STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235004	A. Building B. Wing	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Muskegon	1061 W Hackley Ave Muskegon, MI 49441

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 This citation refers to MI00124948, MI00124429, and MI00124983. Based on interview and record review, the facility failed to implement and operationalize care plans for 5 residents (R6, R7, R8, R10, and R11), resulting in R7 and R8 developing pressure ulcers and the potential for the development of serious complications (e.g. infection, declining health status) from the pressure ulcers, and resulting in R6 having significant weight loss and R6, R10, R11 being at risk for future weight loss and choking hazards due to lack of feeding support. R8 having poor pain control and poor tolerance to activity due to pain. Findings include: R7 A review of R7's Admission Record, dated 12/15/21, revealed R7 was an 87 -year-old resident admitted to the facility on [DATE]. In addition, R7's Admission Record revealed R7 had multiple diagnoses that included diabetes, difficulty walking, and paraplegia (paralysis of lower body and legs). A review of R7's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 10/21/21, revealed R7 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) assessment which revealed R7 had short-term and long-term memory problems. In addition, R7's MDS revealed R7 had moderately impaired cognitive decision-making skills. R7's MDS also revealed R7 did not have any pressure ulcers or sores. A review of R7's impaired skin integrity care plan, revised 1/25/21, revealed R7 had impaired skin integrity related to decreased mobility, resistance to repositioning, incontinence of bowel and bladder (Date Initiated: 09/02/2020). R7's impaired skin integrity care plan also revealed an intervention of Elevate heels off bed surface while at rest in bed (Date Initiated: 10/26/2020). A review of R7's Skin & Wound Evaluations, dated 11/11/21, revealed the following: - Left heel- Stage 3 pressure ulcer (involves the full thickness of the skin and may extend into the subcutaneous tissue layer; granulation tissue and epibole (rolled wound edges) are often present). (continued on next page)

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	- 11/11/21= 4.1 cm (centimeters) x (by) 3.6 cm (length by width). Area= 11 cm2 (centimeters squared). - Right heel- unstageable pressure ulcer (Full thickness tissue loss in which the actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed). -11/11/21= 3.2 cm x 2.6 cm. Area= 6.1 cm2. A review of R7's General Progress Note, dated 11/12/21, revealed, observed resident to have bilateral heels elevated up on pillows , heels had lotion on them, they were cracked open and tender to the touch left heel measured at - 5.3 cm x 4.4 cm x .2 cm deep, right heel measured at 5.6 cm x 4.3 cm x 1.4 cm deep, no drainage present, surrounding tissue dry and cracked, 70% pink, 30% eschar, treatment started, notifications completed, wound care to follow weekly on wound rounds, encourage resident to use heel bridge, and will have his bed length extended to help prevent his heels from resting on the foot board. A review of R7's Skin Observation Tools, dated 10/11/21 to 11/10/21, failed to reveal any skin alterations or wounds. R7's Skin Observation Tools revealed R7 had normal appearing skin and no new alterations in skin integrity including open areas of any type. During an interview on 12/15/21 at 2:45 PM, R7 stated he developed sores on his heels because they were laying on the bed. He stated when the staff were made aware of his pressure sores, they put them up on pillows. They keep them up on pillows now. During an interview on 12/16/21 at 11:10 AM, Registered Nurse Unit Manager (UM) N stated on 11/10/21, a nursing assistant filled out a skin alert note. She stated she (UM N) evaluated R7's wound and did measurements on 11/10/21. She stated R7 had wounds on his right heel and left heel (one each). UM N stated R7 was non-compliant with positioning, including being boosted up in bed when he slides down towards the foot board. UM N stated she asked R7 if he knew how he developed the pressure ulcers on each heel. He told her he did not. UM N stated R7 probably developed the bilateral heel pressure ulcers because he would slide down in bed, refused to be boosted/pulled up in bed, and his feet would rest on the foot boards. UM N stated on 11/10/21, she completed a Focused Incident Review for New or Worsened Pressure Ulcer/Injury form for R7's bilateral heel pressure ulcers and R7's wound measurements were 5.3 cm x 4.4 cm x 0.2 cm (left heel) and 5.6 cm x 4.3 cm x 1.4 cm (right heel). UM N stated that she locked (completed) R7's Focused Incident Review for New or Worsened Pressure Ulcer/Injury form on 11/12/21 and on that date the progress note was entered with the measurements she did. 38659 (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of facility policy with the subject Weight Management with adopted date 9/11/20 revealed weight loss is defined as: significant weight loss (5% in one (1) month, 7.5% in three (3) months, or 10% in six (6) months) . should be addressed in the care plan. Facility approaches to address weight loss may include an ongoing search for the cause(s) of weight loss .once the cause(s) is/are identified, relevant care plan decisions are made and documented. Ongoing interventions are evaluated and modified as needed. The procedure includes the resident being weighed monthly and as needed .Monthly weights are to be completed by the 7th day of each month and reviewed by the Nutrition Committee within a reasonable period of time thereafter .any resident weight that varies from the previous reporting period by 5% in 30 days, 7.5% in 90 days and 10% in 180 days will be evaluated by the Interdisciplinary Team to determine the cause of the weight gain/loss and the intervention(s) required .any resident meeting the criteria for weight loss .will be weighed weekly, with the weight entered in the resident's medical record . Review of the facility policy with the subject Nutrition Monitoring & Management Program with the adopted date of 7/11/18 revealed a purpose: To provide care and services including .defining and implementing interventions for maintaining or improving nutritional status that are consistent with resident needs, goals and recognized standards of practice .monitoring and evaluating the resident's response or lack of response to the interventions . Dietary evaluations are assessed on admission and at least quarterly thereafter, and following a change in condition. R6 Review of R6's face sheet revealed she had originally admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnosis that included: dementia, dysphagia (difficulty swallowing), deficiency of vitamins, weakness, lack of coordination, and cognitive communication deficit. Review of R6's kardex revealed under food/fluids: 1:1 feeding assistance at all meals . check mouth after meal for pocketed foods and debris . instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly . There is a conflicting entry in the kardex, which stated R 6 is able to eat independently. Under the section special needs weight is noted to be taken weekly as well as monthly. Review of R6's care plan revealed under the focus ADL (activities of daily living) self-care deficit r/t (related to) weakness, confusion, impaired balance, limited mobility an intervention that states The resident is able to: eat independently with an initiation date of 4/27/20. Under the focus area: [R6] has a Nutritional status risk AEB (as evidenced by) Dx (diagnosis) of .dementia . dysphagia w/ need for altered textured diet/fluids in place; chronic variable po (by mouth) intake; h/o (history of) wt (weight) fluctuations; and advanced age with interventions that included: 1:1 feeding assistance at all meals with an initiated date of 12/7/21, Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of dysphagia ., review routine weights, and weigh resident per facility protocol . Under the focus area has a swallowing problem r/t (related to) dysphagia, poor dentition interventions included: check mouth after meal for pocketed food and debris ., instruct, assist and/or encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly, and Monitor for .choking . Review of physician note from 11/22/21 revealed R6 was being seen for a complaint of weight loss. Lab work, dietary evaluation and weekly weight checks to further monitor weight loss were ordered. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	On 12/16/21 at approximately 8:35 AM, no staff other than a housekeeper were observed on the 400 hall or in resident rooms and residents were eating breakfast. R6 was observed in her room, not being assisted with her meal. One of her roommates had completely finished their meal at this time and the other roommate was about half complete in consuming her meal. R6 was viewed to have her food untouched and had a glass of clear red honey thick liquid to her mouth with her eyes closed. R6 was approached and appeared to be asleep with the glass to her mouth. She did not respond to verbal attempts to get her attention for about a minute. R6's shoulder was rubbed when speaking to her and she slowly opened her eyes, but kept the glass to her lips briefly and then slowly lowered it. R6 continued to not respond verbally and looked around the room with confusion, not making eye contact. A discussion was completed with R6's roommate, who stated that usually someone will come help R6 at with her meal, but they don't usually assist her until later, so someone may come back to help her. Conversation was attempted again with R 6 and she was not communicative and did not make eye contact. Upon exiting the room and walking the hall again, no staff other than housekeeping was viewed on the hall or in resident rooms. R6 was watched from the hall consuming her breakfast. She took a limited amount of very small bites, moving very slowly. At approximately 8:47 AM, a CNA (certified nursing assistant) entered the hall and appeared to have gotten additional food from the kitchen for a resident and delivered it to their rooms. At 8:52 AM CNA X entered the room of R 10. At 8:55 AM CNA X exited R10's room with their meal tray and then went into R 11's room. At 8:58 AM CNA X exited R11's room with their meal tray and then entered the room of R 6. CNA X was viewed to briefly check on R6 and walked away as she was viewed to be very slowly feeding herself. CNA X was in the room with R6 for approximately 2 minutes. CNA X was asked if she was the only aide assigned to the hall that morning and she stated yes, I am the only one on the hall, it's like this every day. CNA X was asked if anyone on the hall needed feeding assistance and she said at least 3 and pointed to the rooms of R6, R10, and R11. CNA X was asked specifically about R6 and her needs. CNA X stated she seems to be doing good now, but you have to keep checking on her to make sure she's not choking. But she is doing good on her own today. CNA X was asked how she managed to assist 3 residents at once who needed feeding assistance and she stated that she just has to keep going back and forth between them. On 12/16/21 at 10:50 AM, an interview was completed with Dietician Y regarding R6's nutritional status. Dietician Y stated R6 has had weight loss recently and overall a decline and had a downgrade in her swallowing ability. The dietary plan was to add supplements to meals as well as provide feeding assistance to R6. Dietician Y stated R6 can feed herself at times, but that staff usually need to initiate feeding and provide encouragement. The food acceptance logs for R6 were reviewed with Dietician Y and she stated it appears R6's acceptance increases when she has staff assistance. Dietician Y agreed there were some holes in the food acceptance documentation and stated she would expect each meal to be documented. Dietician Ys stated R6 was placed on weekly weights as of 11/23/21, this was discontinued for some reason, but reordered on 12/6/21. Weekly weights were ordered to be completed on Mondays for 4 weeks. Dietician Y stated she is also completing weekly dietary evaluations of R 6 due to the significant weight loss, which would include reviewing her intake and weights. Dietician Y was asked how she completed her review of R6 on 12/14/21 (a Tuesday) if R6's weekly weight was missed on 12/13/21 (Monday). Dietician Y stated it does appear R6 needed another weight to be completed. Dietician Y was informed missing the weekly weight was concerning and also informed R6 was not viewed to be getting assistance with her breakfast meal. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	On 12/16/21 at 12:08 PM, lunch meal trays were observed to begin to be delivered to the 400 hall. R6 was viewed to be asleep in bed. There were between 2 to 3 CNA staff on the hall at various times delivering the meal trays to residents in their rooms. At 12:13 PM a CNA entered R6's room to deliver her tray. They elevated R 6 in bed, set up her meal and then exited the room by 12:17 PM without assisting the resident to begin eating. At 12:21 PM, R6 had yet to take a bit and the surveyor entered the room. R6 was asked how she was today and how her meal was. R6 stared blankly at the surveyor and then slowly took one small bite of ice cream. Upon exiting R6's room at 12:23 PM, it was viewed that no staff were in the hall and a nurse was completing medication pass. There were 2 staff in the dining room area and 1 staff was assisting a resident with their meal. At 12:28 PM, Nurse Z returned to the hall. R6 was not eating any further bites of food. At 12:31 PM Nurse Z entered R6's room with medications and asked R6 if she needed help. At this time the resident took one more very slow bite of ice cream. Nurse Z appeared to be looking for another staff member and came across CNA X briefly exiting the dining room, Nurse Z asked CNA X to assist R6 with lunch. CNA X stated she could not because she was assisting residents in the dining room and was overheard saying she [R6] did not do great at breakfast. Nurse Z then left the hall and there was not any nursing staff on the hall for about 3 minutes. Nurse Z then returned to the hall and to R6's room and began to assist her with eating at approximately 12:35 PM. On 12/16/21 at 12:03 PM, an email request was made to the director of nursing (DON) and nursing home administrator (NHA) requesting the staff covering the 400 hall for the morning of 12/16/21, since the schedule appeared to be unclear. The DON responded by email on 12/16/21 at 12:08 PM that 2 CNAs and one nurse were assigned to the hall for that shift. During a follow up interview on 12/16/21 at 3:20 PM, the DON and NHA were informed of the lack of staff viewed on the hall during meal service that day, which was concerning with there being at least 3 identified residents who required 1:1 assistance with meals due to choking hazards and/or weight loss. The DON and NHA were informed of the extensive concerns rising to a level of immediate jeopardy with R6's weight loss and lack of interventions being implemented. On 12/17/21 at 9:05 AM, R6 was viewed being transported to the dining room in her wheelchair by staff. She was viewed to be attached to a bag of IV fluids and was smiling and making eye contact. On 12/17/21 at 9:55 AM Unit Manager (UM) Z was observed feeding R6 in the main dining room. R6 had an IV in her arm. The Surveyor asked R6 how her food tasted, and she responded, I do not know. R6's had her eyes wide open and was watching UM Z. When the spoon came to her mouth, she opened it without cueing. On 12/21/21 at 9:00 AM, UM Z was observed feeding R6 in the main dining room. R6 did not have an IV running. UM Z was giving R6 spoonfuls of thickened cranberry juice. R6 had her eyes open and did not need verbal cues to open her mouth when the spoon reached her lips. The Surveyor asked R6 how her food tasted, and she responded good. Review of R6's weights revealed the following weights in the last approximately 3 months: 9/2/21 127.6 pounds, 10/1/21 125.6 pounds, 11/17/21 116.6 pounds, 12/1/21 109.0 pounds, 12/6/21 109.0 pounds, 12/16/21 106.3 pounds, 12/20/21 105.1 pounds. Between 10/1/21 and 11/17/21 (1 month) sustained a 7.1 % weight loss. Between 11/17/21 and 12/1/21 (2 weeks) R6 sustained another 6.5% weight loss. Between 9/2/21 and 12/1/21 (3 months) R6 sustained a 14.5% weight loss. The monthly weight in November was completed late during a time period where R6 sustained a significant weight loss and weekly weights were missed the week of 11/29/21 and 12/13/21 where R6 continued to lose weight. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of R6's progress notes revealed no dietary progress notes from 5/17/21 until 11/18/21. A nutrition progress note from 11/18/21 revealed: Resident triggered a 8.6% significant wt loss x1.5mo with her CBW (current body weight) at 117# (11/17) and BMI 22.0. Wt hx reviewed: 126# (10/1), 127# (8/3), and 125# (5/2) . Meal intake reviewed which remains fair, consuming 60% on average over a 14-day lookback period. She is supplemented with House Shake . Will increase her supplement to TID to support wt maintenance. MD notified of significant wt loss as well. A nutrition progress note for 11/23/21 revealed: Weekly Review: Resident's meal intake remains fair, consuming 56% on average over the past week. She is provided with House Shake supplement TID (three times a day) (200kcals, 6g pro each) for increased kcal and nutrient intake. Noted orders for weekly wts to monitor trends. Will continue with all other nutrition interventions in place and continue to monitor resident weekly and PRN for changes A nutrition progress note for 11/30/21 revealed: Weekly Review: Resident's meal intake remains fair, consuming 55% on average over the past week. She continues to have good acceptance of her House Shake supplement provided TID (200kcals, 6g pro each) for increased kcal and nutrient intake. Goal po (by mouth) intake is >60% average and prevent ongoing wt loss. Will continue with current nutrition interventions in place and monitor resident weekly and PRN (as needed) for changes. A nutrition progress note from 12/2/21 revealed Resident's weight obtained and is triggering a 7.6% significant wt loss x2wk. Her CBW (current body weight) is 109# (12/1) and BMI 20. 6. Wt hx reviewed: 117# (11/17), 128# (9/2) and 123# (6/3). Recommend Enhanced foods to maximize kcal intake. Will continue with all other nutrition interventions in place and continue to monitor trends weekly x4wks and PRN (as needed) for further changes. If decline continues, resident may benefit from alternative means of nutrition vs. comfort care. A behavior progress note from 12/7/21 revealed Note Text: Resident alert with confusion. Not engaged with staff today. Resisted am cares and refused medications this morning. Resident is now a 'feed' due to poor intake, as seen by recent weight loss. Noted drooling and coughing while feeding in up right position of 45+ degrees. Speech therapist in with resident and downgrading fluids to honey thick. Provider notified. Resident staying in bed today per her choice. A nutrition note for 12/7/21 revealed: Resident's diet has been downgraded to Honey-thickened liquids with recommendations for 1:1 feeding assistance at all meals per SLP (speech-language pathology). Supplement updated to Nutritional Treat TID (3 times a day) (300kcals, 11g pro each) in place of House Shakes for appropriate consistency and increased kcal intake. A nutrition note from 12/14/21 revealed: Resident's meal intake remains fair/poor, consuming only 35% on average over the past week. She is accepting of most supplements and fluids throughout the day. She is provided with Nutritional Treat TID (300kcals, 11g pro each) for increased kcal and nutrient intake. Supplement updated from House Shake d/t downgrade to HTL (honey thick liquids). Noted referral for hospice care in place. PO (by mouth) intake anticipated to remain variable given overall decline. Will continue to monitor weekly and PRN (as needed) for further changes. A general progress note from 12/16/21 revealed: A hydration assessment was completed on this resident. She presented with dry mucus membranes. Her skin turgor is poor and tenting . Physician on-call [name of physician] notified. Order received for one liter of NS (normal saline) to be ran @ 100cc/hr. IV started in resident's left forearm. Site is patent and is infusing well. Review of R6's meal intake records for the last 30 days (from 11/17/21 to 12/16/21) revealed 11 days when only 2 meals were charted and 6 days when only 1 meal was charted. The entries did not indicate what meal was being charted. Approximately 37 of the meals charted stated the resident was independent with eating with no staff oversight or help at any time (8 of those meals were after 12/7/21 even though she was care planned for 1:1 assistance at that time and 2 meals were charted for 12/16/21- one at 1:46 PM with 25% eaten and one at 1:47 PM- with 75% eaten. Both were coded as the resident being totally dependent on staff). (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	R10 Review of R10's face sheet revealed he originally admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnosis that included: acute respiratory failure, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), dysphagia (difficulty swallowing), vascular dementia, lack of coordination and convulsions. Review of R10's kardex revealed under food/fluids: 1:1 feeding assistance at all meals as resident allows . check mouth after meals for pocketed food and debris .instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew eat bite thoroughly . Review of R10's care plan revealed a focus area of ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia, Hemiplegia, Impaired balance, Limited Mobility, Limited ROM (range of motion), Stroke) interventions include: EATING: 1:1 feeding assistance at all meals as resident allows. Under focus area [R 10] has a potential for swallowing problems r/t Dysphagia interventions include: Alternate small bites and sips . check mouth after meals for pocketed food and debris . instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew eat bite thoroughly . Monitor/document/report PRN (as needed) and s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Report to nurse and/or MD and adjust plan of care as indicated. Review of R10's progress notes for 10/3/21 revealed: .Resident prefers being fed his meals as he struggles to keep food on his utensil. Assisted with lunch today, he ate 100%. Will notify UM (unit manager) and SLP (Speech-Language Pathology) for possible evaluation. R11 Review of R11's face sheet revealed she was initially admitted to the facility on [DATE] with diagnosis that included: obstructive hydrocephalus (blockage of fluid in the brain), adult failure to thrive, weakness, dysphagia and cognitive communication deficiency. Review of R11's kardex revealed under Food/fluids: Assist resident to consume food/fluids as resident allows; encourage self-feeding .The resident requires extensive assistance by 1 staff to eat Review of R11's care plan revealed a focus area ADL self-care performance deficit r/t Confusion, Fatigue, Impaired balance, Limited Mobility with interventions including EATING: The resident requires extensive assistance by 1 staff to eat . Under the focus area Nutritional status risk AEB (as evidenced by) dx (diagnosis) of .cognitive communication deficit .h/o (history of) dysphagia; self-feeding deficits r/t (related to) blindness and tremors; need for feeding assistance and adaptive equipment . interventions include assist resident to consume food/fluids as resident allows . Monitor/document/report PRN (as needed) and s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Report to nurse and/or MD and adjust plan of care as indicated. Review of R11's progress notes for 10/8/21 revealed: CNA reported to the the (sic) writer that resident has been noted holding food in her mouth, appetite has decreased . (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	28101 Review of R8's face sheet dated 12/16/21 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Schizophrenia, obsessive compulsive disorder, blindness, anxiety disorder, major depressive disorder, and need for assistance with personal care. R8 was his own responsibility party. Review of R8's Brief Interview of Mental Status (BIMS) score dated 11/18/21 revealed he scored 15/15 (normal cognition). Review of R8's physician progress note dated 11/15/21 at 6:50 PM revealed, R8 was treated at the hospital for a right hip fracture. When R 8 returned to the facility he complained of persistent pain and a repeat x-ray showed an addition femur fracture. He returned to the hospital for a revision of his Open Reduction Internal Fixation (ORIF), surgical repair of the right femur. Under Assessment/Plan revealed, Change Norco to 5/325 TID (narcotic pain medication three times a day) as patients pain is not well controlled. He has mental illness and is not remembering to ask for pain medication. After skin revealed, Inspection and palpation (touch): warm and dry. No indication of skin break down. After musculoskeletal revealed, Right leg swelling greater than left leg. Review of R8's physician progress note dated 11/24/21 at 2:00 PM revealed, The patient is seen today for skilled follow-up evaluation. The patient recently had a right femur fracture. He is motivated, cooperative and is making good progress with therapy. He denies any pain, has no acute concerns. He is eating and sleeping well. Review of R8's physician progress noted dated 11/29/21 at 3:00 PM revealed, R8 is seen today for evaluation of the patient at the request of nursing for lower extremity swelling and also abrasion over the right lower extremity. The patient had a dressing on and he had a recent hip fracture. Incision is very well approximated. Sutures are still in place. The patient thinks that his pain is much better than before. After plan revealed, 1. encourage pt (patient) to limit his time in chair to 2 hours. 2. Pain in right hip joint- externally rotated. Patient instructions. Continue current treatment. Review of R8's physician note dated 12/6/21 at 2:10 PM revealed, R8 is seen today for evaluation of the patient for complaints of pain. He had a femur fracture. The patient has less pain when he is in bed. His leg is still externally rotated. We are attempting to procure specialized shoes that he is able to maintain his right lower extremity in an anatomical position. At this time, I would like to start him on Lidoderm patch in an effort to reduce the effect of narcotic pain medicine and also start him on muscle relaxant in an effort to improve PT and OT to work with the patient. His lower extremity edema is much improved. He is alert, awake, confused, in no acute distress. He denies any acute problem. He is painful when he is able to bear weight. No mention of pressure ulcer on right lower extremity. (continued on next page)

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	235004	A. Building B. Wing	12/21/2021

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of R8's physician progress note dated 12/20/21 at 1:40 PM revealed, Patient is seen today for evaluation of right hip pain. I have been asked to evaluate the patient for increased pain and discomfort. Patient has a history of right femur fracture and is currently on Norco 3-325 TID (narcotic pain medication 3 times a day). Patient is seen lying in bed. He denies any current pain. He denies hip pain however does mention that he experiences occasional pain in his right knee. He denies knee pain at this moment. Nursing reports that the patient was exhibiting pain this morning during care and repositioning however, nurse says he has just receive a pain pill prior to care and it may not have taken affect at that time. Nursing also mentions that the patients right hip pain is well controlled with a lidocaine patch and is requesting a lidocaine patch for the patients right knee. Review of R8's Skin & Wound Evaluation dated 12/2/21 at 9:17 AM revealed, he had a new unstageable ulcer on his right lateral malleolus that measured 7.3 cm x 4.1 cm x 2.5 cm and was 0.1 cm deep. Review of a pressure ulcer report for R8 dated 11/27/21 at 10:05 AM revealed, Therapist reported to this nurse, an open area on the outer right ankle area. 4.5 cm in length 5.5 cm in width. Some serosanguino (sp) drainage (fluid containing blood) drainage noted on linen. Right leg is externally rotated with no tolerance of correcting this position. Resident was unaware of open area on right ankle. After notes revealed, 11/29/21 Wound nurse to examine to determine if pressure related. 12/10/21 Root Cause: Related to resident having recent surger with external rotation noted. Bed and wheelchair checked for any sharp surfaces and none noted. Edema to lower leg noted to be contributing factor. Wound team following. Boot and positioning in devices in place. Ordered positioning device for positioning. Therapy to assess for any further positioning recommendations. Review of R8's care plan revealed a care plan for actual impairment to skin integrity related to current break in skin integrity, multiple incision sites to his right lower extremity and pressure injury to his right lateral ankle. Date initiated was 10/26/21 and last revision was on 12/2/21. Interventions included, 12/17/21 position pillow to be place mid back when lying on side. 12/2/21 Prevalon boot with outer wedge to right foot when in bed as tolerated, 12/17/21 resident needs pressure reduction interventions: positioning pillow between knees when side lying and while turning resident. Review of R8's care plan for limited physical mobility related to weakness and history of right fibula fracture date initiated 5/28/19 and last revision on 12/16/21 revealed, 9/17/21 The resident is NON WEIGHT BEARING TO RLE (right lower extremity) and FULL WEIGHT BEARING to LLE (left lower extremity). 10/28/21 Bed Mobility: resident requires assistance of one staff member. (All observations 12/17/21 to 12/21/21 R 8 required the assistance of 2 staff for bed mobility). 12/22/20 Locomotion: The resident uses a two wheeled walker for locomotion (R 8 was not able to stand and was not able to bear weight on his right leg). Review of R8's care plan for chronic pain dated initiated 1/14/21 and revision on 11/12/21 revealed, 5/29/19 Administer analgesia per physician orders. Anticipate and treat before, during, and after treatment tat may cause increased pain or discomfort. Review of R8's Kardex dated 12/19/21 revealed he required assistance of one person for bed mobility. However, all observations of care for R8 from 12/17/21 to 12/21/21 R8's had 2 people assisting him with movement in bed as his right leg was very painful and he was not able to move his right leg without assistance. R8 also required physical assistance to roll and two people to pull him up in bed. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of R8's IDT (interdisciplinary note) dated 12/20/21 revealed, Heal suspension boot discontinued, AMP (alternating pressure mattress) in place now. Care plan did not reflect these changes. Review of R8's wound timeline provided by the facility revealed the following measurements: 11/27/21 - 4.5 cm x 5 x 5 cm 12/2/21 - 7.3 cm x 4.1 cm x 2.5 cm 12/9/21 3.2 cm x 2.5 cm x 1.7 cm 12/17/21 2.8 cm x 3.2 cm x UTD (undermined depth). The last Skin & Wound evaluation located in R8's record and provided by the facility was dated 12/9/21 and revealed a facility acquired, unstageable pressure ulcer on R8's right lateral malleolus that measured 3.2 cm x 2.5 cm x 1.7 cm and was 0.2 depth. Assessment [TRUNCATED]

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 This citation refers to MI00124948. Based on interview and record review, the facility failed to prevent, assess, and monitor pressure ulcers for 2 of 3 residents (R7 and 8), resulting in R7and R8 developing pressure ulcers and R7's and R8's pressure ulcers not being timely assessed and monitored and the potential for the facility not being aware of a worsening of R7's and R8's pressure ulcers and wounds, should it occur, and a delay in the implementation of new interventions, if warranted, in a timely manner. Findings include: A review of R7's Admission Record, dated 12/15/21, revealed R7 was an 87 -year-old resident admitted to the facility on [DATE]. In addition, R7's Admission Record revealed R7 had multiple diagnoses that included diabetes, difficulty walking, and paraplegia (paralysis of lower body and legs). A review of R7's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 10/21/21, revealed R7 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) assessment which revealed R7 had short-term and long-term memory problems. In addition, R7's MDS revealed R7 had moderately impaired cognitive decision-making skills. R7's MDS also revealed R7 did not have any pressure ulcers or sores. A review of R7's impaired skin integrity care plan, revised 1/25/21, revealed R7 had impaired skin integrity related to decreased mobility, resistance to repositioning, incontinence of bowel and bladder (Date Initiated: 09/02/2020). R7's impaired skin integrity care plan also revealed an intervention of Elevate heels off bed surface while at rest in bed (Date Initiated: 10/26/2020). A review of R7's Skin & Wound Evaluations, dated 11/10/21 to 12/16/21, revealed the following: - Left heel- Stage 3 pressure ulcer (involves the full thickness of the skin and may extend into the subcutaneous tissue layer; granulation tissue and epibole (rolled wound edges) are often present). - 11/11/21= 4.1 cm (centimeters) x (by) 3.6 cm (length by width). Area= 11 cm2 (centimeters squared). - 11/18/21= 2.8 cm x 1.8 cm x 0.2 cm (length by width by depth). Area= 3.9 cm2. - 12/2/21= 0.9 cm x 0.3 cm x 0.1 cm. Area= 0.2 cm2. This measurement was done 14 days after the previous one. - 12/16/21= No open area. This measurement was done 14 days after the previous one. - Right heel- unstageable pressure ulcer (Full thickness tissue loss in which the actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-11/11/21= 3.2 cm x 2.6 cm. Area= 6.1 cm2. - 11/18/21 at 8:57 AM= 2.4 cm x 0.8 cm. Area= 1.2 cm2. - 11/18/21 at 8:59 AM= 2 cm x 1.2 cm. Area= 1.9 cm2. - 12/2/21= 0.6 cm x 0.4 cm x 0.2 cm. Area= 0.1 cm2. This measurement was done 14 days after the previous one. - 12/16/21= 1.1 cm x 0.7 cm. Area= 0.6 cm2. This measurement was done 14 days after the previous one. A review of R7's progress notes, dated 11/1/21 to 12/16/21, revealed the above mentioned measurements were also in the progress notes. In addition to the following note and measurement: - General Progress Note, dated 11/12/21, revealed, observed resident to have bilateral heels elevated up on pillows , heels had lotion on them, they were cracked open and tender to the touch left heel measured at - 5. 