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	03/17/2023

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 This citation pertains to intake number MI00134976 and MI00135157. Based on interview and record review, the facility failed to notify the resident representative to make treatment decisions for 1 resident, Resident #1 (R1) reviewed for notification. This deficient practice resulted in R1's Representative being unaware of new onset of hip swelling, increased pain, the need for an X-ray and not being included in the treatment and decision-making process. Findings include: R1 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of (but not limited to) Alzheimer's/Dementia (short- and long-term memory impairment), stroke with left sided weakness, osteoarthritic, and a left femur (leg) fracture with surgical repair. Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which represented R1 had severe cognitive impairment. R1 required extensive staff assistance of 1-2 with all activities of daily living. During an interview on 3/14/23 at approximately 2:20 PM, CNA F stated she worked on 2/22/23 from 2:00 PM to 10:00 PM and was assigned to R1. CNA F stated the previous shift reported that R1 repeatedly asked to go to the bathroom and had increased behaviors. CNA F stated that approximately 2:15 PM, she observed R1 in her room by the closet doors, seated in her wheelchair. CNA F stated that R1 was visibly upset and swinging her arms about. CNA F stated that R1 grabbed her shirt and when she attempted to back up away from R1, R1 slid forward out of the wheelchair. CNA F stated that R1 had her bottom off the wheelchair seat, her left leg caught up in the footrest behind her and her right foot forward. CNA F stated she called out for help and CNA G entered the room. CNA F stated together they lifted R1 off the floor and back into the wheelchair, pushed the wheelchair over to the bed and then transferred R1 into bed. CNA F stated that R1 remained upset and combative with the CNA F and CNA G. CNA F stated she did not report the fall/incident to R1's nurse. CNA F stated that she did not know that was considered a fall and did not report the incident until she was interviewed by the NHA on 2/27/23. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review the progress note dated 2/26/23 at 1:50 PM, entered late for 2/22/23 (4 days later) at 2:44 PM, written by RN B was reviewed. The note reflected, Late Entry: Note Text: CNA notified nurse that resident was having pain to her left hip. Resident wound not allow CNA to get her out of bed d/t (due to) the pain she was having. Nurse assessed bilateral hips. Minimal swelling noted to the left side compared to the right. Nurse administered PRN pain medication at that time and notified on call physician of findings NP ordered an x-ray to be completed for her left hip and pelvis. Nurse faxed order over to (name of company) Diagnostics. During a telephone interview on 3/15/23 at 11:55 AM, this surveyor read the progress note written RN B on 2/26/23 to her. When asked why the progress was entered on 2/26/23 for an assessment done on 2/22/23 (4 days later), RN B stated she worked 6:00 AM - 6:00 PM on 2/26/23 and it was her first day back after being off. RN B stated she heard from other staff members that R1 had sustained a fractured hip and was hospitalized . When asked if R1's ROM (range of motion) was assessed, RN B stated, No, not unless it's indicated. She (R1) would barely let me touch it. RN B stated she medicated R1 with Norco, and the MAR reflected that Norco was signed out at 9:49 AM and rated the pain at a 5 for moderate pain. This was inconsistent with RN B statement that R1 would barely let me touch it. No other pain medication was signed out as given until 8:36 PM (11 hours later). When asked why the progress note and the X-ray order were done after 2 PM when the Norco was given at 9:49 AM, RN B stated she was behind in her charting. When asked if she reassessed R1 during the remainder of her shift and RN B stated, Nothing more on my shift. When asked why R1's Resident Representative was not notified to of the new onset of joint swelling with increase in pain and to obtain permission for the X-ray, RN B stated, I wasn't thinking about that at the time, and you don't need permission to order an X-ray. When asked about the assessment finding that R1 wouldn't allow you to touch her, why the X-ray wasn't ordered STAT instead of routine, RN B stated, That's the way the doctor ordered it. When asked if the new onset of swelling and pain along with the pending X-ray was reported in the shift-to-shift report with LPN C on 2/26/23 at 6:00 PM, RN B stated, Yes. During an interview on 3/14/23 at 2:35 PM, LPN D stated she worked the day shift 2/23/23 and started at 6:00 AM. LPN D stated that early in the shift CNA I reported that R1 had pain and refused to get up. LPN D stated she went to assess her right away. LPN D stated, I saw her (R1) leg inverted, jacked up, and swollen. I called the doctor and sent her to ER about 9:30 AM. When asked what R1's pain level was, LPN D stated that she did not attempt ROM and rated R1's pain a 10 on 10 pain scale which was severe. LPN D stated it took 4 people to lift R1 onto the EMS cart when they arrived and R1 really cried out when then moved her. According to the Femur X-ray dated 2/23/23 at 1:22 PM reflected, Impression 1. Displaced comminuted left intertrochanteric fracture . During an interview and record review on 3/16/23 at 1:40 PM, the Director of Nursing and the Unit Manager, LPN A was asked about RN B's note that was a Late Entry on 2/26/23 for a pain assessment on 2/22/23 at 2:44 PM. Both the DON and UM, LPN A stated they were dissatisfied with RN B's note. Both agreed that R1's Resident Representative should have been notified and permission obtained. During a telephone interview on 3/14/23 at 1:30 PM, R1's Resident Representative stated that he was not notified of the new onset of left hip swelling, increased pain nor that an X-ray was ordered on 2/22/23 at 2:08 PM. R1's Resident Representative was upset that the facility was not notifying him of changes in condition with R1 and asking permission for X-rays.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 This citation pertains to intake number MI00134976 and MI00135157. Based on observation, interview, and record review, the facility failed to prevent neglect for 1 resident, Resident #1 (R1) reviewed for abuse/neglect. The deficient practice resulted in R1 sustaining a femur (leg) fracture after staff did not following the plan of care and sustained a fall with serious injury that went unreported and unassessed with prolonged severe pain and emotional suffering to occur, when R1 was denied appropriate medical care from being rendered for approximately 19 hours. Findings include: The facility provided a copy of the Policy/Procedure - Nursing Administration, Abuse and Neglect dated 7/11/18 and updated on 10/31/22. The policy reflected, The administrator is the abuse coordinator in this facility and is responsible for developing and implementing the abuse prevention training curriculum and conducting the investigation in situations of alleged abuse/neglect .Neglect is the failure to care for a person in a manner, which would avoid harm and pain .Neglect may or may not be intentional. