the Facility] and who are required to have professional licensure or certification were contacted to provide current, updated proof of licensure. - Licensures and certifications were audited to determine any other employees on a probationary or restricted license or certification. - The Board of Nursing will be contacted within 30 days to report the nurse's employment at [the Facility] while on a suspended license. - Residents were interviewed to determine any potential concerns regarding nurse care rendered on the night shift. - Upon further investigation the Director of Nursing was suspended. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Measure to ensure deficient practice will not recur: - Licensed Nurses will be educated on reporting any actions or pending actions with professional licensure. CENAs will be educated on reporting any actions or pending actions against their certifications. - All staff, including but not limited to nurses and CENAs, will be educated on notifying the facility administrator of any knowledge of pending legal issues, any arrests, or any concerns with licensure's or certifications. - The Administrator was educated to report any nurses on probation to the parent company . The company will verify that stipulations of probation including submission of quarterly reports if required as a condition of probation, are being submitted and conditions of probation are being met. - The VP (Vice President) of clinical services provided education to the facility Administrator, Director of Nursing, and Human Resource Representative on reporting to the company when concerns arise regarding licensure or certification. - The Facility Human Resources Representative was educated to audit the licensure of employees on restricted licensure/probation every 2 weeks to ensure licensure remains active and the employee is working within licensure restrictions and conditions of probation. - The Administrator will complete a timeline, full root-cause analysis, and investigation for submission to the facility QAPI Committee. Monitoring of corrective actions to ensure deficient practice will not recur: - The Human Resource Representative or designee will audit nursing licenses and CENA certifications every 6 months to verify active licensure and certification. Identified concerns will be addressed immediately. Audit results will be submitted to the QAPI Committee twice yearly. - A Human Resource Representative or designee from [Facility Corporation] will review monthly to ensure any employee conditions of probation/restrictions are being met, including any reports required to be submitted by the employee. Identified concerns will be addressed immediately. Findings will be provided to the company QAPI Committee monthly. - The facility Human Resources Representative will audit licensure/certifications every 2 weeks for nurses or CENAs who are on probation or who have restricted licensure/certification to ensure licenses/certification remains active. Identified concerns will be reported immediately to the Administrator for follow up. Audits will be submitted to the QAPI Committee monthly. Person responsible for attaining and sustaining substantial compliance: Administrator. Date substantial compliance achieved: [DATE]. Signed by the facility Administrator. As the facility self-identified the deficiency, implemented interventions to correct, educated, and monitored for resolution and prevention of further deficiency, past non-compliance was determined corrected, and no deficiency will be cited.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 This deficiency pertains to Intakes #MI00131669. All times are recorded in Eastern Standard Time (EST) unless otherwise noted. Based on observation, interview, and record review, the facility failed to offer a binding arbitration agreement that provided for the selection of a neutral arbitrator agreed upon by both parties and provided for the selection of a venue that was convenient to both parties for 5 of 6 residents (R4, R8, R19, R30, and R35) with signed binding arbitration agreements. This deficient practice failed to provide a neutral and fair arbitration process and had the potential to affect all residents and responsible parties entering into this agreement. Findings include: A complaint was received by the State Agency (SA) on 9/21/22 regarding the binding arbitration agreement for Resident 35 (R35). A call was placed to the complainant on 11/30/22 at 8:24 AM to clarify the details of the complaint regarding the facility's use of a binding arbitration agreement. During an interview on 11/30/22 at 10:03 AM, the Social Services Director, Licensed Practical Nurse (LPN) Z stated she did the admission paperwork for residents. She presented an arbitration agreement stating, It is part of the paperwork that is explained upon admission but not all residents sign it. LPN Z explained, It does expedite the grievance