3 cm x 4.4 cm x .2 cm deep, right heel measured at 5.6 cm x 4.3 cm x 1.4 cm deep, no drainage present, surrounding tissue dry and cracked, 70% pink, 30% eschar, treatment started, notifications completed, wound care to follow weekly on wound rounds, encourage resident to use heel bridge, and will have his bed length extended to help prevent his heels from resting on the foot board. A review of R7's Skin Observation Tools, dated 10/11/21 to 11/10/21, failed to reveal any skin alterations or wounds. R7's Skin Observation Tools revealed R7 had normal appearing skin and no new alterations in skin integrity including open areas of any type. During an interview on 12/15/21 at 2:45 PM, R7 stated he developed sores on his heels because they were laying on the bed. He stated when the staff were made aware of his pressure sores, they put them up on pillows. They keep them up on pillows now. During an interview on 12/16/21 at 11:10 AM, Registered Nurse Unit Manager (UM) N stated on 11/10/21, a nursing assistant filled out a skin alert note. She stated she (UM N) evaluated R7's wound and did measurements on 11/10/21. She stated R7 had wounds on his right heel and left heel (one each). UM N stated R7 was non-compliant with positioning, including being boosted up in be when he slides down towards the foot board. UM N stated she asked R7 if he knew how he developed the pressure ulcers on each heel. He told her he did not. UM N stated R7 probably developed the bilateral heel pressure ulcers because he would slide down in bed, refuse to be boosted/pulled up in bed, and his feet would rest on the foot boards. UM N stated on 11/10/21, she completed a Focused Incident Review for New or Worsened Pressure Ulcer/Injury form for R7's bilateral heel pressure ulcers and R7's wound measurements were 5.3 cm x 4.4 cm x 0.2 cm (left heel) and 5.6 cm x 4.3 cm x 1.4 cm (right heel). UM N stated that she locked (completed) R7's Focused Incident Review for New or Worsened Pressure Ulcer/Injury form on 11/12/21 and on that date the progress note was entered with the measurements she did. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/16/21 at 11:10 AM, UM N stated on 11/11/21, the wound team looked at R7's wounds and initiated treatments. However, prior to the wound team evaluating R7's pressure ulcers on 11/11/21, UM N stated she had initiated a heel bridge (a pillow-like object) to lift R7's heels off the bed and obtained a bed extension piece to extend R7's bed another three inches in length. UM N stated she obtained the bed extension piece because R7 refused to be boosted up in bed when he slides down and the extension will give him more feet room. She stated the bed extension piece was not a result of R7 being too tall for the bed. UM N also stated residents with pressure ulcers are assessed and measurements are done weekly. During an interview on 12/16/21 at 11:10 AM, UM N stated all of R7's wound measurements were in his progress notes and that there were not any other wound measurements anywhere else in his medical record. A review of the facility's Documentation of Wounds policy and procedure, revised on 2/1/21, revealed, 1. Wound assessments are documented upon admission, weekly, and as needed . 4. Additional documentation shall include, but is not limited to: a. Date and time of wound management treatments b. Weekly progress towards healing and/or effectiveness of current intervention . 28101 Review of R8's face sheet dated 12/16/21 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Schizophrenia, obsessive compulsive disorder, blindness, anxiety disorder, major depressive disorder, and need for assistance with personal care. R8 was his own responsibility party. Review of R8's Brief Interview of Mental Status (BIMS) score dated 11/18/21 revealed he scored 15/15 (normal cognition). Review of R8's physician progress note dated 11/15/21 at 6:50 PM revealed, R8 was treated at the hospital for a right hip fracture. When R8 returned to the facility he complained of persistent pain and a repeat x-ray showed an addition femur fracture. He returned to the hospital for a revision of his Open Reduction Internal Fixation (ORIF), surgical repair of the right femur. Under Assessment/Plan revealed, Change Norco to 5/325 TID (narcotic pain medication three times a day) as patients pain is not well controlled. He has mental illness and is not remembering to ask for pain medication. After skin revealed, Inspection and palpation (touch): warm and dry. No indication of skin break down. After musculoskeletal revealed, Right leg swelling greater than left leg. Review of R8's physician progress note dated 11/24/21 at 2:00 PM revealed, The patient is seen today for skilled follow-up evaluation. The patient recently had a right femur fracture. He is motivated, cooperative and is making good progress with therapy. He denies any pain, has no acute concerns. He is eating and sleeping well. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R8's care plan for limited physical mobility related to weakness and history of right fibula fracture date initiated 5/28/19 and last revision on 12/16/21 revealed, 9/17/21 The resident is NON WEIGHT BEARING TO RLE (right lower extremity) and FULL WEIGHT BEARING to LLE (left lower extremity). 10/28/21 Bed Mobility: resident requires assistance of one staff member. (All observations 12/17/21 to 12/21/21 R8 required the assistance of 2 staff for bed mobility). 12/22/20 Locomotion: The resident uses a two wheeled walker for locomotion (R8 was not able to stand and was not able to bear weight on his right leg). Review of R8's care plan for chronic pain dated initiated 1/14/21 and revision on 11/12/21 revealed, 5/29/19 Administer analgesia per physician orders. Anticipate and treat before, during, and after treatment tat may cause increased pain or discomfort. Review of R8's Kardex dated 12/19/21 revealed he required assistance of one person for bed mobility. However, all observations of care for R8 from 12/17/21 to 12/21/21 R8's had 2 people assisting him with movement in bed as his right leg was very painful and he was not able to move his right leg without assistance. R8 also required physical assistance to roll and two people to pull him up in bed. Review of R8's IDT (interdisciplinary note) dated 12/20/21 revealed, Heal suspension boot discontinued, AMP (alternating pressure mattress) in place now. Care plan did not reflect these changes. Review of R8's wound timeline provided by the facility revealed the following measurements: 11/27/21 - 4.5 cm x 5 x 5 cm 12/2/21 - 7.3 cm x 4.1 cm x 2.5 cm 12/9/21 3.2 cm x 2.5 cm x 1.7 cm 12/17/21 2.8 cm x 3.2 cm x UTD (undermined depth). The last Skin & Wound evaluation located in R8's record and provided by the facility was dated 12/9/21 and revealed a facility acquired, unstageable pressure ulcer on R8's right lateral malleolus that measured 3.2 cm x 2.5 cm x 1.7 cm and was 0.2 depth. Assessments did not indicate any drainage. On 12/17/21 at 9:55 AM, R8 was observed eating in bed. The head of his bed was elevated about 20 to 30 degrees. R8 was dropping a lot of his food in bed. His body was covered with a sheet. R8 said he had not been provided any care yet this morning. He was feeding himself. On 12/17/21 at 10:09 AM CNA AA said she was assigned to R8 today and started work at 6:00 AM. CNA AA said the only care she had provided for R8 this morning was to reposition him around 6:00 AM. CNA AA said she was also responsible for residents on another hall. CNA AA said she was caring for 11 residents and was on a split hall. CNA AA said there was one on other CNA working with her that morning. During an interview with Unit Manager Z on 12/17/21 at 10:15 AM, she confirmed CNA AA was assigned to R8. CNA AA was assigned to care for 11 residents on the unit and 6 of the residents on the unit were care planned to need 2 people for care. The other CNA on the unit this morning was CNA X. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview with CNA X on 12/17/21 at 10:18 AM, CNA X said she had not provided any care for R8 this morning. R8 was observed in bed on 12/17/21 at 10:20 AM, R8 had a dressing on his right hip over his surgical incision with no date or initials, he had a lidocaine patch on his right thigh and a dressing on his right lower leg just above his malleolus with no date or initials. The dressings did not have any drainage showing through. Unit Manager Z removed the dressing on his right hip and the incision under the dressing had red areas on the boarder and an indentation about approximately .5 cm in length at the distal end of the incision. No dressing was placed back over R8's incision on his right hip. No drainage was observed on the dressing that was removed. CNA AA and Unit Manager Z rolled R8 in bed to remove his saturated brief and sheet. R8 grimaced and hit his fisted hands on the mattress with movement. R8 did not yell out in pain or ask staff to stop moving him. Urine had soak through to his sheet. R8 did yell out in pain at times when staff were moving his right leg to provide care and positioning. During care R 10 said his pain was at 10 on a 1-10 scale when he was asked. When pulling back the boot on R8's foot a 1-inch indentation was noted in his skin below the top of the boot. The boot was fastened with a Velcro strap (1 inch pitting edema). When CNA AA and the unit manager rolled R8 in bed they did not support his right leg. R8 indicated his pain was in his right leg. CNA AA said when she came in at 6:00 AM R8 was positioned toward his right side, and she moved the pillow to allow him to be on his back for breakfast. CNA AA and Unit Manager Z placed wedge cushion under R8's right hip and kept the boot fastened on his right foot. On 10/17/21 at approximately 11:00 AM, Physical Therapist Assistant (PTA) BB came in to provided care for R8. Unit Manager Z was still in the room. The Surveyor asked PTA BB if anything could be done to decrease pain in the right leg during movement, how she would instruct staff to do pressure relief in bed and if R8's circulation was being impaired by the boot on his right leg. PTA BB confirmed the boot was causing the indentation on the right foot and need to be replaced by some other device to provide pressure relief and positioning. PTA BB said they had a device on order, but it had not arrived. PTA BB removed the boot and placed a pillow under R8 calf. PTA BB demonstrated and instructed Unit Manager Z to use a pillow between R8's legs when rolling him (log roll). PTA BB instructed Unit Manager Z to place the pillow or wedge behind R8's back (not his hip) when positioning him to his side. (avoid bony areas with positioning devices). R8 complained of less pain with this movement than he did during the observation at 10:20 AM. R8 was able to let staff know he had less pain when he was log rolled in bed and his right leg was supported but he still had a lot of pain with movement. On 12/17/21 at 11:25 AM the Surveyor emailed the Director of Nursing (DON) to inform her R8's boot on his right foot caused 1 inch pitting edema, he was complaining of pain at a 10 on 1-10 scale with movement, staff were having difficulty with providing pressure relief due to pillows placed over bony areas, resident was left soaked in urine for over 4 hours and was not provided any pressure relief for 3 hours. Around noon on 12/17/21 the DON acknowledged receiving the email about R8 and said she would address the issues. The DON did not respond to this email or provide any different information. On 12/21/21 at 8:47 AM R8 was observed up in a wheelchair in the main dining room on his unit. R8's left foot was on a foot pedal and his right foot was on the floor. R8 had gripper socks on both feet. R8's dressing on his right lower leg was visibly soiled. R8 said he had been up in his wheelchair since around 6 or 7 this morning. R8 said his right knee and ankle hurt. R8 was served breakfast at 8:51 AM. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/21/21 at 9:17 AM, PTA BB came in the Main Dining room and removed R8's right leg rest from his chair. When PTA BB moved R8's leg to remove the leg rest she grabbed his leg with her bare hand right over his dressing on the right lower leg that was visible soiled. PTA BB returned to put a leg rest back on R8's wheelchair at 9:29 AM and R8's said it this leg rest felt better. R8's pushed his wheelchair with both arms to the door of the main dining room than requested assistance to get out the door and back to his room. PTA BB was planning on doing therapy at this time but R8 reported his pain was 10 out of 1 - 10. PTA BB checked with LPN CC to see if R8 could get anything for pain. LPN CC said R8 had Norco at 8:08 AM and had his lidocaine patch so he did not have any thing else she could give at this time. LPN CC said R8's nurse would need to contact the doctor. On 12/21/21 at 10:21 AM, the Director of Nursing (DON) informed staff she had contacted R8's doctor and he now had a order for prn (as need) Norco and they could give it now. On 12/21/21 at approximately 11:00 AM CNA B and CNA DD used an electronic lift to put R8 back in bed. R8 grimaced with pain during the transfer. He made fists with both hands and shook his arms but did not yell out in pain or complain during the transfer. He again reported a 10 with pain during movement but reported his pain was 5 when he was not moving in bed. On 12/21/21 at 11: 35 AM LPN EE said she put the dressing on R8's right ankle at 7:15 AM this morning. LPN EE showed where she had written with a light ink pen the date, time and her initials. The dressing was saturated all the way through. There was a large letter C shape in the bloody drainage of the dressing she removed. The wound was facing the mattress so the Surveyor was not able to see the wound. R8 was having too much pain to change his position to allow the Surveyor to view his ankle wound. The Surveyor pointed out that R8 had a dressing over his right hip incision with no date, time or initials. LPN EE said she did not know anything about that dressing. A few minutes later Unit Manager Z arrive at R8's room and said the dressing should not be on R8's right hip. LPN EE removed the dressing on R8's right hip and a 1/2 saturated area was noted on the dressing. The distal area of the incision that had an indentation in it when the undated dressing was removed on 12/17/21 at 10:20 AM. Unit Manager Z was not able to locate any documentation that showed when R8's incision on his right hip started draining, or when the wound on his right ankle started having drainage. Unit Manager Z said she would get new orders for a dressing over R8's right hip. During an interview with the DON on 12/20/21 around noon, the DON was not aware R8's incision on his right hip was draining, she was not aware the dressing on his right ankle was saturated. The DON was asked for all documentation on R8's wounds. Upon exit on 12/21/21 the facility did not provide any documentation that showed they were aware the right hip wound was draining, they had no documentation of who put the dressing on the right hip, they had no full assessment documented or notes on the full condition of R8's right ankle since 12/9/21. None of the documents located from 12/9/21 or after indicated the wound on R8's right ankle was draining.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38659 This citation refers to MI00124983: Based on observation, interview and record review, the facility failed to provide feeding assistance and supervision for 3 residents (R6, R10, R11) who are care planned for 1:1 feeding assistance due to dysphagia and choking risk, resulting in the potential for choking, aspiration, and serious injury due to lack of supervision and assistance. Findings include: Review of facility policy with the subject Weight Management with adopted date 9/11/20 revealed weight loss is defined as: significant weight loss (5% in one (1) month, 7.5% in three (3) months, oR10% in six (6) months) . should be addressed in the care plan. Facility approaches to address weight loss may include an ongoing search for the cause(s) of weight loss .once the cause(s) is/are identified, relevant care plan decisions are made and documented. Ongoing interventions are evaluated and modified as needed. The procedure includes the resident being weighed monthly and as needed .Monthly weights are to be completed by the 7th day of each month and reviewed by the Nutrition Committee within a reasonable period of time thereafter .any resident weight that varies from the previous reporting period by 5% in 30 days, 7.5% in 90 days and 10% in 180 days will be evaluated by the Interdisciplinary Team to determine the cause of the weight gain/loss and the intervention(s) required .any resident meeting the criteria for weight loss .will be weighed weekly, with the weight entered in the resident's medical record . Review of the facility policy with the subject Nutrition Monitoring & Management Program with the adopted date of 7/11/18 revealed a purpose: To provide care and services including .defining and implementing interventions for maintaining or improving nutritional status that are consistent with resident needs, goals and recognized standards of practice .monitoring and evaluating the resident's response or lack of response to the interventions . Dietary evaluations are assessed on admission and at least quarterly thereafter, and following a change in condition. R6 Review of R6's face sheet revealed she had originally admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnosis that included: dementia, dysphagia (difficulty swallowing), deficiency of vitamins, weakness, lack of coordination, and cognitive communication deficit. Review of R6's kardex revealed under food/fluids: 1:1 feeding assistance at all meals . check mouth after meal for pocketed foods and debris . instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly . There is a conflicting entry in the kardex, which stated R6 is able to eat independently. Under the section special needs weight is noted to be taken weekly as well as monthly. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R6's care plan revealed under the focus ADL (activities of daily living) self-care deficit r/t (related to) weakness, confusion, impaired balance, limited mobility an intervention that states The resident is able to: eat independently with an initiation date of 4/27/20. Under the focus area: [R6] has a Nutritional status risk AEB (as evidenced by) Dx (diagnosis) of .dementia . dysphagia w/ need for altered textured diet/fluids in place; chronic variable po (by mouth) intake; h/o (history of) wt (weight) fluctuations; and advanced age with interventions that included: 1:1 feeding assistance at all meals with an initiated date of 12/7/21, Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of dysphagia ., review routine weights, and weigh resident per facility protocol . Under the focus area has a swallowing problem r/t (related to) dysphagia, poor dentition interventions included: check mouth after meal for pocketed food and debris ., instruct, assist and/or encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly, and Monitor for .choking . Review of physician note from 11/22/21 revealed R6 was being seen for a complaint of weight loss. Lab work, dietary evaluation and weekly weight checks to further monitor weight loss were ordered. On 12/16/21 at approximately 8:35 AM, no staff other than a housekeeper were observed on the 400 hall or in resident rooms and residents were eating breakfast. R6 was observed in her room, not being assisted with her meal. One of her roommates had completely finished their meal at this time, and the other roommate was about half complete in consuming her meal. R6 was viewed to have her food untouched and had a glass of clear red honey thick liquid to her mouth with her eyes closed. R6 was approached and appeared to be asleep with the glass to her mouth, she did not respond to verbal attempts to get her attention for about a minute. R6's shoulder was rubbed when speaking to her and she slowly opened her eyes, but kept the glass to her lips briefly and then slowly lowered it. R6 continued to not respond verbally and looked around the room with confusion, not making eye contact. A discussion was completed with R6's roommate, who stated that usually someone will come help R6 at with her meal, but they don't usually assist her until later, so someone may come back to help her. Conversation was attempted again with R6 and she was not communicative and did not make eye contact. Upon exiting the room and walking the hall again, no staff other than housekeeping was viewed on the hall or in resident rooms. R6 was watched from the hall consuming her breakfast. She took a limited amount of very small bites, moving very slowly. At approximately 8:47 AM, a CNA (certified nursing assistant) entered the hall and appeared to have gotten additional food from the kitchen for a resident and delivered it to their rooms. At 8:52 AM CNA X entered the room of R10. At 8:55 AM CNA X exited R10's room with their meal tray and then went into R11's room. At 8:58 AM CNA X exited R11's room with their meal tray and then entered the room of R6. CNA X was viewed to briefly check on R6 and walked away as she was viewed to be very slowly feeding herself. CNA X was in the room with R6 for approximately 2 minutes. CNA X was asked if she was the only aide assigned to the hall the morning and she stated yes, I am the only one on the hall, it's like this every day. CNA X was asked if anyone on the hall needed feeding assistance and she said at least 3 and pointed to the rooms of R6, R10 and R11. CNA X was asked specifically about R6 and her needs. CNA X stated she seems to be doing good now, but you have to keep checking on her to make sure she's not choking, but she is doing good on her own today. CNA X was asked how she managed to assist 3 residents at once who needed feeding assistance and she stated that she just has to keep going back and forth between them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/16/21 at 10:50 AM, an interview was completed with Dietician Y regarding R6's nutritional status. Dietician Y stated R6 has had weight loss recently and overall a decline and had a downgrade in her swallowing ability. The dietary plan was to add supplements to meals as well as provide feeding assistance to R6. Dietician Y stated R6 can feed herself at times, but that staff usually need to initiate feeding and provide encouragement. The food acceptance logs for R6 were reviewed with Dietician Y and she stated it appears R6's acceptance increases when she has staff assistance. Dietician Y agreed there were some holes in the food acceptance documentation and stated she would expect each meal to be documented. Dietician Ys stated R6 was placed on weekly weights as of 11/23/21, this was discontinued for some reason, but reordered on 12/6/21. Weekly weights were ordered to be completed on Mondays for 4 weeks. Dietician Y stated she is also completing weekly dietary evaluations of R6 due to the significant weight loss, which would include reviewing her intake and weights. Dietician Y was asked how she completed her review of R6 on 12/14/21 (a Tuesday) if R6's weekly weight was missed on 12/13/21 (Monday). Dietician Y stated it does appear R6 needed another weight to be completed. Dietician Y was informed missing the weekly weight was concerning and also informed R6 was not viewed to be getting assistance with her breakfast meal. On 12/16/21 at 12:08 PM, lunch meal trays were observed to begin to be delivered to the 400 hall. R6 was viewed to be asleep in bed. There were between 2-3 CNA staff on the hall at various times delivering the meal trays to resident in their rooms. At 12:13 PM a CNA entered R6's room to deliver her tray. They elevated R6 in bed, set up her meal and then exited the room by 12:17 PM without assisting the resident to begin eating. At 12:21 PM, R6 had yet to take a bit and the surveyor entered the room. R6 was asked how she was today and how her meal was. R6 stared blankly at the surveyor and then slowly took one small bite of ice cream. Upon exiting R6's room at 12:23 PM, it was viewed that no staff were in the hall and a nurse was completing medication pass. There was 2 staff in the dining room area and 1 staff was assisting a resident with their meal. At 12:28 PM, Nurse Z returned to the hall. R6 was not eating any further bites of food. At 12:31 PM Nurse Z entered R6's room with medications and asked R6 if she needed help, at this time the resident took one more very slow bite of ice cream. Nurse Z appeared to be looking for another staff member and came across CNA X briefly exiting the dining room, Nurse Z asked CNA X to assist R6 with lunch. CNA X stated she could not because she was assisting residents in the dining room and was overheard saying she [R6] did not do great at breakfast. Nurse Z then left the hall and there was no nursing staff on the hall for about 3 minutes. Nurse Z then returned to the hall and to R6's room and began to assist her with eating at approximately 12:35 PM. On 12/16/21 at 12:03 PM email request was made to the director of nursing (DON) and nursing home administrator (NHA) requesting the staff covering the 400 hall for the morning of 12/16/21, since the schedule appeared to be unclear. The DON responded by email on 12/16/21 at 12:08 PM that 2 CNAs and one nurse were assigned to the hall for that shift. During a follow up interview on 12/16/21 at 3:20 PM, the DON and NHA were informed of the lack of staff viewed on the hall during meal service that day, which was concerning with there being at least 3 identified residents who required 1:1 assistance with meals due to choking hazards and/or weight loss. The DON and NHA were informed of the extensive concerns rising to a level of immediate jeopardy with R6's weight loss and lack of interventions being implemented. On 12/17/21 at 9:05 AM, R6 was viewed being transported to the dining room in her wheelchair by staff. She was viewed to be attached to a bag of IV fluids and was smiling and making eye contact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/21 at 9:55 AM, Unit Manager (UM) Z was observed feeding R6 in the main dining room. R6 had an IV in her arm. The Surveyor asked R6 how her food tasted, and she responded, I do not know. R6's had she eyes wide open and was watching UM Z. When the spoon came to her mouth, she opened it without cueing. On 12/21/21 at 9:00 AM, UM Z was observed feeding R6 in the main dining room. R6 did not have an IV running. UM Z was giving R6 spoonfuls of thickened cranberry juice. R6 had her eyes open and did not need verbal cues to open her mouth when the spoon reached her lips. The Surveyor asked R6 how her food tasted, and she responded good. Review of R6's weights revealed the following weights in the last approximately 3 months: 9/2/21 127.6 pounds, 10/1/21 125.6 pounds, 11/17/21 116.6 pounds, 12/1/21 109.0 pounds, 12/6/21 109.0 pounds, 12/16/21 106.3 pounds, 12/20/21 105.1 pounds. Between 10/1/21 and 11/17/21 (1 month) sustained a 7.1 % weight loss. Between 11/17/21 and 12/1/21 (2 weeks) R6 sustained another 6.5% weight loss. Between 9/2/21 and 12/1/21 (3 months) R6 sustained a 14.5% weight loss. The monthly weight in November was completed late during a time period where R6 sustained a significant weight loss and weekly weights were missed the week of 11/29/21 and 12/13/21 where R6 continued to lose weight. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R6 progress notes revealed no dietary progress notes from 5/17/21 until 11/18/21. A nutrition progress note from 11/18/21 revealed: Resident triggered a 8.6% significant wt loss x 1.5mo with her CBW (current body weight) at 117# (11/17) and BMI 22.0. Wt hx reviewed: 126# (10/1), 127# (8/3), and 125# (5/2) . Meal intake reviewed which remains fair, consuming 60% on average over a 14-day lookback period. She is supplemented with House Shake . Will increase her supplement to TID to support wt maintenance. MD notified of significant wt loss as well. A nutrition progress note for R11/23/21 revealed: Weekly Review: Resident's meal intake remains fair, consuming 56% on average over the past week. She is provided with House Shake supplement TID (three times a day) (200kcals, 6g pro each) for increased kcal and nutrient intake. Noted orders for weekly wts to monitor trends. Will continue with all other nutrition interventions in place and continue to monitor resident weekly and PRN for changes A nutrition progress note for R11/30/21 revealed: Weekly Review: Resident's meal intake remains fair, consuming 55% on average over the past week. She continues to have good acceptance of her House Shake supplement provided TID (200kcals, 6g pro each) for increased kcal and nutrient intake. Goal po (by mouth) intake is >60% average and prevent ongoing wt loss. Will continue with current nutrition interventions in place and monitor resident weekly and PRN (as needed) for changes. A nutrition progress note from 12/2/21 revealed Resident's weight obtained and is triggering a 7.6% significant wt loss x2wk. Her CBW (current body weight) is 109# (12/1) and BMI 20. 6. Wt hx reviewed: 117# (11/17), 128# (9/2) and 123# (6/3). Recommend Enhanced foods to maximize kcal intake. Will continue with all other nutrition interventions in place and continue to monitor trends weekly x4wks and PRN (as needed) for further changes. If decline continues, resident may benefit from alternative means of nutrition vs. comfort care. A behavior progress note from 12/7/21 revealed Note Text: Resident alert with confusion. Not engaged with staff today. Resisted am cares and refused medications this morning. Resident is now a 'feed' due to poor intake, as seen by recent weight loss. Noted drooling and coughing while feeding in up right position of 45+ degrees. Speech therapist in with resident and downgrading fluids to honey thick. Provider notified. Resident staying in bed today per her choice. A nutrition note for 12/7/21 revealed: Resident's diet has been downgraded to Honey-thickened liquids with recommendations for 1:1 feeding assistance at all meals per SLP (speech-language pathology). Supplement updated to Nutritional Treat TID (3 times a day) (300kcals, 11g pro each) in place of House Shakes for appropriate consistency and increased kcal intake. A nutrition note from 12/14/21 revealed: Resident's meal intake remains fair/poor, consuming only 35% on average over the past week. She is accepting of most supplements and fluids throughout the day. She is provided with Nutritional Treat TID (300kcals, 11g pro each) for increased kcal and nutrient intake. Supplement updated from House Shake d/t downgrade to HTL (honey thick liquids). Noted referral for hospice care in place. PO (by mouth) intake anticipated to remain variable given overall decline. Will continue to monitor weekly and PRN (as needed) for further changes. A general progress note from 12/16/21 revealed: A hydration assessment was completed on this resident. She presented with dry mucus membranes. Her skin turgor is poor and tenting . Physician on-call [name of physician] notified. Order received for one liter of NS (normal saline) to be ran @ 100cc/hr. IV started in resident's left forearm. Site is patent and is infusing well. Review of R6's meal intake records for the last 30 days (from 11/17-12/16/21) revealed 11 days when only 2 meals were charted and 6 days when only 1 meal was charted. The entries did not indicate what meal was being charted. Approximately 37 of the meals charted stated the resident was independent with eating with no staff oversight or help at any time, 8 of those meals were after 12/7/21 even though she was care planned for 1:1 assistance at that time. 2 meals were charted for 12/16/21, one at 1:46 PM with 25% eaten and one at 1:47 PM with 75% eaten. Both were coded as the resident being totally dependent on staff. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R10 Review of R10's face sheet revealed he originally admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnosis that included: acute respiratory failure, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), dysphagia (difficulty swallowing), vascular dementia, lack of coordination and convulsions. Review of R10's kardex revealed under food/fluids: 1:1 feeding assistance at all meals as resident allows . check mouth after meals for pocketed food and debris .instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew eat bite thoroughly . Review of R10's care plan revealed a focus area of ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia, Hemiplegia, Impaired balance, Limited Mobility, Limited ROM (range of motion), Stroke) interventions include: EATING: 1:1 feeding assistance at all meals as resident allows. Under focus area [R10] has a potential for swallowing problems r/t Dysphagia interventions include: Alternate small bites and sips . check mouth after meals for pocketed food and debris . instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew eat bite thoroughly . Monitor/document/report PRN (as needed) and s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Report to nurse and/or MD and adjust plan of care as indicated. Review of R10's progress notes for R10/3/21 revealed: .Resident prefers being fed his meals as he struggles to keep food on his utensil. Assisted with lunch today, he ate 100%. Will notify UM (unit manager) and SLP (Speech-Language Pathology) for possible evaluation. R11 Review of R11's face sheet revealed she was initially admitted to the facility on [DATE] with diagnosis that included: obstructive hydrocephalus (blockage of fluid in the brain), adult failure to thrive, weakness, dysphagia and cognitive communication deficiency. Review of R11's kardex revealed under Food/fluids: Assist resident to consume food/fluids as resident allows; encourage self-feeding .The resident requires extensive assistance by 1 staff to eat Review of R11's care plan revealed a focus area ADL self-care performance deficit r/t Confusion, Fatigue, Impaired balance, Limited Mobility with interventions including EATING: The resident requires extensive assistance by 1 staff to eat . Under the focus area Nutritional status risk AEB (as evidenced by) dx (diagnosis) of .cognitive communication deficit .h/o (history of) dysphagia; self-feeding deficits r/t (related to) blindness and tremors; need for feeding assistance and adaptive equipment . interventions include assist resident to consume food/fluids as resident allows . Monitor/document/report PRN (as needed) and s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Report to nurse and/or MD and adjust plan of care as indicated. Review of R11's progress notes for R10/8/21 revealed: CNA reported to the the (sic) writer that resident has been noted holding food in her mouth, appetite has decreased .