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress .Signs and symptoms of suspected abuse/neglect 1. Prolonged interval between trauma/illness and seeking medical attention . R1 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of (but not limited to) Alzheimer's/Dementia (short- and long-term memory impairment), stroke with left sided weakness, osteoarthritis, and a left femur (leg) fracture with surgical repair. Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which represented R1 had severe cognitive impairment. R1 required extensive staff assistance of 1-2 with all activities of daily living. (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 0600 Level of Harm - Actual harm Residents Affected - Few	An interview and observation was conducted on 3/14/23 at approximately 4:00 PM with R4, who was in her bed watching TV. R4 was the roommate of R1 on 2/22/23 and 2/23/23. R4 stated that on 2/22/23, R1 was making a ruckus in the hall on the 1st shift, and they moved R1 back to her room. R4 stated just after second shift came on, she recalled R1 giving the staff quite a time. R4 stated that R1 was in her wheelchair, next to the foot of R4's bed (which is next to the closet doors). The surveyor was able to observe and confirm the area R4 was describing. When asked if the privacy curtain was open or closed the afternoon of 2/22/23, R4 stated it was opened all the way and she could see the staff interacting with R1 near the foot of her bed. The surveyor observed that R4's head of bed was against the wall and R1's bed was placed with the foot of the bed facing R4's bed with the right side placed against the wall. R4 confirmed the beds were still in the same placement. When the privacy curtain was pushed open it still provided privacy to R4's upper body while in bed, but R4 was unable to view R1's bed. R4 stated R1's wheelchair was facing the door and when CNA F came in to put R1 to bed, she saw R1 grabbing at CNA F as CNA F went around to the back of the wheelchair. At that time R1 started propelling herself forward in the wheelchair as CNA F held the wheelchair (from behind) and R1 slid forward out of the wheelchair hitting R4's over the bed table as R1 landed on the floor sending the table into foot of R4's bed. R4 stated another CNA came in and they lifted her back to her wheelchair and then into bed which she could not see from where she was laying in her bed but recalled hearing them fighting with her and remembered the privacy curtain moving during that time. R4 stated, (Name of R1) doesn't always take her pain medication and it's just awful to hear her cry when they clean her. According to R4's MDS dated [DATE], Section C: Brief Interview for Mental Status (BIMS) reflected a score of 14 out of 15 which represented R4 was cognitively intact. During an interview on 3/14/23 at approximately 2:20 PM, CNA F stated she worked on 2/22/23 from 2:00 PM to 10:00 PM and was assigned to R1. CNA F stated the previous shift reported that R1 repeatedly asked to go to the bathroom and had increased behaviors. CNA F stated that approximately 2:15 PM, she observed R1 in her room by the closet doors, seated in her wheelchair. CNA F stated that R1 was visibly upset and swinging her arms about. CNA F stated that R1 grabbed her shirt and when she attempted to back up away from R1, R1 slid forward out of the wheelchair. CNA F stated that R1 had her bottom off the wheelchair seat, her left leg caught up in the footrest behind her and her right foot forward. CNA F stated she called out for help and CNA G entered the room. CNA F stated together they lifted R1 off the floor and back into the wheelchair, pushed the wheelchair over to the bed and then transferred R1 into bed. CNA F stated that R1 remained upset and combative with the CNA F and CNA G. CNA F stated she did not report the fall/incident to R1's nurse. CNA F stated that she did not know that was considered a fall and did not report the incident until she was interviewed by the NHA on 2/27/23. CNA F stated that she received education and discipline for not reporting the fall. During a telephone interview on 3/15/23 at 2:54 PM, CNA G stated that she worked 2:00 PM until 10:00 PM on 2/22/23. CNA G stated that about 2:15 PM, she was passing waters in the hallway when she heard CNA F call out for help. CNA G stated that she entered R1's room and observed R1 in front of her wheelchair (facing her with her bottom off the seat), slid down resting on her own legs, on the floor and next to the closet door. CNA G stated that R1 was fighting them. Both CNAs lifted R1 and placed her back into the wheelchair. CNA G stated that they moved R1 next to the bed and transferred R1 into bed. When asked about R1's behavior and response during this process, CNA G stated that R1 continued to swing her arms at them, yelling and swearing at them. CNA G stated that they felt it was better to put her into bed then to leave her up in the wheelchair. CNA G stated that she also received education and discipline for not reporting the fall. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A record review the progress note dated 2/26/23 at 1:50 PM, entered late for 2/22/23 (4 days later) at 2:44 PM, written by RN B was reviewed. The note reflected, Late Entry: Note Text: CNA notified nurse that resident was having pain to her left hip. Resident wound not allow CNA to get her out of bed d/t (due to) the pain she was having. Nurse assessed bilateral hips. Minimal swelling noted to the left side compared to the right. Nurse administered PRN pain medication at that time and notified on call physician of findings NP ordered an x-ray to be completed for her left hip and pelvis. Nurse faxed order over to (name of company) Diagnostics. According to the February Medication Administration Record (MAR) reflected the following as needed pain medications given on 2/22/23: -Norco Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 0.5 tablet by mouth every 8 hours as needed for pain. On 2/22/23 it was signed out at 9:49 AM by Registered Nurse (RN) B for a pain level of 5 (moderate) and once more at 8:36 PM by Licensed Practical Nurse (LPN) C for a pain level of 5. -Acetaminophen Tablet 325 MG, give 2 tablets by mouth every 4 hours as needed for General Discomfort. There were no doses