process, and said signing the agreement was not a condition of admission. The binding arbitration agreement for R35 was received for review on 11/30/22 at 11:32 AM from the Business Office Manager (Staff T). The Agreement to Resolve Legal Disputes Through Arbitration for R35 had been signed on 5/26/22 for the initial admission with the error of the Durable Power of Attorney (DPOA) listed as the Resident and R35 written into the agreement as the Representative. R35 was readmitted [DATE] and the same arbitration agreement was again signed 8/12/22 with the Resident R35 and DPOA listed in the proper blanks. Upon review of the Agreement to Resolve Legal Disputes Through Arbitration form there were multiple blanks and typographical errors including: B. an (sic) judgement . B. This paragraph ends as follows: . The decision of the arbitrator shall be binding on all of the parties to the arbitration, and also on their successors and assigns, including the agents (multiple blank lines followed) and then continued and employees of [Name of facility] , and all persons whose claim is derived through or on behalf of Resident, including, but not limited to, that of any parent, spouse, child, guardian, executor, administrator, legal . The sentence ends without conclusion or period punctuation. A space follows under this paragraph which appears to have been erased or whited out. C. Who Wil (sic) Conduct Arbitration . (continued on next page)

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. will be resolved through arbitration administered by the American Health Layers (sic) Association (AHLA) . C. or AHLS is unwilling tor (sic) unable . C. This paragraph ends as follows: . If the parties are unable to agree on an alternative organization, The sentence ends without conclusion or period punctuation. A space follows under this paragraph which appears to have been erased or whited out. D. Where the Arbitration Will Take Place. The parities (sic) . D. then at (Name of Facility) s (sic) option . During an interview on 11/30/22 at 12:16 PM, Regional Operations Director S and Nursing Home Administrator (NHA) reviewed the signed Agreement to Resolve Legal Disputes Through Arbitration for R35. The Regional Operations Director S stated, It appears there would be a missing rest of the sentence in (paragraph) B and C. On 11/30/22 at 12:22 PM, the Regional Operations Director S invited Staff T to join the discussion. Regional Operations Director S stated the form signed was the wrong form and there was a computer form that was supposed to be used from the corporate office. Staff T explained for admissions, LPN Z made copies and did not use electronic forms. Regional Operations Director S said, I did not realize that he (DPOA for R35) signed an agreement with missing sentences. Staff T said, We both have been making copies of that form for over a year. Regional Operations Director S questioned the validity of the form and invited LPN Z into the discussion. LPN Z confirmed and said, This is the original that he (DPOA for R35) signed. LPN Z stated, I have been making copies of the same copies for the last year. The conversation continued with Regional Operations Director S and the NHA. The required clauses: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties. were not found in the Agreement to Resolve Legal Disputes Through Arbitration. Paragraph C stated a national dispute resolution service would be used as a neutral arbitrator, but went on to state, If the parties are unable to agree on an alternative organization. Here the paragraph ends, and the selection of a neutral arbitrator is not provided for. Paragraph D read: The parities (sic) will mutually agree to a location where the arbitration will take place. If the parties cannot agree to a location, then at (Name of Facility) s (sic) option, the arbitration will take place at (Name of Facility), or at a location affiliated with (Name of Facility). The clause states the parties will mutually agree, but if they cannot, it will be the choice of the facility. This agreement did not provide for the selection of a venue convenient to both parties. (continued on next page)

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regional Operations Director S stated, That regulation did not go into effect until October 24, 2022, and so the agreements did not have to have those clauses. This surveyor invited presentation of further information to fulfill the regulation. On 11/30/22 at 2:15 PM, a list of residents who had entered into a binding arbitration agreement on or after September 16, 2019, was requested. A list of 22 current residents who had signed binding arbitration agreements was presented. A review of the arbitration agreements for R4, R8, R19, and R30 revealed the same form with errant, missing, and incomplete paragraphs had been signed. These Agreements to Resolve Legal Disputes Through Arbitration also failed to offer a binding arbitration agreement that provided for the selection of a neutral arbitrator agreed upon by both parties and provided for the selection of a venue that was convenient to both parties.