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Skld Muskegon	1061 W Hackley Ave Muskegon, MI 49441

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38659 This citation refers to MI00124429: Based on observation, interview and record review the facility failed to provide adequate nutrition monitoring and interventions for 3 residents (R6, R10, R11) of 7 residents reviewed for nutrition/hydration resulting in an Immediate Jeopardy (IJ) that began on 12/13/2021 when R6 experienced a significant weight loss and the facility failed to implement identified interventions to prevent weight loss and R6 continued to lose weight. This deficient practice has the high likelihood to affect all residents in this facility potentially resulting in harm, serious injury or death. Findings include: Review of facility policy with the subject Weight Management with adopted date 9/11/20 revealed weight loss is defined as: significant weight loss (5% in one (1) month, 7.5% in three (3) months, oR10% in six (6) months) . should be addressed in the care plan. Facility approaches to address weight loss may include an ongoing search for the cause(s) of weight loss .once the cause(s) is/are identified, relevant care plan decisions are made and documented. Ongoing interventions are evaluated and modified as needed. The procedure includes the resident being weighed monthly and as needed .Monthly weights are to be completed by the 7th day of each month and reviewed by the Nutrition Committee within a reasonable period of time thereafter .any resident weight that varies from the previous reporting period by 5% in 30 days, 7.5% in 90 days and 10% in 180 days will be evaluated by the Interdisciplinary Team to determine the cause of the weight gain/loss and the intervention(s) required .any resident meeting the criteria for weight loss .will be weighed weekly, with the weight entered in the resident's medical record . Review of the facility policy with the subject Nutrition Monitoring & Management Program with the adopted date of 7/11/18 revealed a purpose: To provide care and services including .defining and implementing interventions for maintaining or improving nutritional status that are consistent with resident needs, goals and recognized standards of practice .monitoring and evaluating the resident's response or lack of response to the interventions . Dietary evaluations are assessed on admission and at least quarterly thereafter, and following a change in condition. R6 Review of R6's face sheet revealed she had originally admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnosis that included: dementia, dysphagia (difficulty swallowing), deficiency of vitamins, weakness, lack of coordination, and cognitive communication deficit. Review of R6's kardex revealed under food/fluids: 1:1 feeding assistance at all meals . check mouth after meal for pocketed foods and debris . instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly . There is a conflicting entry in the kardex, which stated R6 is able to eat independently. Under the section special needs weight is noted to be taken weekly as well as monthly. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R6's care plan revealed under the focus ADL (activities of daily living) self-care deficit r/t (related to) weakness, confusion, impaired balance, limited mobility an intervention that states The resident is able to: eat independently with an initiation date of 4/27/20. Under the focus area: [R6] has a Nutritional status risk AEB (as evidenced by) Dx (diagnosis) of .dementia . dysphagia w/ need for altered textured diet/fluids in place; chronic variable po (by mouth) intake; h/o (history of) wt (weight) fluctuations; and advanced age with interventions that included: 1:1 feeding assistance at all meals with an initiated date of 12/7/21, Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of dysphagia ., review routine weights, and weigh resident per facility protocol . Under the focus area has a swallowing problem r/t (related to) dysphagia, poor dentition interventions included: check mouth after meal for pocketed food and debris ., instruct, assist and/or encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly, and Monitor for .choking . Review of physician note from 11/22/21 revealed R6 was being seen for a complaint of weight loss. Lab work, dietary evaluation and weekly weight checks to further monitor weight loss were ordered. On 12/16/21 at approximately 8:35 AM, no staff other than a housekeeper were observed on the 400 hall or in resident rooms and residents were eating breakfast. R6 was observed in her room, not being assisted with her meal. One of her roommates had completely finished their meal at this time, and the other roommate was about half complete in consuming her meal. R6 was viewed to have her food untouched and had a glass of clear red honey thick liquid to her mouth with her eyes closed. R6 was approached and appeared to be asleep with the glass to her mouth, she did not respond to verbal attempts to get her attention for about a minute. R6's shoulder was rubbed when speaking to her and she slowly opened her eyes, but kept the glass to her lips briefly and then slowly lowered it. R6 continued to not respond verbally and looked around the room with confusion, not making eye contact. A discussion was completed with R6's roommate, who stated that usually someone will come help R6 at with her meal, but they don't usually assist her until later, so someone may come back to help her. Conversation was attempted again with R6 and she was not communicative and did not make eye contact. Upon exiting the room and walking the hall again, no staff other than housekeeping was viewed on the hall or in resident rooms. R6 was watched from the hall consuming her breakfast. She took a limited amount of very small bites, moving very slowly. At approximately 8:47 AM, a CNA (certified nursing assistant) entered the hall and appeared to have gotten additional food from the kitchen for a resident and delivered it to their rooms. At 8:52 AM, CNA X entered the room of R10. At 8:55 AM CNA X exited R10's room with their meal tray and then went into R11's room. At 8:58 AM, CNA X exited R11's room with their meal tray and then entered the room of R6. CNA X was viewed to briefly check on R6 and walked away as she was viewed to be very slowly feeding herself. CNA X was in the room with R6 for approximately 2 minutes. CNA X was asked if she was the only aide assigned to the hall that morning and she stated yes, I am the only one on the hall, it's like this every day. CNA X was asked if anyone on the hall needed feeding assistance and she said at least 3 and pointed to the rooms of R6, R10 and R11. CNA X was asked specifically about R6 and her needs. CNA X stated she seems to be doing good now, but you have to keep checking on her to make sure she's not choking, but she is doing good on her own today. CNA X was asked how she managed to assist 3 residents at once who needed feeding assistance and she stated that she just has to keep going back and forth between them. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/16/21 at 10:50 AM, an interview was completed with Dietician Y regarding R6's nutritional status. Dietician Y stated R6 has had weight loss recently and overall a decline and had a downgrade in her swallowing ability. The dietary plan was to add supplements to meals as well as provide feeding assistance to R6. Dietician Y stated R6 can feed herself at times, but that staff usually need to initiate feeding and provide encouragement. The food acceptance logs for R6 were reviewed with Dietician Y and she stated it appears R6's acceptance increases when she has staff assistance. Dietician Y agreed there were some holes in the food acceptance documentation and stated she would expect each meal to be documented. Dietician Ys stated R6 was placed on weekly weights as of 11/23/21, this was discontinued for some reason, but reordered on 12/6/21. Weekly weights were ordered to be completed on Mondays for 4 weeks. Dietician Y stated she is also completing weekly dietary evaluations of R6 due to the significant weight loss, which would include reviewing her intake and weights. Dietician Y was asked how she completed her review of R6 on 12/14/21 (a Tuesday) if R6's weekly weight was missed on 12/13/21 (Monday). Dietician Y stated it does appear R6 needed another weight to be completed. Dietician Y was informed missing the weekly weight was concerning and also informed R6 was not viewed to be getting assistance with her breakfast meal. On 12/16/21 at 12:08 PM, lunch meal trays were observed to begin to be delivered to the 400 hall. R6 was viewed to be asleep in bed. There were between 2 to 3 CNA staff on the hall at various times delivering the meal trays to resident in their rooms. At 12:13 PM a CNA entered R6's room to deliver her tray. They elevated R6 in bed, set up her meal and then exited the room by 12:17 PM without assisting the resident to begin eating. At 12:21 PM, R6 had yet to take a bit and the surveyor entered the room. R6 was asked how she was today and how her meal was. R6 stared blankly at the surveyor and then slowly took one small bite of ice cream. Upon exiting R6's room at 12:23 PM, it was viewed that no staff were in the hall and a nurse was completing medication pass. There were 2 staff in the dining room area and 1 staff was assisting a resident with their meal. At 12:28 PM, Nurse Z returned to the hall. R6 was not eating any further bites of food. At 12:31 PM Nurse Z entered R6's room with medications and asked R6 if she needed help. At this time the resident took one more very slow bite of ice cream. Nurse Z appeared to be looking for another staff member and came across CNA X briefly exiting the dining room, Nurse Z asked CNA X to assist R6 with lunch. CNA X stated she could not because she was assisting residents in the dining room and was overheard saying she [R6] did not do great at breakfast. Nurse Z then left the hall and there were not any nursing staff on the hall for about 3 minutes. Nurse Z then returned to the hall and to R6's room and began to assist her with eating at approximately 12:35 PM. On 12/16/21 at 12:03 PM, an email request was made to the director of nursing (DON) and nursing home administrator (NHA) requesting the staff covering the 400 hall for the morning of 12/16/21, since the schedule appeared to be unclear. The DON responded by email on 12/16/21 at 12:08 PM that 2 CNAs and one nurse were assigned to the hall for that shift. During a follow up interview on 12/16/21 at 3:20 PM, the DON and NHA were informed of the lack of staff viewed on the hall during meal service that day, which was concerning with there being at least 3 identified residents who required 1:1 assistance with meals due to choking hazards and/or weight loss. The DON and NHA were informed of the extensive concerns rising to a level of immediate jeopardy with R6's weight loss and lack of interventions being implemented. On 12/17/21 at 9:05 AM, R6 was viewed being transported to the dining room in her wheelchair by staff. She was viewed to be attached to a bag of IV fluids and was smiling and making eye contact. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/17/21 at 9:55 AM, Unit Manager (UM) Z was observed feeding R6 in the main dining room. R6 had an IV in her arm. The Surveyor asked R6 how her food tasted, and she responded, I do not know. R6's had she eyes wide open and was watching UM Z. When the spoon came to her mouth, she opened it without cueing. On 12/21/21 at 9:00 AM, UM Z was observed feeding R6 in the main dining room. R6 did not have an IV running. UM Z was giving R6 spoonfuls of thickened cranberry juice. R6 had her eyes open and did not need verbal cues to open her mouth when the spoon reached her lips. The Surveyor asked R6 how her food tasted, and she responded good. Review of R6's weights revealed the following weights in the last approximately 3 months: 9/2/21 127.6 pounds, 10/1/21 125.6 pounds, 11/17/21 116.6 pounds, 12/1/21 109.0 pounds, 12/6/21 109.0 pounds, 12/16/21 106.3 pounds, 12/20/21 105.1 pounds. Between 10/1/21 and 11/17/21 (1 month) sustained a 7.1 % weight loss. Between 11/17/21 and 12/1/21 (2 weeks) R6 sustained another 6.5% weight loss. Between 9/2/21 and 12/1/21 (3 months) R6 sustained a 14.5% weight loss. The monthly weight in November was completed late during a time period where R6 sustained a significant weight loss and weekly weights were missed the week of 11/29/21 and 12/13/21 where R6 continued to lose weight. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R6 progress notes revealed no dietary progress notes from 5/17/21 until 11/18/21. A nutrition progress note from 11/18/21 revealed: Resident triggered a 8.6% significant wt loss x 1.5mo with her CBW (current body weight) at 117# (11/17) and BMI 22.0. Wt hx reviewed: 126# (10/1), 127# (8/3), and 125# (5/2) . Meal intake reviewed which remains fair, consuming 60% on average over a 14-day lookback period. She is supplemented with House Shake . Will increase her supplement to TID to support wt maintenance. MD notified of significant wt loss as well. A nutrition progress note for R11/23/21 revealed: Weekly Review: Resident's meal intake remains fair, consuming 56% on average over the past week. She is provided with House Shake supplement TID (three times a day) (200kcals, 6g pro each) for increased kcal and nutrient intake. Noted orders for weekly wts to monitor trends. Will continue with all other nutrition interventions in place and continue to monitor resident weekly and PRN for changes A nutrition progress note for R11/30/21 revealed: Weekly Review: Resident's meal intake remains fair, consuming 55% on average over the past week. She continues to have good acceptance of her House Shake supplement provided TID (200kcals, 6g pro each) for increased kcal and nutrient intake. Goal po (by mouth) intake is >60% average and prevent ongoing wt loss. Will continue with current nutrition interventions in place and monitor resident weekly and PRN (as needed) for changes. A nutrition progress note from 12/2/21 revealed Resident's weight obtained and is triggering a 7.6% significant wt loss x2wk. Her CBW (current body weight) is 109# (12/1) and BMI 20. 6. Wt hx reviewed: 117# (11/17), 128# (9/2) and 123# (6/3). Recommend Enhanced foods to maximize kcal intake. Will continue with all other nutrition interventions in place and continue to monitor trends weekly x4wks and PRN (as needed) for further changes. If decline continues, resident may benefit from alternative means of nutrition vs. comfort care. A behavior progress note from 12/7/21 revealed Note Text: Resident alert with confusion. Not engaged with staff today. Resisted am cares and refused medications this morning. Resident is now a 'feed' due to poor intake, as seen by recent weight loss. Noted drooling and coughing while feeding in up right position of 45+ degrees. Speech therapist in with resident and downgrading fluids to honey thick. Provider notified. Resident staying in bed today per her choice. A nutrition note for 12/7/21 revealed: Resident's diet has been downgraded to Honey-thickened liquids with recommendations for 1:1 feeding assistance at all meals per SLP (speech-language pathology). Supplement updated to Nutritional Treat TID (3 times a day) (300kcals, 11g pro each) in place of House Shakes for appropriate consistency and increased kcal intake. A nutrition note from 12/14/21 revealed: Resident's meal intake remains fair/poor, consuming only 35% on average over the past week. She is accepting of most supplements and fluids throughout the day. She is provided with Nutritional Treat TID (300kcals, 11g pro each) for increased kcal and nutrient intake. Supplement updated from House Shake d/t downgrade to HTL (honey thick liquids). Noted referral for hospice care in place. PO (by mouth) intake anticipated to remain variable given overall decline. Will continue to monitor weekly and PRN (as needed) for further changes. A general progress note from 12/16/21 revealed: A hydration assessment was completed on this resident. She presented with dry mucus membranes. Her skin turgor is poor and tenting . Physician on-call [name of physician] notified. Order received for one liter of NS (normal saline) to be ran @ 100cc/hr. IV started in resident's left forearm. Site is patent and is infusing well. Review of R6's meal intake records for the last 30 days (from 11/17-12/16/21) revealed 11 days when only 2 meals were charted and 6 days when only 1 meal was charted. The entries did not indicate what meal was being charted. Approximately 37 of the meals charted stated the resident was independent with eating with no staff oversight or help at any time (8 of those meals were after 12/7/21 even though she was care planned for 1:1 assistance at that time and 2 meals were charted for 12/16/21- one at 1:46 PM with 25% eaten and one at 1:47 PM with 75% eaten. Both were coded as the resident being totally dependent on staff). (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R10 Review of R10's face sheet revealed he originally admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnosis that included: acute respiratory failure, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), dysphagia (difficulty swallowing), vascular dementia, lack of coordination and convulsions. Review of R10's kardex revealed under food/fluids: 1:1 feeding assistance at all meals as resident allows . check mouth after meals for pocketed food and debris .instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew eat bite thoroughly . Review of R10's care plan revealed a focus area of ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia, Hemiplegia, Impaired balance, Limited Mobility, Limited ROM (range of motion), Stroke) interventions include: EATING: 1:1 feeding assistance at all meals as resident allows. Under focus area [R10] has a potential for swallowing problems r/t Dysphagia interventions include: Alternate small bites and sips . check mouth after meals for pocketed food and debris . instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew eat bite thoroughly . Monitor/document/report PRN (as needed) and s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Report to nurse and/or MD and adjust plan of care as indicated. Review of R10's progress notes for R10/3/21 revealed: .Resident prefers being fed his meals as he struggles to keep food on his utensil. Assisted with lunch today, he ate 100%. Will notify UM (unit manager) and SLP (Speech-Language Pathology) for possible evaluation. R11 Review of R11's face sheet revealed she was initially admitted to the facility on [DATE] with diagnosis that included: obstructive hydrocephalus (blockage of fluid in the brain), adult failure to thrive, weakness, dysphagia and cognitive communication deficiency. Review of R11's kardex revealed under Food/fluids: Assist resident to consume food/fluids as resident allows; encourage self-feeding .The resident requires extensive assistance by 1 staff to eat Review of R11's care plan revealed a focus area ADL self-care performance deficit r/t Confusion, Fatigue, Impaired balance, Limited Mobility with interventions including EATING: The resident requires extensive assistance by 1 staff to eat . Under the focus area Nutritional status risk AEB (as evidenced by) dx (diagnosis) of .cognitive communication deficit .h/o (history of) dysphagia; self-feeding deficits r/t (related to) blindness and tremors; need for feeding assistance and adaptive equipment . interventions include assist resident to consume food/fluids as resident allows . Monitor/document/report PRN (as needed) and s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Report to nurse and/or MD and adjust plan of care as indicated. Review of R11's progress notes for R10/8/21 revealed: CNA reported to the the (sic) writer that resident has been noted holding food in her mouth, appetite has decreased . (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/16/21 at 3:20 PM, the NHA was informed of an Immediate (IJ) related to F 600 that began on 12/13/21 when the facility failed to assist R6 (who weighs 109 pounds) with nutritional needs per the plan of care and doctor's orders which include: performing weekly weights, providing 1:1 assistance or supervision for choking risk (dysphagia) and nutritional needs; monitoring food intake and monitoring nutritional and hydration status timely per standards of practice. The identified risk of serious injury, serious harm, serious impairment or death was evidenced by: R6 had a 14.5% weight loss in 3 months and a 6.5% weight loss in the last 2 weeks. Surveyor observations revealed no or little assistance or supervision for R6 who could not eat on her own. R6 is likely to incur further weight loss, functional decline, serious harm and/or hastened death if weight loss continues without monitoring and interventions to prevent weight loss in place. The need for immediate action was: The facility interdisciplinary team must immediately review and monitor R6 for her significant weight loss and decline, and ensure that all residents at risk for nutrition and/or hydration are assessed to ensure nutrition and hydration needs are being met per plan of care, doctor's orders, and standards of practice. On 12/17/2021, the facility plan to remove the Immediate Jeopardy was accepted and the state survey agency began to validate the removal plan which included: [Name of facility] is providing the following information to demonstrate that the immediacy of the cited deficiency F692 has been removed. 1. Response to Cited Areas: - Resident 6 had a current weight obtained. The physician has assessed the resident, a nutrition assessment has been completed and plan of care has been reviewed to ensure appropriate interventions are in place. - A review has been completed on current residents to ensure a current weight is documented. - A review of current residents that need supervision or 1:1 assistance with feeding have been reviewed to ensure nutritional needs are met and proper assistance is provided. - A review of current resident's nutrition acceptance record has been reviewed to ensure no significant changes in nutritional status. - Residents that have been identified as having an altercation in hydration or nutritional status have been reviewed to ensure appropriate interventions and monitoring is in place. 2. Other Residents at Potential Risk: - On December 16th, 2021, an audit was completed on the 81 residents residing in the facility to identify which residents are at risk for hydration and/or nutritional interventions and monitoring. - 10 residents have been identified as at risk for alterations in hydration or nutritional status and have had a nutritional assessment completed along with a plan of care review and update as needed. 3. Process Implemented to prevent further incidence: - On December 16th, 2021, 22 out of 67 nursing staff members have been educated on the nutrition monitoring and management program with special attention to: (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Weekly weight process o Providing proper assistance with oral intake o Documenting intake o Notification of changes in nutritional status timely - On December 16th, 2021, 1 out of 1 registered dietician has been educated on the nutrition monitoring and management program. - Any staff member that has not been educated will be educated prior to the start of their shift. 4. Monitoring: - The DON/designee will complete 5 random audits on residents, weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the nutrition monitoring and management program is being followed including appropriate nutritional interventions, weekly weights, intake documentation and proper assistance being provided during meals, as applicable The facility alleges that the immediacy with the deficient practice has been removed on December 16th, 2021. Although the Immediate Jeopardy was removed on 12/16/2021, the facility remained out of compliance with a scope of pattern and severity of actual harm that is not immediate jeopardy due to sustained compliance not being verified by the state agency.