signed out as given on 2/22/23. Record review of the X-ray order for a 2 View Left Hip and Pelvis Dx (diagnosis) Pain Created by (name of RN B) on 2/22/23 at 1408 (2:08 PM) Revised by (name of RN B) on 2/22/23 at 1408 (2:08 PM) Signed by (name of Provider) on 2/22/23 at 17:47 (5:47 PM) During a telephone interview on 3/15/23 at 11:55 AM, this surveyor read the progress note written by RN B on 2/26/23 to her. When asked why the progress was entered on 2/26/23 for an assessment done on 2/22/23 (4 days later), RN B stated she worked 6:00 AM - 6:00 PM on 2/26/23 and it was her first day back after being off. RN B stated she heard from other staff members that R1 had sustained a fractured hip and wanted to make sure her note was entered. When asked if R1's ROM (range of motion) was assessed, RN B stated, No, not unless it's indicated. She (R1) would barely let me touch it. RN B stated she medicated R1 with Norco, but the MAR reflected that Norco was signed out at 9:49 AM (not at 2:00 PM) and rated the pain at a 5 for moderate pain. This is inconsistent with RN B statement that R1 would barely let me touch it. No other pain medication was signed out as given until 8:36 PM (11 hours later). When asked why the progress note and the X-ray order were done after 2 PM when the Norco was given at 9:49 AM, RN B stated she was behind in her charting. When asked if she reassessed R1 during the remainder of her shift and RN B stated, Nothing more on my shift. When asked why R1's Resident Representative was not notified to of the new onset of joint swelling with increase in pain and to obtain permission for the X-ray, RN B stated, I wasn't thinking about that at the time, and you don't need permission to order an X-ray. When asked about the assessment finding that R1 wouldn't allow you to touch her, why the X-ray wasn't ordered STAT instead of routine, RN B stated, That's the way the doctor ordered it. When asked if the new onset of swelling and pain along with the pending X-ray was reported in the shift-to-shift report with LPN C on 2/26/23 at 6:00 PM, RN B stated, Yes. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 3/14/23 at 5:50 PM, LPN C stated that she was assigned to R1's care from 6:00 PM on 2/22/23 until 6:00 AM on 2/23/23. LPN C stated that she was unaware of R1's new hip swelling, increased pain, and X-ray order. LPN C stated that she did not recall that R1's change in condition was reported to her in the shift-to-shift report and had she known she would have specifically assessed R1 for that. LPN C stated that no X-rays were taken during her shift. During a telephone interview on 3/15/23 at 1:45 PM, CNA H stated that she worked from 10:00 PM on 2/22/23 until 6:00 AM on 2/23/23 and was assigned to R1. CNA H stated that R1 complained about her left leg hurting and she noticed an abrasion on R1's left knee. CNA H stated that she assumed R1 hit her knee on the TV that swings out from the wall over the bed on a long extending bracket. According to the February MAR, no pain medications were administered on the night shift for R1. During an interview on 3/14/23 at 2:35 PM, LPN D stated she worked the day shift 2/23/23 and started at 6:00 AM. LPN D stated that early in the shift CNA I reported that R1 had pain and refused to get up. LPN D stated she went to assess her right away. LPN D stated, I saw her (R1) leg inverted, jacked up, and swollen. I called the doctor and sent her to ER about 9:30 AM. When asked what R1's pain level was, LPN D stated that she did not attempt ROM and rated R1's pain a 10 on 10 pain scale which was severe. LPN D stated it took 4 people to lift R1 onto the EMS cart when they arrived and R1 really cried out when then moved her. LPN D stated she received a call from the hospital shortly after sending her asking what she had eaten for breakfast because they needed to send her to surgery to repair a fracture. During an observation and interview on 3/15/23 at 12:15 PM, CNA I and CNA J repositioned R1 in bed. R1 had visible discomfort with repositioning with mild facial grimacing noted. R1 had noted surgical wounds in different stages of healing on her left leg and an abrasion to the left knee approximately 2 cm x 1 cm. CNA I stated that she was assigned to R1 the morning of 2/23/23 when R1 was transferred to the hospital. CNA I stated that she knew right away that something was wrong with R1's hip from just looking at it, it was protruding and red. CNA I stated that she went to get the nurse right away. CNA I stated, I noticed a bandaid on her left knee that was new so, I pulled it back to see what was under it. CNA I stated that LPN D came to her shortly after sending R1 to the emergency room , and needed to know what R1 had eaten for breakfast because she had broken her hip and needed to have surgery. According to the Femur X-ray dated 2/23/23 at 1:22 PM reflected, Impression 1. Displaced comminuted left intertrochanteric fracture . According to the Wound Summary in the hospital records dated 2/23/23 reflected an abrasion to the anterior (front) knee that was covered with a bandaid upon arrival from the facility. According to the Fixation Left Hip IM Nail (L) Operative Noted dated 2/23/23 at 3:35 PM reflected, Based on the tension required for reduction with traction, I suspect the fracture is greater than 24 hours. It may coincide with the abrasion noted on her left knee in terms of timing. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview and record review on 3/16/23 at 1:40 PM, the Director of Nursing and the Unit Manager, LPN A was asked about RN B's note that was a Late Entry on 2/26/23 for a pain assessment on 2/22/23 at 2:44 PM. Both the DON and UM, LPN A stated they were dissatisfied with RN B's note. Both agreed that the X-ray should have been ordered STAT and a call placed to R1's Resident Representative for notification and permission. UM, LPN A stated the nurse should always notify the manager or DON when ordering an X-ray, so no one is caught off guard. When asked if an assessment of increased joint swelling and pain should include a ROM assessment, both said yes and indicated it was their expectation to rate the pain level and do follow-up assessment regarding the pain. During a telephone interview on 3/14/23 at 1:30 PM, R1's Resident Representative stated that he was not notified of the new onset of left hip swelling, increased pain nor that an X-ray that were ordered on 2/22/23 at 2:08 PM. R1's Resident Representative was upset that the facility was not notifying him of changes in condition with R1 and asking permission for X-rays. R1's Resident Representative stated that he was not made aware of anything until he got a call the morning of 2/23/23 informing him that R1 needed to be sent to the emergency room for evaluation. R1's Resident Representative stated that doctor (at the hospital) told him about the fracture and gave him two treatment options. The first option was to not fix it and manage R1's pain for the rest of her life or surgery to fix it, which they could not even guarantee R1 would survive. R1's Resident Representative stated that was the hardest decision he's ever had to make for someone, but he didn't want to see R1 suffer.