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 This deficiency pertains to Intake #MI00129273. All times are recorded in Eastern Standard Time (EST) unless otherwise noted. Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices for: 1) Donning and doffing of Personal Protective Equipment (PPE); 2) Proper disinfection of PPE; 3) Performance of hand hygiene; 4) Complete surveillance for infection control tracking; 5) Complete surveillance/audits for infection control tracking; 6) Proper disposal of biohazardous materials; 7) Ensure resident compliance with source control measure to hinder the spread of infection of Covid-19; and 8) Ensure visitors adhered to infection control practices during visitation in the facility. These deficient practices had the potential to result in the transmission of infectious organisms and the development of new or recurring infections in all 29 facility residents. Findings include: During an initial observation on 11/28/22 at 12:30 PM, signage outside the facility's entrance vestibule posted: Covid positives - 4 residents and 3 staff dated 11/28/22. Per the Nursing Home Administrator (NHA), who greeted the survey team upon entry, stated the last Covid positive was a resident tested on [DATE] and the facility was currently in an outbreak mode. There were Transmission Based Precautions (TBP) rooms located on both [NAME] and South Halls. Staff and visitors were directed to wear PPE while providing care or entering TBP rooms. During on observation on 11/28/22 at 2:17 PM, Registered Nurse (RN) B was standing in the [NAME] Hall outside of a TBP room for Covid-19. RN B wore an N-95 mask improperly with both straps around the base of her neck. RN B repeatedly adjust her N-95 mask on her face prior to entering the TBP room without sanitizing her hands. RN B exited the TBP room and failed to sanitize her eye protection and change out her mask. RN B assisted an unidentified resident in a wheelchair in the hall to the nurse's station. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/29/22 at 8:00 AM, an interview was conducted with Licensed Practical Nurse (LPN) D. LPN D was asked who her Certified Nurse Aides (CNA's) were and responded a name of her coworker and another down the South Hall and third that was a float. LPN D further responded that all the CNA's help down both halls when providing care for residents. Indicating there was not dedicated staff to care for residents under TBP for Covid-19. During an observation on 11/29/22 at 9:12 AM, RN B was pushing a two-tiered cart down the [NAME] Hall with Covid-19 rapid testing supplies on the top, on the bottom there were tests waiting to be resulted, and a regular clear trash bag tied to the side of the cart with disposed used dirty tests. On 11/29/22 at approximately 10:30 AM, an interview was conducted with RN B. RN B was asked where staff complete their Covid-19 tests. RN B took this Surveyor to a small room near the front entrance. In the small room where staff completed Covid-19 testing daily there was a regular trash can, a biohazard trash can, a used Covid-19 test on top of a counter and an old dirty Covid-19 test discarded in the regular trash. When asked if the old dirty Covid-19 test was disposed of in the regular trash RN B responded, No. That should not be in the regular trash. All the old Covid-19 tests are to be placed in a biohazard trash bag. During an observation on 11/29/22 at 11:28 AM, Staff L exited a TBP Covid-19 room down the South Hall. Staff L failed to sanitize her hands after she cleaned off her eye protection and changed her dirty mask. During an interview on 11/29/22 at 2:30 PM, Infection Control Preventionist / Director of Nursing (DON) and Regional Clinical RN M, were asked who the remaining residents were on TBP related to Covid-19. The DON responded, one resident was in room [ROOM NUMBER] down the [NAME] Hall and one was in room [ROOM NUMBER] down the South Hall. This Surveyor questioned the room assignment to 119 as there were two residents in that room. The DON and Staff M, were asked how much longer the resident in room [ROOM NUMBER] was to be on quarantine for and when the other came off quarantine, and they responded, The one came off of quarantine yesterday and the other resident has six more days of quarantine. When asked if it was possible to move either resident from the TBP room so that isolation could be lifted from the Covid-19 recovered resident, they responded, We did not even think about that. On 11/29/22 at approximately 2:45 PM, the DON was asked what types of Covid-19 mitigation for new admissions were in place and if they were being followed. The DON responded, The new admissions are tested for Covid-19 during the first 24 hours