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Skld Muskegon	1061 W Hackley Ave Muskegon, MI 49441

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 This citation pertains to MI00124948: Based on observation, interview and record review the facility failed to adequately evaluate, reassess and implement care plan interventions to address pain for 1 Resident (R8) resident reviewed for pain, resulting in the R8 experiencing continued pain. Findings include: Review of R8's face sheet dated 12/16/21 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Schizophrenia, obsessive compulsive disorder, blindness, anxiety disorder, major depressive disorder, and need for assistance with personal care. R8 was his own responsibility party. Review of R8's Brief Interview of Mental Status (BIMS) score dated 11/18/21 revealed he scored 15/15 (normal cognition). Review of R8's physician progress note dated 11/15/21 at 6:50 PM revealed, R8 was treated at the hospital for a right hip fracture. When R8 returned to the facility he complained of persistent pain and a repeat x-ray showed an addition femur fracture. He returned to the hospital for a revision of his Open Reduction Internal Fixation (ORIF), surgical repair of the right femur. Under Assessment/Plan revealed, Change Norco to 5/325 TID (narcotic pain medication three times a day) as patients pain is not well controlled. He has mental illness and is not remembering to ask for pain medication. After skin revealed, Inspection and palpation (touch): warm and dry. No indication of skin break down. After musculorskeletal revealed, Right leg swelling greater than left leg. Review of R8's physician progress note dated 11/24/21 at 2:00 PM revealed, The patient is seen today for skilled follow-up evaluation. The patient recently had a right femur fracture. He is motivated, cooperative and is making good progress with therapy. He denies any pain, has no acute concerns. He is eating and sleeping well. Review of R8's physician progress noted dated 11/29/21 at 3:00 PM revealed, R8 is seen today for evaluation of the patient at the request of nursing for lower extremity swelling and also abrasion over the right lower extremity. The patient had a dressing on and he had a recent hip fracture. Incision is very well approximated. Sutures are still in place. The patient thinks that his pain is much better than before. After plan revealed, 1. encourage pt (patient) to limit his time in chair to 2 hours. 2. Pain in right hip joint- externally rotated. Patient instructions. Continue current treatment. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R8's physician note dated 12/6/21 at 2:10 PM revealed, R8 is seen today for evaluation of the patient for complaints of pain. He had a femur fracture. The patient has less pain when he is in bed. His leg is still externally rotated. We are attempting to procure specialized shoes that he is able to maintain his right lower extremity in an anatomical position. At this time, I would like to start him on Lidoderm patch in an effort to reduce the effect of narcotic pain medicine and also start him on muscle relaxant in an effort to improve PT and OT to work with the patient. His lower extremity edema is much improved. He is alert, awake, confused, in no acute distress. He denies any acute problem. He is painful when he is able to bear weight. No mention of pressure ulcer on right lower extremity. Review of R8's physician progress note dated 12/20/21 at 1:40 PM revealed, Patient is seen today for evaluation of right hip pain. I have been asked to evaluate the patient for increased pain and discomfort. Patient has a history of right femur fracture and is currently on Norco 3-325 TID (narcotic pain medication 3 times a day). Patient is seen lying in bed. He denies any current pain. He denies hip pain however does mention that he experiences occasional pain in his right knee. He denies knee pain at this moment. Nursing reports that the patient was exhibiting pain this morning during care and repositioning however, nurse says he has just receive a pain pill prior to care and it may not have taken affect at that time. Nursing also mentions that the patients right hip pain is well controlled with a lidocaine patch and is requesting a lidocaine patch for the patients right knee. Review of R8's Skin & Wound Evaluation dated 12/2/21 at 9:17 AM revealed, he had a new unstageable ulcer on his right lateral malleolus that measured 7.3 cm x 4.1 cm x 2.5 cm and was 0.1 cm deep. Review of a pressure ulcer report for R8 dated 11/27/21 at 10:05 AM revealed, Therapist reported to this nurse, an open area on the outer right ankle area. 4.5 cm in length 5.5 cm in width. Some serosanguino (sp) drainage (fluid containing blood) drainage noted on linen. Right leg is externally rotated with no tolerance of correcting this position. Resident was unaware of open area on right ankle. After notes revealed, 11/29/21 Wound nurse to examine to determine if pressure related. 12/10/21 Root Cause: Related to resident having recent surgery with external rotation noted. Bed and wheelchair checked for any sharp surfaces and none noted. Edema to lower leg noted to be contributing factor. Wound team following. Boot and positioning in devices in place. Ordered positioning device for positioning. Therapy to assess for any further positioning recommendations. Review of R8's care plan revealed a care plan for actual impairment to skin integrity related to current break in skin integrity, multiple incision sites to his right lower extremity and pressure injury to his right lateral ankle. Date initiated was 10/26/21 and last revision was on 12/2/21. Interventions included, 12/17/21 position pillow to be place mid back when lying on side. 12/2/21 Prevalon boot with outer wedge to right foot when in bed as tolerated, 12/17/21 resident needs pressure reduction interventions: positioning pillow between knees when side lying and while turning resident. Review of R8's care plan for limited physical mobility related to weakness and history of right fibula fracture date initiated 5/28/19 and last revision on 12/16/21 revealed, 9/17/21 The resident is NON WEIGHT BEARING TO RLE (right lower extremity) and FULL WEIGHT BEARING to LLE (left lower extremity). 10/28/21 Bed Mobility: resident requires assistance of one staff member. (All observations 12/17/21 to 12/21/21 R8 required the assistance of 2 staff for bed mobility). 12/22/20 Locomotion: The resident uses a two wheeled walker for locomotion (R8 was not able to stand and was not able to bear weight on his right leg). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R8's care plan for chronic pain dated initiated 1/14/21 and revision on 11/12/21 revealed, 5/29/19 Administer analgesia per physician orders. Anticipate and treat before, during, and after treatment that may cause increased pain or discomfort. Review of R8's Kardex dated 12/19/21 revealed he required assistance of one person for bed mobility. However, all observations of care for R8 from 12/17/21 to 12/21/21 R8's had 2 people assisting him with movement in bed as his right leg was very painful and he was not able to move his right leg without assistance. R8 also required physical assistance to roll and two people to pull him up in bed. Review of R8's IDT (interdisciplinary note) dated 12/20/21 revealed, Heal suspension boot discontinued, AMP (alternating pressure mattress) in place now. Care plan did not reflect these changes. Review of R8's wound timeline provided by the facility revealed the following measurements: 11/27/21 - 4.5 cm x 5 x 5 cm 12/2/21 - 7.3 cm x 4.1 cm x 2.5 cm 12/9/21 3.2 cm x 2.5 cm x 1.7 cm 12/17/21 2.8 cm x 3.2 cm x UTD (undermined depth). The last Skin & Wound evaluation located in R8's record and provided by the facility was dated 12/9/21 and revealed a facility acquired, unstageable pressure ulcer on R8's right lateral malleolus that measured 3.2 cm x 2.5 cm x 1.7 cm and was 0.2 depth. Assessments did not indicate any drainage. On 12/17/21 at 9:55 AM, R8 was observed eating in bed. The head of his bed was elevated about 20 to 30 degrees. R8 was dropping a lot of his food in bed. His body was covered with a sheet. R8 said he had not been provided any care yet this morning. He was feeding himself. On 12/17/21 at 10:09 AM CNA AA said she was assigned to R8 today and started work at 6:00 AM. CNA AA said the only care she had provided for R8 this morning was to reposition him around 6:00 AM. CNA AA said she was also responsible for residents on another hall. CNA AA said she was caring for 11 residents and was on a split hall. CNA AA said there was one on other CNA working with her that morning. During an interview with Unit Manager Z on 12/17/21 at 10:15 AM, she confirmed CNA AA was assigned to R8. CNA AA was assigned to care for 11 residents on the unit and 6 of the residents on the unit were care planned to need 2 people for care. The other CNA on the unit this morning was CNA X. During an interview with CNA X on 12/17/21 at 10:18 AM, CNA X said she had not provided any care for R8 this morning. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8 was observed in bed on 12/17/21 at 10:20 AM, R8 had a dressing on his right hip over his surgical incision with no date or initials, he had a lidocaine patch on his right thigh and a dressing on his right lower leg just above his malleolus with no date or initials. The dressings did not have any drainage showing through. Unit Manager Z removed the dressing on his right hip and the incision under the dressing had red areas on the boarder and an indentation about approximately .5 cm in length at the distal end of the incision. No dressing was placed back over R8's incision on his right hip. No drainage was observed on the dressing that was removed. CNA AA and Unit Manager Z rolled R8 in bed to remove his saturated brief and sheet. R8 grimaced and hit his fisted hands on the mattress with movement. R8 did not yell out in pain or ask staff to stop moving him. Urine had soak through to his sheet. R8 did yell out in pain at times when staff were moving his right leg to provide care and positioning. During care R 10 said his pain was at 10 on a 1-10 scale when he was asked. When pulling back the boot on R8's foot a 1-inch indentation was noted in his skin below the top of the boot. The boot was fastened with a Velcro strap (1 inch pitting edema). When CNA AA and the unit manager rolled R8 in bed they did not support his right leg. R8 indicated his pain was in his right leg. CNA AA said when she came in at 6:00 AM R8 was positioned toward his right side, and she moved the pillow to allow him to be on his back for breakfast. CNA AA and Unit Manager Z placed wedge cushion under R8's right hip and kept the boot fastened on his right foot. On 10/17/21 at approximately 11:00 AM, Physical Therapist Assistant (PTA) BB came in to provided care for R8. Unit Manager Z was still in the room. The Surveyor asked PTA BB if anything could be done to decrease pain in the right leg during movement, how she would instruct staff to do pressure relief in bed and if R8's circulation was being impaired by the boot on his right leg. PTA BB confirmed the boot was causing the indentation on the right foot and need to be replaced by some other device to provide pressure relief and positioning. PTA BB said they had a device on order, but it had not arrived. PTA BB removed the boot and placed a pillow under R8 calf. PTA BB demonstrated and instructed Unit Manager Z to use a pillow between R8's legs when rolling him (log roll). PTA BB instructed Unit Manager Z to place the pillow or wedge behind R8's back (not his hip) when positioning him to his side. (avoid bony areas with positioning devices). R8 complained of less pain with this movement than he did during the observation at 10:20 AM. R8 was able to let staff know he had less pain when he was log rolled in bed and his right leg was supported but he still had a lot of pain with movement. On 12/17/21 at 11:25 AM, the Surveyor emailed the Director of Nursing (DON) to inform her R8's boot on his right foot caused 1 inch pitting edema, he was complaining of pain at a 10 on 1-10 scale with movement, staff were having difficulty with providing pressure relief due to pillows placed over bony areas, resident was left soaked in urine for over 4 hours and was not provided any pressure relief for 3 hours. Around noon on 12/17/21 the DON acknowledged receiving the email about R8 and said she would address the issues. The DON did not respond to this email or provide any different information. On 12/21/21 at 8:47 AM, R8 was observed up in a wheelchair in the main dining room on his unit. R8's left foot was on a foot pedal and his right foot was on the floor. R8 had gripper socks on both feet. R8's dressing on his right lower leg was visibly soiled. R8 said he had been up in his wheelchair since around 6 or 7 this morning. R8 said his right knee and ankle hurt. R8 was served breakfast at 8:51 AM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/21/21 at 9:17 AM, PTA BB came in the Main Dining room and removed R8's right leg rest from his chair. When PTA BB moved R8's leg to remove the leg rest she grabbed his leg with her bare hand right over his dressing on the right lower leg that was visible soiled. PTA BB returned to put a leg rest back on R8's wheelchair at 9:29 AM and R8's said it this leg rest felt better. R8's pushed his wheelchair with both arms to the door of the main dining room than requested assistance to get out the door and back to his room. PTA BB was planning on doing therapy at this time but R8 reported his pain was 10 out of 1 - 10. PTA BB checked with LPN CC to see if R8 could get anything for pain. LPN CC said R8 had Norco at 8:08 AM and had his lidocaine patch so he did not have any thing else she could give at this time. LPN CC said R8's nurse would need to contact the doctor. On 12/21/21 at 10:21 AM, the Director of Nursing (DON) informed staff she had contacted R8's doctor and he now had a order for prn (as need) Norco and they could give it now. On 12/21/21 at approximately 11:00 AM, CNA B and CNA DD used an electronic lift to put R8 back in bed. R8 grimaced with pain during the transfer. He made fists with both hands and shook his arms but did not yell out in pain or complain during the transfer. He again reported a 10 with pain during movement but reported his pain was 5 when he was not moving in bed. On 12/21/21 at 11: 35 AM, LPN EE said she put the dressing on R8's right ankle at 7:15 AM this morning. LPN EE showed where she had written with a light ink pen the date, time and her initials. The dressing was saturated all the way through. There was a large letter C shape in the bloody drainage of the dressing she removed. The wound was facing the mattress so the Surveyor was not able to see the wound. R8 was having too much pain to change his position to allow the Surveyor to view his ankle wound. The Surveyor pointed out that R8 had a dressing over his right hip incision with no date, time or initials. LPN EE said she did not know anything about that dressing. A few minutes later Unit Manager Z arrive at R8's room and said the dressing should not be on R8's right hip. LPN EE removed the dressing on R8's right hip and a 1/2 saturated area was noted on the dressing. The distal area of the incision that had an indentation in it when the undated dressing was removed on 12/17/21 at 10:20 AM. Unit Manager Z was not able to locate any documentation that showed when R8's incision on his right hip started draining, or when the wound on his right ankle started having drainage. Unit Manager Z said she would get new orders for a dressing over R8's right hip. During an interview with the DON on 12/20/21 around noon, the DON was not aware R8's incision on his right hip was draining, she was not aware the dressing on his right ankle was saturated. The DON was asked for all documentation on R8's wounds. Upon exit on 12/21/21 the facility did not provide any documentation that showed they were aware the right hip wound was draining, they had no documentation of who put the dressing on the right hip, they had no full assessment documented or notes on the full condition of R8's right ankle since 12/9/21. None of the documents located from 12/9/21 or after indicated the wound on R8's right ankle was draining.