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 This citation pertains to intake number MI00134976 and MI00135157. Based on observation, interview, and record review, the facility failed to timely and thoroughly investigate an injury of unknow origin for 1 resident, Resident #1 (R1) reviewed for abuse/neglect investigation. This deficient practice resulted in R1 sustaining a serious injury of unknown origin (a left leg fracture) that was not immediately reported to the State Agency and was not thoroughly investigated with the potential for other residents to sustain serious injuries of unknown origin. Findings include: The facility provided a copy of the Policy/Procedure - Nursing Administration, Abuse and Neglect dated 7/11/18 and updated on 10/31/22. The policy reflected, The administrator is the abuse coordinator in this facility and is responsible for developing and implementing the abuse prevention training curriculum and conducting the investigation in situations of alleged abuse/neglect .Neglect is the failure to care for a person in a manner, which would avoid harm and pain .Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress .Signs and symptoms of suspected abuse/neglect 1. Prolonged interval between trauma/illness and seeking medical attention .Investigation: Investigate all allegations of abuse, neglect, misappropriation of property and incidents such as injuries of unknown source. All allegations will be investigated by the Administrator or Designee immediately .All allegations and/or suspicions of abuse must be reported to the administrator immediately. If the Administrator's Designee. If the Administrator is not present, the report must be made to the Administrator's Designee .The abuse coordinator must submit a preliminary investigation report to the appropriate State Agencies immediately .However, if the event that caused the allegation involved abuse or resulted in serious bodily injury, the allegation of abuse must be reported to appropriate state agencies immediately and not later than 2 hours after receiving the allegation . R1 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of (but not limited to) Alzheimer's/Dementia (short- and long-term memory impairment), stroke with left sided weakness, osteoarthritis, and a left femur (leg) fracture with surgical repair. Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which represented R1 had severe cognitive impairment. R1 required extensive staff assistance of 1-2 with all activities of daily living. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/23 at approximately 2:20 PM, CNA F stated she worked on 2/22/23 from 2:00 PM to 10:00 PM and was assigned to R1. CNA F stated the previous shift reported that R1 repeatedly asked to go to the bathroom and had increased behaviors. CNA F stated that approximately 2:15 PM, she observed R1 in her room by the closet doors, seated in her wheelchair. CNA F stated that R1 was visibly upset and swinging her arms about. CNA F stated that R1 grabbed her shirt and when she attempted to back up away from R1, R1 slid forward out of the wheelchair. CNA F stated that R1 had her bottom off the wheelchair seat, her left leg caught up in the footrest behind her and her right foot forward. CNA F stated she called out for help and CNA G entered the room. CNA F stated together they lifted R1 off the floor and back into the wheelchair, pushed the wheelchair over to the bed and then transferred R1 into bed. CNA F stated that R1 remained upset and combative with the CNA F and CNA G. CNA F stated she did not report the fall/incident to R1's nurse. CNA F stated that she did not know that was considered a fall and did not report the incident until she was interviewed by the NHA on 2/27/23 (4 days after the facility became aware of the injury of unknown origin). CNA F stated that she received education and discipline for not reporting the fall on 2/27/23. During a telephone interview on 3/15/23 at 2:54 PM, CNA G stated that she worked 2:00 PM until 10:00 PM on 2/22/23. CNA G stated that about 2:15 PM, she was passing waters in the hallway when she heard CNA F call out for help. CNA G stated that she entered R1's room and observed R1 in front of her wheelchair (facing her with her bottom off the seat), slid down resting on her own legs, on the floor and next to the closet door. CNA G stated that R1 was fighting them. Both CNAs lifted R1 and placed her back into the wheelchair. CNA G stated that they moved R1 next to the bed and transferred R1 into bed. When asked about R1's behavior and response during this process, CNA G stated that R1 continued to swing her arms at them, yelling and swearing at them. CNA G stated that they felt it was better to put her into bed then to leave her up in the wheelchair. CNA G stated that she did not know that was considered a fall and did not report the incident until she was interviewed by the NHA on 2/27/23 (4 days after the facility became aware of the injury of unknown origin). CNA G stated that she received education and discipline for not reporting the fall on 2/27/23. The facility investigation submitted to the State Agency on 3/3/23 at 12:03 PM reflected, On 2/27/23, Administrator interviewed resident roommate (name of R4). (Name of R4) reported that she witnessed the incident. She stated that her privacy curtains were closed, however, she could hear (name of R1) giving the CNAs a hard time. At one point, (name of R4) heard a bang and at the same time her bedside table moved. (Name of R4) reported that (Name of R1) told her that she fell on the concrete. According to R4's MDS dated [DATE], Section C: Brief Interview for Mental Status (BIMS) reflected a score of 14 out of 15 which represented R4 was cognitively intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation was conducted on 3/14/23 at approximately 4:00 PM with R4, who was in her bed watching TV. R4 was the roommate of R1 on 2/22/23 and 2/23/23. R4 stated that on 2/22/23, R1 was making a ruckus in the hall on the 1st shift, and they moved R1 back to her room. R4 stated just after second shift came on, she recalled R1 giving the staff quite a time. R4 stated that R1 was in her wheelchair, next to the foot of R4's bed (which is next to the closet doors). The surveyor was able to observe and confirm the area R4 was describing. When asked if the privacy curtain was open or closed the afternoon of 2/22/23, R4 stated it was opened all the way and