after arriving to the facility, then on day three and again on day five. They are also to wear a face mask after admission for ten days. The DON was asked if Resident #20 who was admitted on [DATE] wore or was encouraged to wear a face mask, and responded, We tried, but he just would not wear one. R20 contracted Covid-19 on 11/11/22 and was the first resident to contract Covid-19 during the outbreak. After R20 there was further spread of Covid-19 to seventeen other residents between 11/15/22 until 11/24/22 and five other facility employees between 11/9/22 through 11/22/22. No documentation was provided to support a mask was offered to or refused by R20 to mitigate the spread of Covid-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/30/22 at 8:10 AM, an interview was conducted with Resident #19. R19 was asked about being in quarantine and Covid-19 recovered. R19 stated that she was not aware that her roommate was under quarantine and the staff never told her. R19 also stated that she thought it was her that was still on quarantine and further expressed that she was glad that the other resident was moved to a different room as she liked the door open, and it was a lot quieter now that the TV was not on all night. R19 said she was to have a shower yesterday and did not get one and was not sure why. On 11/30/22 at 8:20 AM, an interview was conducted with the DON. The DON was asked if she knew why R19 did not get a shower yesterday, and responded, I will find out. The DON was asked if it was related to her being on TBP, and responded, I am not sure. The DON was unable to determine the reason R19 did not receive a shower by the end of the survey. During an observation on 11/30/22 at 12:10 PM, down the [NAME] Hall at the end in the resident lounge. The resident lounge door was shut. Inside the resident lounge, there was a resident who sat in her wheelchair, and a staff member Occupational Therapist (OT) N sat in a chair adjacent to one another. They were talking and the OT N had her mask below her mouth and nose. The OT N made eye contact with this Surveyor looking through the closed door and immediately place her mask on her face correctly. On 11/30/22 at approximately 12:30 PM, the facility mappings, and line listings were reviewed along with other infection control documents related to the current Covid-19 outbreak in the facility. Review of the mapping and line listing for October 2022 revealed a monthly summary which indicated there were audits and education provided to staff regarding urinary tract infections on peri care. The DON was asked to provide the documentation for these audits and education and stated that she did not know where the education and audits had been placed or gone and even looked through the shred box. Further review of the infection control mapping and line listing for November 2022 revealed a line list but lacked any Covid-19 or other facility line listed infections to track trends during a Covid-19 outbreak that began in the facility on 11/2/22 when the first employee tested positive. The DON confirmed that there was not a map that was started yet for infections acquired in November 2022 and this was reviewed on 11/30/22 by this Surveyor. The audits for November 2022 were reviewed and started on 11/16/22 and stopped on 11/22/22. No audits were provided to the surveyor prior to the 11/16/22 date and the outbreak was noted to start on 11/2/22. Review of facility documents (three pages) for Covid-19 surveillance and contact tracing, dated 11/17/22 on the top and titled Infection Control Covid-19 Timeline, revealed incomplete contact tracing. The contact tracing lacked any documentation of the prior three days as to who the Covid-19 positive employee or resident had. The contact tracing did not identify who the employee or resident was, nor provide a specific hall or other individuals they had contact with. Furthermore, lacked employee specific times that were worked in the facility during the outbreak. The DON confirmed the contact tracing should have included more evidence and had a hypothesis of how the Covid-19 outbreak started during an interview on 12/1/22 at approximately 11:15 AM. On 12/1/22 at 12:45 PM, an interview was conducted with Maintenance Director K. Maintenance Director K was asked about increased cleaning during the outbreak, and responded, Cleaning is done daily. Maintenance Director K was then asked about cleaning audits and logs, and responded, I do not have any audits or logs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of communications from the Department of Health and Human Services, dated 11/15/22 and 11/22/22, read in part, .Facility approved for .CR (Covid Relief) Facility designated beds for retention purposes only. Acceptance of this designation constitutes agreement to: .Maintain dedicated staff to serve only the COVID-positive residents . During the time of the survey between 11/28/22 through 12/1/22 none of the 29 residents were seen wearing a mask while in the facility, nor in the communal dining area, and nor in the dining room where activities were being held. Review of facility policy titled, Monitoring Infection Control Practice, date reviewed 01/2022, read in part, Policy: The facility's Infection Control Preventionist will conduct routine monitoring and surveillance to determine compliance with infection control policies and practices. Procedures: Residence Surveillance If suspicion or evidence of an infection is detected within the resident population the following should be done: . 