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	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** 38659 This citation refers to MI00124429: This citation has two deficient practice statements DPS #1 Based on observation, interview and record review the facility failed to provide adequate staff for weight monitoring, feeding assistance and supervision for 3 residents (R6, R10, and R11), resulting in significant weight loss for R6 and the potential for future weight loss, as well as the potential for choking, aspiration, and serious injury due to lack of supervision and meal assistance for R6, R10 and R11. Findings include: Review of facility policy with the subject Weight Management with adopted date 9/11/20 revealed weight loss is defined as: significant weight loss (5% in one (1) month, 7.5% in three (3) months, oR10% in six (6) months) . should be addressed in the care plan. Facility approaches to address weight loss may include an ongoing search for the cause(s) of weight loss .once the cause(s) is/are identified, relevant care plan decisions are made and documented. Ongoing interventions are evaluated and modified as needed. The procedure includes the resident being weighed monthly and as needed .Monthly weights are to be completed by the 7th day of each month and reviewed by the Nutrition Committee within a reasonable period of time thereafter .any resident weight that varies from the previous reporting period by 5% in 30 days, 7.5% in 90 days and 10% in 180 days will be evaluated by the Interdisciplinary Team to determine the cause of the weight gain/loss and the intervention(s) required .any resident meeting the criteria for weight loss .will be weighed weekly, with the weight entered in the resident's medical record . Review of the facility policy with the subject Nutrition Monitoring & Management Program with the adopted date of 7/11/18 revealed a purpose: To provide care and services including .defining and implementing interventions for maintaining or improving nutritional status that are consistent with resident needs, goals and recognized standards of practice .monitoring and evaluating the resident's response or lack of response to the interventions . Dietary evaluations are assessed on admission and at least quarterly thereafter, and following a change in condition. R6 Review of R6's face sheet revealed she had originally admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnosis that included: dementia, dysphagia (difficulty swallowing), deficiency of vitamins, weakness, lack of coordination, and cognitive communication deficit. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Review of R6's kardex revealed under food/fluids: 1:1 feeding assistance at all meals . check mouth after meal for pocketed foods and debris . instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly . There is a conflicting entry in the kardex, which stated R6 is able to eat independently. Under the section special needs weight is noted to be taken weekly as well as monthly. Review of R6's care plan revealed under the focus ADL (activities of daily living) self-care deficit r/t (related to) weakness, confusion, impaired balance, limited mobility an intervention that states The resident is able to: eat independently with an initiation date of 4/27/20. Under the focus area: [R6] has a Nutritional status risk AEB (as evidenced by) Dx (diagnosis) of .dementia . dysphagia w/ need for altered textured diet/fluids in place; chronic variable po (by mouth) intake; h/o (history of) wt (weight) fluctuations; and advanced age with interventions that included: 1:1 feeding assistance at all meals with an initiated date of 12/7/21, Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of dysphagia ., review routine weights, and weigh resident per facility protocol . Under the focus area has a swallowing problem r/t (related to) dysphagia, poor dentition interventions included: check mouth after meal for pocketed food and debris ., instruct, assist and/or encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly, and Monitor for .choking . Review of physician note from 11/22/21 revealed R6 was being seen for a complaint of weight loss. Lab work, dietary evaluation and weekly weight checks to further monitor weight loss were ordered. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 12/16/21 at approximately 8:35 AM, no staff other than a housekeeper were observed on the 400 hall or in resident rooms and residents were eating breakfast. R6 was observed in her room, not being assisted with her meal. One of her roommates had completely finished their meal at this time, and the other roommate was about half complete in consuming her meal. R6 was viewed to have her food untouched and had a glass of clear red honey thick liquid to her mouth with her eyes closed. R6 was approached and appeared to be asleep with the glass to her mouth, she did not respond to verbal attempts to get her attention for about a minute. R6's shoulder was rubbed when speaking to her and she slowly opened her eyes, but kept the glass to her lips briefly and then slowly lowered it. R6 continued to not respond verbally and looked around the room with confusion, not making eye contact. A discussion was completed with R6's roommate, who stated that usually someone will come help R6 at with her meal, but they don't usually assist her until later, so someone may come back to help her. Conversation was attempted again with R6 and she was not communicative and did not make eye contact. Upon exiting the room and walking the hall again, no staff other than housekeeping was viewed on the hall or in resident rooms. R6 was watched from the hall consuming her breakfast. She took a limited amount of very small bites, moving very slowly. At approximately 8:47 AM, a CNA (certified nursing assistant) entered the hall and appeared to have gotten additional food from the kitchen for a resident and delivered it to their rooms. At 8:52 AM CNA X entered the room of R10. At 8:55 AM CNA X exited R10's room with their meal tray and then went into R11's room. At 8:58 AM CNA X exited R11's room with their meal tray and then entered the room of R6. CNA X was viewed to briefly check on R6 and walked away as she was viewed to be very slowly feeding herself. CNA X was in the room with R6 for approximately 2 minutes. CNA X was asked if she was the only aide assigned to the hall the morning and she stated yes, I am the only one on the hall, it's like this every day. CNA X was asked if anyone on the hall needed feeding assistance and she said at least 3 and pointed to the rooms of R6, R10 and R11. CNA X was asked specifically about R6 and her needs. CNA X stated she seems to be doing good now, but you have to keep checking on her to make sure she's not choking, but she is doing good on her own today. CNA X was asked how she managed to assist 3 residents at once who needed feeding assistance and she stated that she just has to keep going back and forth between them. On 12/16/21 at 10:50 AM, an interview was completed with Dietician Y regarding R6's nutritional status. Dietician Y stated R6 has had weight loss recently and overall a decline and had a downgrade in her swallowing ability. The dietary plan was to add supplements to meals as well as provide feeding assistance to R6. Dietician Y stated R6 can feed herself at times, but that staff usually need to initiate feeding and provide encouragement. The food acceptance logs for R6 were reviewed with Dietician Y and she stated it appears R6's acceptance increases when she has staff assistance. Dietician Y agreed there were some holes in the food acceptance documentation and stated she would expect each meal to be documented. Dietician Ys stated R6 was placed on weekly weights as of 11/23/21, this was discontinued for some reason, but reordered on 12/6/21. Weekly weights were ordered to be completed on Mondays for 4 weeks. Dietician Y stated she is also completing weekly dietary evaluations of R6 due to the significant weight loss, which would include reviewing her intake and weights. Dietician Y was asked how she completed her review of R6 on 12/14/21 (a Tuesday) if R6's weekly weight was missed on 12/13/21 (Monday). Dietician Y stated it does appear R6 needed another weight to be completed. Dietician Y was informed missing the weekly weight was concerning and also informed R6 was not viewed to be getting assistance with her breakfast meal. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 12/16/21 at 12:08 PM, lunch meal trays were observed to begin to be delivered to the 400 hall. R6 was viewed to be asleep in bed. There were between 2-3 CNA staff on the hall at various times delivering the meal trays to resident in their rooms. At 12:13 PM a CNA entered R6's room to deliver her tray. They elevated R6 in bed, set up her meal and then exited the room by 12:17 PM without assisting the resident to begin eating. At 12:21 PM, R6 had yet to take a bit and the surveyor entered the room. R6 was asked how she was today and how her meal was. R6 stared blankly at the surveyor and then slowly took one small bite of ice cream. Upon exiting R6's room at 12:23 PM, it was viewed that no staff were in the hall and a nurse was completing medication pass. There was 2 staff in the dining room area and 1 staff was assisting a resident with their meal. At 12:28 PM, Nurse Z returned to the hall. R6 was not eating any further bites of food. At 12:31 PM Nurse Z entered R6's room with medications and asked R6 if she needed help, at this time the resident took one more very slow bite of ice cream. Nurse Z appeared to be looking for another staff member and came across CNA X briefly exiting the dining room, Nurse Z asked CNA X to assist R6 with lunch. CNA X stated she could not because she was assisting residents in the dining room and was overheard saying she [R6] did not do great at breakfast. Nurse Z then left the hall and there was no nursing staff on the hall for about 3 minutes. Nurse Z then returned to the hall and to R6's room and began to assist her with eating at approximately 12:35 PM. On 12/16/21 at 12:03 PM email request was made to the director of nursing (DON) and nursing home administrator (NHA) requesting the staff covering the 400 hall for the morning of 12/16/21, since the schedule appeared to be unclear. The DON responded by email on 12/16/21 at 12:08 PM that 2 CNAs and one nurse were assigned to the hall for that shift. During a follow up interview on 12/16/21 at 3:20 PM, the DON and NHA were informed of the lack of staff viewed on the hall during meal service that day, which was concerning with there being at least 3 identified residents who required 1:1 assistance with meals due to choking hazards and/or weight loss. The DON and NHA were informed of the extensive concerns rising to a level of immediate jeopardy with R6's weight loss and lack of interventions being implemented. On 12/17/21 at 9:05 AM, R6 was viewed being transported to the dining room in her wheelchair by staff. She was viewed to be attached to a bag of IV fluids and was smiling and making eye contact. On 12/17/21 at 9:55 AM Unit Manager (UM) Z was observed feeding R6 in the main dining room. R6 had an IV in her arm. The Surveyor asked R6 how her food tasted, and she responded, I do not know. R6's had she eyes wide open and was watching UM Z. When the spoon came to her mouth, she opened it without cueing. On 12/21/21 at 9:00 AM UM Z was observed feeding R6 in the main dining room. R6 did not have an IV running. UM Z was giving R6 spoonfuls of thickened cranberry juice. R6 had her eyes open and did not need verbal cues to open her mouth when the spoon reached her lips. The Surveyor asked R6 how her food tasted, and she responded good. Review of R6's weights revealed the following weights in the last approximately 3 months: 9/2/21 127.6 pounds, 10/1/21 125.6 pounds, 11/17/21 116.6 pounds, 12/1/21 109.0 pounds, 12/6/21 109.0 pounds, 12/16/21 106.3 pounds, 12/20/21 105.1 pounds. Between 10/1/21 and 11/17/21 (1 month) sustained a 7.1 % weight loss. Between 11/17/21 and 12/1/21 (2 weeks) R6 sustained another 6.5% weight loss. Between 9/2/21 and 12/1/21 (3 months) R6 sustained a 14.5% weight loss. The monthly weight in November was completed late during a time period where R6 sustained a significant weight loss and weekly weights were missed the week of 11/29/21 and 12/13/21 where R6 continued to lose weight. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Review of R6 progress notes revealed no dietary progress notes from 5/17/21 until 11/18/21. A nutrition progress note from 11/18/21 revealed: Resident triggered a 8.6% significant wt loss x 1.5mo with her CBW (current body weight) at 117# (11/17) and BMI 22.0. Wt hx reviewed: 126# (10/1), 127# (8/3), and 125# (5/2) . Meal intake reviewed which remains fair, consuming 60% on average over a 14-day lookback period. She is supplemented with House Shake . Will increase her supplement to TID to support wt maintenance. MD notified of significant wt loss as well. A nutrition progress note for R11/23/21 revealed: Weekly Review: Resident's meal intake remains fair, consuming 56% on average over the past week. She is provided with House Shake supplement TID (three times a day) (200kcals, 6g pro each) for increased kcal and nutrient intake. Noted orders for weekly wts to monitor trends. Will continue with all other nutrition interventions in place and continue to monitor resident weekly and PRN for changes A nutrition progress note for R11/30/21 revealed: Weekly Review: Resident's meal intake remains fair, consuming 55% on average over the past week. She continues to have good acceptance of her House Shake supplement provided TID (200kcals, 6g pro each) for increased kcal and nutrient intake. Goal po (by mouth) intake is >60% average and prevent ongoing wt loss. Will continue with current nutrition interventions in place and monitor resident weekly and PRN (as needed) for changes. A nutrition progress note from 12/2/21 revealed Resident's weight obtained and is triggering a 7.6% significant wt loss x2wk. Her CBW (current body weight) is 109# (12/1) and BMI 20. 6. Wt hx reviewed: 117# (11/17), 128# (9/2) and 123# (6/3). Recommend Enhanced foods to maximize kcal intake. Will continue with all other nutrition interventions in place and continue to monitor trends weekly x4wks and PRN (as needed) for further changes. If decline continues, resident may benefit from alternative means of nutrition vs. comfort care. A behavior progress note from 12/7/21 revealed Note Text: Resident alert with confusion. Not engaged with staff today. Resisted am cares and refused medications this morning. Resident is now a 'feed' due to poor intake, as seen by recent weight loss. Noted drooling and coughing while feeding in up right position of 45+ degrees. Speech therapist in with resident and downgrading fluids to honey thick. Provider notified. Resident staying in bed today per her choice. A nutrition note for 12/7/21 revealed: Resident's diet has been downgraded to Honey-thickened liquids with recommendations for 1:1 feeding assistance at all meals per SLP (speech-language pathology). Supplement updated to Nutritional Treat TID (3 times a day) (300kcals, 11g pro each) in place of House Shakes for appropriate consistency and increased kcal intake. A nutrition note from 12/14/21 revealed: Resident's meal intake remains fair/poor, consuming only 35% on average over the past week. She is accepting of most supplements and fluids throughout the day. She is provided with Nutritional Treat TID (300kcals, 11g pro each) for increased kcal and nutrient intake. Supplement updated from House Shake d/t downgrade to HTL (honey thick liquids). Noted referral for hospice care in place. PO (by mouth) intake anticipated to remain variable given overall decline. Will continue to monitor weekly and PRN (as needed) for further changes. A general progress note from 12/16/21 revealed: A hydration assessment was completed on this resident. She presented with dry mucus membranes. Her skin turgor is poor and tenting . Physician on-call [name of physician] notified. Order received for one liter of NS (normal saline) to be ran @ 100cc/hr. IV started in resident's left forearm. Site is patent and is infusing well. Review of R6's meal intake records for the last 30 days (from 11/17-12/16/21) revealed 11 days when only 2 meals were charted and 6 days when only 1 meal was charted. The entries did not indicate what meal was being charted. Approximately 37 of the meals charted stated the resident was independent with eating with no staff oversight or help at any time, 8 of those meals were after 12/7/21 even though she was care planned for 1:1 assistance at that time. 2 meals were charted for 12/16/21, one at 1:46 PM with 25% eaten and one at 1:47 PM with 75% eaten. Both were coded as the resident being totally dependent on staff. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	R10 Review of R10's face sheet revealed he originally admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnosis that included: acute respiratory failure, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), dysphagia (difficulty swallowing), vascular dementia, lack of coordination and convulsions. Review of R10's kardex revealed under food/fluids: 1:1 feeding assistance at all meals as resident allows . check mouth after meals for pocketed food and debris .instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew eat bite thoroughly . Review of R10's care plan revealed a focus area of ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia, Hemiplegia, Impaired balance, Limited Mobility, Limited ROM (range of motion), Stroke) interventions include: EATING: 1:1 feeding assistance at all meals as resident allows. Under focus area [R10] has a potential for swallowing problems r/t Dysphagia interventions include: Alternate small bites and sips . check mouth after meals for pocketed food and debris . instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew eat bite thoroughly . Monitor/document/report PRN (as needed) and s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Report to nurse and/or MD and adjust plan of care as indicated. Review of R10's progress notes for R10/3/21 revealed: .Resident prefers being fed his meals as he struggles to keep food on his utensil. Assisted with lunch today, he ate 100%. Will notify UM (unit manager) and SLP (Speech-Language Pathology) for possible evaluation. R11 Review of R11's face sheet revealed she was initially admitted to the facility on [DATE] with diagnosis that included: obstructive hydrocephalus (blockage of fluid in the brain), adult failure to thrive, weakness, dysphagia and cognitive communication deficiency. Review of R11's kardex revealed under Food/fluids: Assist resident to consume food/fluids as resident allows; encourage self-feeding .The resident requires extensive assistance by 1 staff to eat Review of R11's care plan revealed a focus area ADL self-care performance deficit r/t Confusion, Fatigue, Impaired balance, Limited Mobility with interventions including EATING: The resident requires extensive assistance by 1 staff to eat . Under the focus area Nutritional status risk AEB (as evidenced by) dx (diagnosis) of .cognitive communication deficit .h/o (history of) dysphagia; self-feeding deficits r/t (related to) blindness and tremors; need for feeding assistance and adaptive equipment . interventions include assist resident to consume food/fluids as resident allows . Monitor/document/report PRN (as needed) and s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Report to nurse and/or MD and adjust plan of care as indicated. Review of R11's progress notes for R10/8/21 revealed: CNA reported to the the (sic) writer that resident has been noted holding food in her mouth, appetite has decreased . (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	28101 DPS #2 Based on observation interview and record review the facility failed to provide adequate staffing for 1 Resident (R8) to provided timely repositioning and incontinence care, resulting in R8 not being repositioned in over 2 hours and left soiled for over 4 hours. Findings include: Review of R8's face sheet dated 12/16/21 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Schizophrenia, obsessive compulsive disorder, blindness, anxiety disorder, major depressive disorder, and need for assistance with personal care. R8 was his own responsibility party. Review of R8's Brief Interview of Mental Status (BIMS) score dated 11/18/21 revealed he scored 15/15 (normal cognition). On 12/17/21 at 9:55 AM, R8 was observed eating in bed. The head of his bed was elevated about 20 to 30 degrees. R8 was dropping a lot of his food in bed. His body was covered with a sheet. R8 said he had not been provided any care yet this morning. He was feeding himself. On 12/17/21 at 10:09 AM, CNA AA said she was assigned to R8 today and started work at 6:00 AM. CNA AA said the only care she had provided for R8 this morning was to reposition him around 6:00 AM. CNA AA said she was also responsible for residents on another hall. CNA AA said she was caring for 11 residents and was on a split hall. CNA AA said there was one on other CNA working with her that morning. During an interview with Unit Manager Z on 12/17/21 at 10:15 AM, she confirmed CNA AA was assigned to R8. CNA AA was assigned to care for 11 residents on the unit and 6 of the residents on the unit were care planned to need 2 people for care. The other CNA on the unit this morning was CNA X. During an interview with CNA X on 12/17/21 at 10:18 AM, CNA X said she had not provided any care for R8 this morning. R8 was observed in bed on 12/17/21 at 10:20 AM, CNA AA and Unit Manager Z rolled R8 in bed to remove his saturated brief and sheet. .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 This citation refers to MI00124948. Based on interview and record review, the facility failed to maintain accurate medical records for 1 of 11 residents (R7), resulting in inaccurate medical records and the potential for providers not having an accurate and complete picture of the resident's medical condition and/or stay at the facility. Findings include: A review of R7's Admission Record, dated 12/15/21, revealed R7 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 7's Admission Record revealed R7 had multiple diagnoses that included diabetes, difficulty walking, and paraplegia (paralysis of lower body and legs). A review of R7's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 10/21/21, revealed R7 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) assessment which revealed R7 had short-term and long-term memory problems. In addition, R7's MDS revealed R7 had moderately impaired cognitive decision-making skills. R7's MDS also revealed R7 did not have any pressure ulcers or sores. A review of R7's impaired skin integrity care plan, revised 1/25/21, revealed R7 had impaired skin integrity related to decreased mobility, resistance to repositioning, incontinence of bowel and bladder (Date Initiated: 09/02/2020). R7's impaired skin integrity care plan also revealed an intervention of Elevate heels off bed surface while at rest in bed (Date Initiated: 10/26/2020). A review of R7's Skin & Wound Evaluations, dated 11/10/21 to 12/16/21, revealed the following: - Left heel- Stage 3 pressure ulcer (involves the full thickness of the skin and may extend into the subcutaneous tissue layer; granulation tissue and epibole (rolled wound edges) are often present). - 11/11/21= 4.1 cm (centimeters) x (by) 3.6 cm (length by width). Area= 11 cm2 (centimeters squared). - 11/18/21= 2.8 cm x 1.8 cm x 0.2 cm (length by width by depth). Area= 3.9 cm2. - 12/2/21= 0.9 cm x 0.3 cm x 0.1 cm. Area= 0.2 cm2. This measurement was done 14 days after the previous one. - 12/16/21= No open area. This measurement was done 14 days after the previous one. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Right heel- unstageable pressure ulcer (Full thickness tissue loss in which the actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed). -11/11/21= 3.2 cm x 2.6 cm. Area= 6.1 cm2. - 11/18/21 at 8:57 AM= 2.4 cm x 0.8 cm. Area= 1.2 cm2. - 11/18/21 at 8:59 AM= 2 cm x 1.2 cm. Area= 1.9 cm2. - 12/2/21= 0.6 cm x 0.4 cm x 0.2 cm. Area= 0.1 cm2. This measurement was done 14 days after the previous one. - 12/16/21= 1.1 cm x 0.7 cm. Area= 0.6 cm2. This measurement was done 14 days after the previous one. A review of R7's progress notes, dated 11/1/21 to 12/16/21, revealed the above mentioned measurements were also in the progress notes. In addition to the following note and measurement: - General Progress Note, dated 11/12/21, revealed, observed resident to have bilateral heels elevated up on pillows , heels had lotion on them, they were cracked open and tender to the touch left heel measured at - 5. 3 cm x 4.4 cm x .2 cm deep, right heel measured at 5.6 cm x 4.3 cm x 1.4 cm deep, no drainage present, surrounding tissue dry and cracked, 70% pink, 30% eschar, treatment started, notifications completed, wound care to follow weekly on wound rounds, encourage resident to use heel bridge, and will have his bed length extended to help prevent his heels from resting on the foot board. A review of R7's Skin Observation Tools, dated 11/10/21 (at 9:45 PM) and 11/17/21, failed to reveal any skin alterations or wounds. R7's Skin Observation Tools revealed R7 had normal appearing skin and no new alterations in skin integrity including open areas of any type. However, R7 did have pressure ulcers that were discovered on 11/10/21 noted on R7's Skin & Wound Evaluation, dated 11/11/21 and on R7's Focused Incident Review for New or Worsened Pressure Ulcer/Injury form, dated 11/10/21 (at 4:16 PM) and completed on 11/12/21. During an interview on 12/16/21 at 11:10 AM, Registered Nurse Unit Manager (UM) N stated on 11/10/21, a nursing assistant filled out a skin alert note. She stated she (UM N) evaluated R7's wound and did measurements on 11/10/21. She stated R7 had wounds on his right heel and left heel (one each). UM N stated on 11/10/21, she completed a Focused Incident Review for New or Worsened Pressure Ulcer/Injury form for R7's bilateral heel pressure ulcers and R7's wound measurements were 5.3 cm x 4.4 cm x 0.2 cm (left heel) and 5.6 cm x 4.3 cm x 1.4 cm (right heel). UM N stated that she locked (completed) R7's Focused Incident Review for New or Worsened Pressure Ulcer/Injury form on 11/12/21 and on that date the progress note was entered with the measurements she did. UM N stated that even though she did do R7's measurements on 11/10/21, it did appear they were done (according to the progress notes) on 11/12/21. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/21 at 11:10 AM, UM N was shown R7's Skin & Wound Evaluations progress notes, dated 11/18/21 at 8:57 AM and 8:59 AM and R7's Skin & Wound Evaluations, dated 11/18/21 at 8:57 AM and 8:59 AM . UM N appeared to be surprised that there were two entries for that date in the progress notes and on the wound evaluation forms. She stated R7's Skin & Wound Evaluation, dated 11/18/21 at 8:57 AM, and R7's Skin & Wound Evaluations progress note, dated 11/18/21 at 8:57 AM, were inaccurate and made in error. However, there were not any notes or annotations in R7's medical record reflecting this. In addition, UM N stated the system they use to do wound measurements and enter them into the computer may have accidentally entered the data. She stated she did not know why or how it happened since the measurements differed from the ones she actually did. UM N stated, It must have been a malfunction or something. I don't know how it even got these measurements.

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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. 30120 Based on observation, interview, and record review, the facility failed to implement proper infection control practices in the facility and resident care areas, resulting in the potential for the spread of infection, illness, and disease. Findings include: A review of the facility's Infection Prevention Control policy and procedure, updated 9/20/21, revealed, This document is designed to provide guidance to the facility regarding the COVID19 core practices that should remain in place whether or not the facility is experiencing outbreaks of SARS-CoV-2 (COVID-19) . 6. The facility will implement source control measures and physical distancing measures. Source control refers to use of well-fitting cloth masks, face masks, or respirators to cover a person's mouth and nose to prevent the spread of respiratory secretions when they are breathing, talking, sneezing, or coughing . Staff members should wear an NIOSH approved N95 or equivalent or higher-level respirator, eye protection (eye goggles or a face shield that covers the front and sides of the face), gloves, and gown. A review of the Centers for Disease Control and Prevention (CDC) Use of Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 policy and procedure, undated, revealed, PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas . Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients. Respirator: Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). During an interview on 12/15/21 at 9:15 AM, Receptionist O stated everyone (staff, vendors, visitors, state agency personnel) needs to wear N95 respirators while in the facility. During an interview on 12/15/21 at 10:20 AM, certified nursing assistant (CNA) M stated staff are supposed to wear N95 respirators and face shields on the COVID unit while in the hallways. She stated staff will wear gloves and gowns when they go into the rooms. CNA M stated when staff leave the resident rooms, they are supposed to remove their gowns and gloves, but can leave their N95 respirators and face shields on. During an observation on 12/15/21 at 3:05 PM, dietary aide (DA) P was observed standing in lobby area talking with Food Service Director (FSD) R and Receptionist O. DA P's N95 respirator was down around her throat and not covering her mouth or nose. Even though FSD R and Receptionist O were talking to DA P, and looking directly at her, neither one mentioned to her that she was not wearing her N95 respirator properly. During an observation on 12/15/21 at 3:15 PM, CNA Q was observed with only the top strap of her N95 on. The bottom strap was dangling under her chin. However when she saw the surveyor coming down the hallway, she quickly struggled to get the bottom strap over her head and in place at the back of her neck. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 12/15/21 at 3:20 PM, CNA S had the bottom strap of her N95 respirator tucked into her mask under her chin. She stated she did not know the personal protective equipment (PPE) requirement throughout the facility because she had been off and just recently came back to work. During an observation on 12/15/21 at 3:25 PM, CNA Q was observed with the bottom strap of her N95 respirator tucked into her respirator under her chin. She stated the 500 Hall was an observation hall and staff are required to wear gowns and gloves when they enter the hall just like on the COVID unit. She stated staff are supposed to wear KN95's throughout the building like the one you're wearing (the surveyor was wearing a white N95 respirator that resembles a KN95 respirator). During an observation on 12/15/21 at 3:25 PM, CNA T was observed walking up and down the 400 Hall with the bottom strap of her N95 tucked into her respirator under her chin. During an interview on 12/15/21 at 4:15 PM, the Director of Nursing (DON) stated staff are to wear N95 respirators when they are in the facility. She stated on the COVID unit and 500 Hall, staff are to wear the N95 respirator in the halls and face shields, gowns, and gloves in the individual resident rooms. She stated face shields are not required in the halls of the COVID unit and 500 Hall (observation unit). During an interview on 12/16/21 at 8:00 AM, Receptionist O stated staff are supposed to wear both straps of their N95 respirators on. She stated they should not be wearing N95 respirators with only one strap secured. During an observation on 12/16/21 at 8:25 AM, DA U was observed pushing a food cart down the 300 Hall with only her top strap of her N95 respirator on. The bottom strap was dangling below her chin. During an observation of the COVID unit on 12/16/21 from 10:45 AM to 10:55 AM, Registered Nurse (RN) V was observed coming out of a resident's room with a gown on, walking to medication cart and rummaging around, and then closing the medication cart and leaving the resident care area through the double doors with the same gown still on. 38659 On 12/15/21 at 9:13 AM, CNA A was viewed assisting a resident out of the building with one strap of her N95 mask hanging loose underneath her chin. On 12/15/21 at 9:27 AM, CNA B was viewed at the nurses station with both straps of her N95 mask low and within a quarter inch on each other. On 12/15/21 at 2:23 PM Staff C was viewed in the hall with both straps of their N95 low under their ears. On 12/15/21 at 2:25 PM CNA D was viewed exiting the restroom with the straps of their N95 overlapping. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235004	A. Building B. Wing	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Muskegon	1061 W Hackley Ave Muskegon, MI 49441

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/15/21 at 2:30 PM Nurse E was viewed at the 400 hall nurses station with the straps on their N95 overlapping. 3 CNA staff were viewed on the unit with one of their N95 straps below their chin or tucked into the bottom part of their mask. CNA I was viewed entering a resident room with one N95 strap below their chin. This staff member later spoke to a Nurse E as well as Nurse J on the 300 hall with the strap dangling loose and neither corrected CNA I. On 12/17/21 at 8:49 AM a staff member was viewed walking down the 300 hall with a cart of linens with the lower strap of her N95 mask loose and under her chin. On 12/17/21 at 8:52 AM CNA B was viewed on a resident unit delivering the meal cart with both straps of her N95 mask low and within a quarter inch on each other. On 12/21/21 at 8:42 AM a CNA was viewed speaking to a nurse at the nurses station with both straps of their N95 low and overlapping. On 12/21/21 at 8:49 AM a CNA was viewed exiting the employee lounge with both straps of their N95 low and overlapping. On 12/21/21 at 8:56 AM CNA B was viewed on a resident unit with both straps of her N95 mask low and within a quarter inch on each other.