she could see the staff interacting with R1 near the foot of her bed. The Surveyor observed that R4's head of bed was against the wall and R1's bed was placed with the foot of the bed facing R4's bed with the right side placed against the wall. R4 confirmed the beds were still in the same placement. When the privacy curtain was pushed open it still provided privacy to R4's upper body while in bed, but R4 was unable to view R1's bed. R4 stated R1's wheelchair was facing the door and when CNA F came in to put R1 to bed, she saw R1 grabbing at CNA F as CNA F went around to the back of the wheelchair. R1 started propelling herself forward in the wheelchair as CNA F held the wheelchair (from behind) and R1 slid forward out of the wheelchair hitting R4's over the bed table as R1 landed on the floor sending the table into foot of R4's bed. R4 stated another CNA came in and they lifted her back to her wheelchair and then into bed which she could not see from where she was laying in her bed but recalled hearing them fighting with her and remembered the privacy curtain moving during that time. R4 stated, (Name of R1) doesn't always take her pain medication and it's just awful to hear her cry when they clean her. The facility investigation submitted to the State Agency on 3/3/23 at 12:03 PM reflected, On 2/27/23, Administrator interviewed (Name of LPN E). (Name of LPN E) stated that on 2/23/23 she was scheduled to work. (Name of LPN E) stated that both (Name of CNA F and name of CNA G) reported that they had difficult time getting (Name of R1) transferred to bed. (Name of LPN E) reported both CNAs stated (Name of R1) was combative with them; hitting, kicking, and yelling at them. (Name of LPN E) assessed (Name of R1) and she denied having any pain at that time. During a telephone interview on 3/15/23 at 1:50 PM, the surveyor read the facility's investigation statement to LPN E, and she stated that is not correct because she never worked during that period. LPN E stated that she worked on 2/20/23, called in for 2/21/23, 2/22/23 was her scheduled day off, called in on 2/23/23 and was scheduled off on 2/24/23. A record review the progress note dated 2/26/23 at 1:50 PM, entered late for 2/22/23 (4 days later) at 2:44 PM, written by RN B was reviewed. The note reflected, Late Entry: Note Text: CNA notified nurse that resident was having pain to her left hip. Resident wound not allow CNA to get her out of bed d/t (due to) the pain she was having. Nurse assessed bilateral hips. Minimal swelling noted to the left side compared to the right. Nurse administered PRN pain medication at that time and notified on call physician of findings NP ordered an x-ray to be completed for her left hip and pelvis. Nurse faxed order over to (name of company) Diagnostics. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/15/23 at 11:55 AM, RN B confirmed that she worked 6:00 AM to 6:00 PM on 2/22/23 (the day R1 sustained an unreported fall). This surveyor read the progress note written by RN B on 2/26/23 to her. When asked why the progress was entered on 2/26/23 for an assessment done on 2/22/23 (4 days later), RN B stated she worked 6:00 AM - 6:00 PM on 2/26/23 and it was her first day back after being off. RN B stated she heard from other staff members that R1 had sustained a fractured hip and was hospitalized on [DATE]. RN B stated that she wanted to ensure her note was in the progress notes. When asked if she was ever interviewed during the facility investigation, RN B stated, No. RN B's interview and progress note was not included in the facility investigation submitted to the State Agency. The NHA provided the facility investigation file to the Surveyor following the entrance conference on 3/14/23. The file contained staff education regarding falls, falls reporting, safe patient transfers and abuse. Approximately 25% of the staff signed with the date of 2/27/23. During an interview on 3/14/23 at 12:00 PM, the NHA was asked why the investigation in the file folder did not match the investigation that was submitted to the State Agency for review, and the NHA stated, that she forgot to inform the Surveyor of the changes that were noted after the report was submitted and could not upload the revised version of the investigation. The new version omitted LPN E interview and did not include RN B's progress note nor an interview. When asked if R1's Resident Representative was interviewed regarding his complaint, the NHA stated, No and explained that R1's Resident Representative just mentioned when he returned was at the facility (upon R1's readmission on 2/27/23 at approximately 2:26 PM) that he would like to know what happened to R1. During an interview and record review on 3/16/23 at 1:40 PM, the Director of Nursing and the Unit Manager, LPN A was asked when they became aware that R1 had fractured her leg and required surgery, both responded that LPN D first notified them during the morning meeting. UM, LPN A stated LPN D came in to tell us and wanted to know if she should wait for x-ray to come to the facility or send her. UM, LPN A stated that R1 had unrelieved pain and signs of a serious injury, so the doctor was notified and R1 was transferred to the emergency room . When asked how the facility became aware of the leg fracture, UM, LPN A stated the hospital called and needed to know what R1 had eaten for breakfast because she needed surgery. When asked if the NHA was aware of this as well, UM, LPN A and the DON stated yes, and indicated that the NHA was also in the morning meeting. When asked when the facility started to investigate the injury of unknown origin, both responded right away. The surveyor confirmed by asking if that was the morning of 2/23/23 after the hospital called the facility and both responded yes. The DON and the UM, LPN A was asked if the facility did a root cause analysis of R1's fall on 2/22/23 and circumstances surrounding the fall. Both stated the follow up portion of the fall investigation was not completed and therefore nothing more could be provided for review. The UM, LPN A stated that contributing factors to the fall were identified as combative behaviors with care which can change by the minute. The facility investigation submitted to the State Agency on 3/3/23 at 12:03 PM reflected, On 3/1/23, (Name of Dr. K), followed up with (Name of R1) and reviewed her hospital records. She had a displaced comminuted left intertrochanteric fracture, osteopenia, and degenerative changes. Intramedullary nail fixation was completed. (Name of Dr. K) also stated that with these conditions, abnormal posture, abnormalities of gait and other comorbidities, it is plausible that the fracture could have occurred during routine care or transfer. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation submitted to the State Agency on 3/3/23 at 12:03 PM reflected, Conclusion: Based on schedule review, interviews with team members, review of clinical medical record and diagnosis, a decisive decision was made that the allegation of mistreatment was refuted by evidence collected during the investigation. The NHA provided the following hospital records for review: -According to the Femur X-ray dated 2/23/23 at 1:22 PM reflected, Impression 1. Displaced comminuted left intertrochanteric fracture. 2. Osteopenia (weakened bone) and degenerative changes. -According to the Wound Summary in the hospital records dated 2/23/23 reflected an abrasion to the anterior (front) knee that was covered with a bandaid upon arrival from the facility. -According to the Fixation Left Hip IM Nail (L) Operative Noted dated 2/23/23 at 3:35 PM reflected, Based on the tension required for reduction with traction, I suspect the fracture is greater than 24 hours. It may coincide with the abrasion noted on her left knee in terms of timing. During a telephone interview on 3/14/23 at 5:50 PM, LPN C stated that she was assigned to R1's care from 6:00 PM on 2/22/23 until 6:00 AM on 2/23/23. LPN C stated that she was unaware of R1's new hip swelling, increased pain, and X-ray order. LPN C stated that she did not recall that R1's change in condition was reported to her in the shift-to-shift report and had she known, she would have specifically assessed R1 for that. LPN C stated that no X-rays were taken during her shift. When asked if she was interviewed during the facility investigation, LPN C stated, No. According to the late entered progress note entered on 2/26/23 for 2/22/23, the note would not have been there for LPN C to view since it was documented after her shift. During a telephone interview on 3/15/23 at 1:45 PM, CNA H stated that she worked from 10:00 PM on 2/22/23 until 6:00 AM on 2/23/23 and was assigned to R1. CNA H stated that R1 complained about her left leg hurting and she noticed an abrasion on R1's left knee. CNA H stated that she assumed R1 hit her knee on the TV that swings out from the wall over the bed on a long extending bracket. When asked if she was interviewed during the facility investigation, CNA H stated, No. There were no pain medications signed out on the February MAR for R1 during this night shift. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 3/17/23 at 5:20 PM, the Surveyor asked how the facility decided which residents to interview regarding the injury of unknown injury, the NHA stated, they interviewed residents just on R1's unit that had a BIMs of 8 or greater. The current census of the building was 96 and the facility interviewed just 10 residents regarding abuse and falls. When asked how cognitive impaired residents were assessed or interviewed, the NHA stated that staff were asked about changes in those residents. When asked if there were any documents to review that this took place, the NHA stated, No. The nursing progress notes reflected that R1 returned to the facility on [DATE] at 2:26 PM. The facility incident submission was dated 2/27/23 at 6:56 PM, which was 4 1/2 hours after the NHA received the complaint from R1's Resident Representative. The facility policy reflected all serious injuries of unknown origin will be reported within 2 hours to the State Agency. When asked how and when the NHA became aware of R1's fractured leg, the NHA stated twice for clarity that she was not aware until 2/27/23 that R1 was being readmitted to the facility, asked the receptionist to look up the online hospital records and discovered that R1 sustained a left femur fracture with surgical repair, which was just before R1 arrived back to the facility. Many of the staff including the DON, UM, LPN A, RN B, LPN D, and CNA I all reported to the Surveyor that they were aware that R1 sustained a serious injury of unknown origin on 2/23/23 which was 4 days before the NHA (the facility's Abuse Coordinator) reported it to the State Agency.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 This citation pertains to intake number MI00134976 and MI00135157. Based on observations, interview, and record review the facility failed to update and revise care planned interventions for 3 residents, Resident #1 (R1), Resident #2 (R2), and Resident #3 (R3) reviewed for care plans. This deficient practice resulted in plans of care not being followed by staff for R1 who sustained a fractured leg during a fall, R2 sustaining repeated falls with minor injury and R3 sustaining falls with lacerations. Findings include: R1 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of (but not limited to) Alzheimer's/Dementia (short- and long-term memory impairment), stroke with left sided weakness, osteoarthritic, and a left femur (leg) fracture with surgical repair. Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which represented R1 had severe cognitive impairment. R1 required extensive staff assistance of 1-2 with all activities of daily living. During an interview on 3/14/23 at approximately 2:20 PM, CNA F stated she worked on 2/22/23 from 2:00 PM to 10:00 PM and was assigned to R1. CNA F stated the previous shift reported that R1 repeatedly asked to go to the bathroom and had increased behaviors. CNA F stated that approximately 2:15 PM, she observed R1 in her room by the closet doors, seated in her wheelchair. CNA F stated that R1 was visibly upset and swinging her arms about. CNA F stated that R1 grabbed her shirt and when she attempted to back up away from R1, R1 slid forward out of the wheelchair. CNA F stated that R1 had her bottom off the wheelchair seat, her left leg caught up in the footrest behind her and her right foot forward. CNA F stated she called out for help and CNA G entered the room. CNA F stated together they lifted R1 off the floor and back into the wheelchair, pushed the wheelchair over to the bed and then transferred R1 into bed. CNA F stated that R1 remained upset and combative with the CNA F and CNA G. During a telephone interview on 3/15/23 at 2:54 PM, CNA G stated that she worked 2:00 PM until 10:00 PM on 2/22/23. CNA G stated that about 2:15 PM, she was passing waters in the hallway when she heard CNA F call out for help. CNA F stated that she entered R1's room and observed R1 in front of her wheelchair (facing her with her bottom off the seat), slid down resting on her own legs, on the floor and next to the closet door. CNA G stated that R1 was fighting them. Both CNAs lifted R1 and placed her back into the wheelchair. CNA G stated that they moved R1 next to the bed and transferred R1 into bed. When asked about R1's behavior and response during this process, CNA G stated that R1 continued to swing her arms at them, yelling and swearing at them. CNA G stated that they felt it was better to put her into bed then to leave her up in the