8.) The Infection Control Preventionist shall review and analyze data monthly (or more frequently if warranted) for trends, rates of infections, clusters of infections, causes of infections and to evaluate the effectiveness of the facility's infection control program .Employee Surveillance: .4.) The Infection Control Preventionist will utilize logs, reports to assist in potential causes of infections and to evaluate the effectiveness of the facility infection control program .Facility Surveillance: 1.) Surveillance of the workplace to ensure that established infection control practices are observed and protective clothing and equipment are available and properly used . Review of facility policy titled, Covid-19 Prevention and Response, date revised 10/2022, read in part, Policy: This facility will respond promptly upon suspicion of illness associated with a SARS-CoV-2 infection in efforts to identify, treat, and prevent the spread of the virus .22.) Managing admissions and residents who leave the facility: .b.) Residents should be advised to wear source control for 10 days following their admission . Review of facility policy titled, Covid-19 Visitation and Communal Activities/Dining, date revised 10/2022, read in part, Policy: This facility will allow visitation of all visitors and non-essential health care personnel and can be conducted through different means based on the facility's structure and resident's needs, such as in resident rooms, dedicated visitation spaces, and outdoors .Policy Explanation and Compliance Guidelines: .4.) .f.) A face covering or mask (covering the mouth and nose) in accordance with CDC guidance .18.) Communal activities (including group activities, communal dining, and resident outings): a.) Communal activities and dining may occur while adhering to the core principles of COVID-19 infection prevention. The safest approach is for everyone .to wear a face covering or mask while in the communal areas of the facility . Review of facility policy titled, Isolation-Categories of Transmission-Based Precautions, date updated 09/2022, read in part, Policy: To provide care to residents documented or suspected to be infected or colonize with highly transmissible microorganisms that require additional precautions beyond Standard Precautions, in order to reduce transmission of these microorganisms .Trash and Soiled Linens .Items that meet the criteria of biohazard medical waste must be disposed of in .a red bag [biohazard] . (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy titled, COVID-19 Testing Policy, dated 10/2022, read in part, .Testing of Staff and Residents in Response to an Outbreak Investigation 1.) An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed .5.) Contact tracing is recommended immediately . Review of facility policy titled, COVID-19 Surveillance Policy, date revised 10/2022, read in part, Policy: This policy will implement heightened surveillance activities for coronavirus illness .8.) The Infection Preventionist, or designee, will track the following information: .d.) Employee compliance with hand hygiene. e.) Employee compliance with standard and transmission-based precautions. f.) Employee compliance with cleaning and disinfection policies and procedures . 40383 On 11/28/22 at 1:34 PM, the clean laundry was observed being delivered on the [NAME] wing by Staff EE. When Staff EE came to room [ROOM NUMBER], a designated Covid-19 positive room, she donned PPE and entered the room. Moments later, Staff EE was observed to exit the room and continue down the hall wearing a face shield. She was asked if her face shield was the same shield worn in the quarantine room and said, Oh yes, I forgot that part. Staff EE then disposed of her face shield, took goggles out of her pocket, and donned them. On 11/28/22 at 2:40 PM, Family Member FF was observed entering a room in the middle of South Hall. Family member FF came into the room after entering at the front door, past the front office, and past the nursing station occupied by one nurse. Family member FF came in the room and placed a large bag of Christmas decorations in the room. Family member FF exclaimed, Oh my, I am not even wearing a mask. I always wear a mask. Family member FF explained they had come in the front door, and no one had even reminded her to wear a mask.