wheelchair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Risk for Changes in Mood and Behavior care plan dated 10/11/18 reflected interventions such as, Remove self if resident is safe and find another staff member to assist. Remove self from situation if resident is safe and come back later to attempt care. Date Initiated: 12/24/18. Review of the Resistant to Care plan of care dated 2/21/18 reflected interventions such as, If resident resists with ADL's (activities of daily living), ensure safe environment, leave, and return 5-10 minutes later and try again. Dated Initiated: 2/21/22 and Praise the resident when behavior is appropriate. Date Initiated: 2/21/22. During an interview and record review on 3/16/23 at 1:40 PM, the Director of Nursing and the Unit Manager (UM), LPN A was asked if the facility did a root cause analysis of R1's fall and circumstances surrounding the fall. Both stated the follow up portion of the fall investigation was not completed and therefore nothing more could be provided for review. The UM, LPN A stated that contributing factors to the fall were identified as combative behaviors with care which can change by the minute. When asked what the facility's expectation was for staff who are attempting to provide care to a combative resident, and the DON stated we educate on how to handle residents with behaviors and do not expect staff to provide care until the behavior subsides. The DON stated it's not good for the resident nor the staff. Both agreed that the staff should ensure the resident is safe and then reapproach. The UM, LPN A stated the care plan was changed from a 1-person physical assist to 2 person assist. When asked if there were any changes or education for the staff regarding behavior management, both stated, no. According to the care plans there were no updates regarding behavior management. R2 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R2 admitted to the facility on [DATE] with diagnosis of (but not limited to) Dementia (short- and long-term memory impairment), heart failure, and chronic kidney disease. Brief Interview for Mental Status (BIMS) reflected a score of 3 out of 15 which represented R2 had severe cognitive impairment. R2 required extensive staff assistance all activities of daily living. During an interview and observation on 3/15/23 at 11:08 AM, R2 was seated on the side of his bed, dressed in a t-shirt and a brief. R2 had dressing to his feet and was wearing oxygen. The Surveyor attempted to interview R2, but he was unable to answer any specific questions. The care plan for Mobility dated 1/19/23 was reviewed and reflected the following intervention that included (but not limited to), The resident is totally dependent on 2 staff for transferring. Date initiated: 1/19/23. The care plan for Falls dated 1/19/23 was reviewed and reflected the following interventions that included (but not limited to), Be sure call light is within reach, provide cueing and reminders for use as appropriate due to level of cognition. Date initiated: 1/19/23. Floor mat on floor next to bed when in bed. Date initiated: 1/23/23. Follow facility fall protocol. Dated initiated: 1/19/23. Frequent rounding and offering toileting throughout the night. Date initiated: 3/6/23 . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 3/16/23 at 1:40 PM, R2's progress notes, neurological checks, post fall documents, care plans and 72-hour post fall documentation was reviewed from 1/21/23 - 3/1/23, with the DON and UM, LPN A. UM, LPN A stated that after a fall occurs the nurses will do Alert Charting each shift for 72 hours following the fall to assess and monitor for latent signs, symptoms and injuries of the fall. UM, LPN A stated the nurses are aware of which residents to chart on because it is kept in the Alert Charting Binder. R2 sustained 5 falls in a 5 1/2 week period and the following is a timeline according to the documents provided for review: #1 - 1/21/23 at 6:20 AM, R2 was observed on the floor, beside his bed. R2 was not able to answer any questions related to the fall and had no initial injuries. The immediate intervention was to lower the bed and provide nonskid socks. #2 - 1/22/23 at 3:00 AM, R2 was observed on the floor and R2 was not able to answer questions regarding the fall. There was no indication that ROM was assessed according to the fall report. The root cause was not identified, the immediate action was left blank and there was no indication of the 72-hour follow-up monitoring in the progress notes. Both the DON and UM, LPN A confirmed there were missing documents and assessments. #3 - 2/6/23 at 7:00 AM, R2 was observed on the floor next to the bed. R2 stated, I slipped off the bed. R2 was alert but confused and sustained an abrasion to the top of the scalp. The report reflected a sleep log was initiated but neither the DON nor UM, LPN A could locate it for review. There was no 72-hour follow-up monitoring documented for 2/8/23 and 2/9/23 to review. There were no updates or changes made to the care plan following this fall. #4 - 2/12/23 at 10:30 AM, R2 was observed on the floor and stated he was trying to get out. No new interventions were added to the care plan and there was no 72-hour follow-up monitoring documented for 2/13/23, 2/24/23, and 2/15/23 to review. #5 - 3/1/23 at 4:11 AM, R2 was observed on the floor beside of the bed. R2 was confused and unable to answer questions regarding the fall. There was no root cause identified, no immediate intervention identified, no documented notification of the doctor or the Resident Representative, and no documented 72-hour follow-up monitoring in the progress notes for 3/2/23, 3/3/23 and 3/4/23. The intervention of frequent rounding and offering toileting throughout the night was added to the care plan 5 days later, on 3/6/23. Both the DON and the UM, LPN A identified that the required documentation for falls is not being completed by the staff and stated they would be doing further education on that. R3 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R3 admitted to the facility on [DATE] with a readmitted [DATE] with diagnosis of (but not limited to) schizoaffective disorder (hearing voices), obsessive compulsive behavior, and muscle weakness. Brief Interview for Mental Status (BIMS) reflected a score of 0 out of 15 which represented R3 had severe cognitive impairment. R3 required extensive staff assistance all activities of daily living. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 3/15/23 at 11:25 AM, R3 was reclined in his bed under the blankets. R3 verbalized that he is hard of hearing. R3 had sutures to his right eyebrow and the bridge of his nose. R3 reported that he fell and hurt himself. When asked specific questions regarding the falls, R3 was not able to answer. There was no visible call light noted and when R3 was asked if he had one, R3 pointed to the wall behind him and stated, Back there. The call light cord extended from the wall and lead up under the blankets. R3 was unable to locate it after being cued that it was under his blanket. The care plan for Falls dated 1/3/23 reflected the following interventions of, Be sure call light is within reach, provide cueing and reminders for use as appropriate due to level of cognition. Date initiated: 1/3/23. Medication review r/t (related to) increase ADLs (activities of daily living) needs. Date initiated: 2/24/23 . Anticipate and meet resident's needs. Date created 3/14/23. During an interview and record review on 3/16/23 at 1:40 PM, all fall related documentation was reviewed with the DON and UM, LPN A for R3's falls from 1/19/23 to 3/7/23. The following is a timeline: #1 - 1/19/23 at 6:30 PM, R3 was observed crawling on the floor in the hall. R3 stated that he had fallen out of bed trying to get away from the voices. UM, LPN A stated she recalled R3 being extremely fearful and unable to manage, so R3 was subsequently sent to the ER and returned on 1/21/23. #2 - 2/23/23 at 11:45 AM, R3 was observed on the floor, flat on his back. R3 sustained a laceration to the right scalp that measured 1.8 cm x 0.4 cm x 0.3 that required a visit to the ER to close it. R3 was unable to answer questions regarding the fall. There was no root cause identified on the fall report and UM, LPN A was unable to locate the documentation for review. There was no 72-hour documentation and monitoring to review for 2/24/23 the day after the fall with injury. UM, LPN A confirmed there was no monitoring of for 2/24/23 located in the progress notes. #3 - 3/7/23 at 4:29 PM, R3 was observed by staff leaning forward in his wheelchair and fell on to the floor. R3 sustained a laceration to the right eyebrow and the nose. R3 was sent to ER to have the wounds sutured and returned the same day. UM, LPN A confirmed by searching the progress notes that no 72-hour follow-up and monitoring was done for 3/8/23, 3/9/23 or 3/10. The DON stated the root cause was the resident leaning forward in the wheelchair, possibly sleeping and stated the facility implemented a high back wheelchair to be used. This intervention was not located on the care plan, so the DON added it during this interview.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 This citation pertains to intake number MI00134976 and MI00135157. Based on observations, interview, and record review the facility failed to assess, monitor, and prevent falls for 3 residents, Resident #1 (R1), Resident #2 (R2), and Resident #3 (R3), reviewed for falls. The deficient practice resulted in R1 sustaining a leg fracture and delay in treatment after a fall went unreported and no preventative measures put in place to prevent reoccurrence. R2 and R3 sustained repeated falls with the lack of follow-up assessments to thoroughly monitor and prevent further falls. Findings include: R1 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of (but not limited to) Alzheimer's/Dementia (short- and long-term memory impairment), stroke with left sided weakness, osteoarthritic, and a left femur (leg) fracture with surgical repair. Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which represented R1 had severe cognitive impairment. R1 required extensive staff assistance of 1-2 with all activities of daily living. During an interview on 3/14/23 at approximately 2:20 PM, CNA F stated she worked on 2/22/23 from 2:00 PM to 10:00 PM and was assigned to R1. CNA F stated the previous shift reported that R1 repeatedly asked to go to the bathroom and had increased behaviors. CNA F stated that approximately 2:15 PM, she observed R1 in her room by the closet doors, seated in her wheelchair. CNA F stated that R1 was visibly upset and swinging her arms about. CNA F stated that R1 grabbed her shirt and when she attempted to back up away from R1, R1 slid forward out of the wheelchair. CNA F stated that R1 had her bottom off the wheelchair seat, her left leg caught up in the footrest behind her and her right foot forward. CNA F stated she called out for help and CNA G entered the room. CNA F stated together they lifted R1 off the floor and back into the wheelchair, pushed the wheelchair over to the bed and then transferred R1 into bed. CNA F stated that R1 remained upset and combative with the CNA F and CNA G. CNA F stated she did not report the fall/incident to R1's nurse. CNA F stated that she did not know that was considered a fall and did not report the incident until she was interviewed by the NHA on 2/27/23. CNA F stated that she received education and discipline for not reporting the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 3/15/23 at 2:54 PM, CNA G stated that she worked 2:00 PM until 10:00 PM on 2/22/23. CNA G stated that about 2:15 PM, she was passing waters in the hallway when she heard CNA F call out for help. CNA F stated that she entered R1's room and observed R1 in front of her wheelchair (facing her with her bottom off the seat), slid down resting on her own legs, on the floor and next to the closet door. CNA G stated that R1 was fighting them. Both CNAs lifted R1 and placed her back into the wheelchair. CNA G stated that they moved R1 next to the bed and transferred R1 into bed. When asked about R1's behavior and response during this process, CNA G stated that R1 continued to swing her arms at them, yelling and swearing at them. CNA G stated that they felt it was better to put her into bed then to leave her up in the wheelchair. CNA G stated that she also received education and discipline for not reporting the fall. Review of the Risk for Changes in Mood and Behavior care plan dated 10/11/18 reflected interventions such as, Remove self if resident is safe and find another staff member to assist. Remove self from situation if resident is safe and come back later to attempt care. Date Initiated: 12/24/18. Review of the Resistant to Care plan of care dated 2/21/18 reflected interventions such as, If resident resists with ADL's (activities of daily living), ensure safe environment, leave, and return 5-10 minutes later and try again. Dated Initiated: 2/21/22 and Praise the resident when behavior is appropriate. Date Initiated: 2/21/22. The NHA provided a copy of the incident/accident report dated 2/24/23 for R1's fall on 2/22/23 at approximately 2:15 PM for review. The facility's incident report was not updated after further details of the fall circumstances were discovered on 2/27/23 during CNA F and CNA G's interviews. The report did not identify the root cause of the fall nor any interventions to prevent future falls from reoccurring. During an interview and record review on 3/16/23 at 1:40 PM, the Director of Nursing and the Unit Manager (UM), LPN A was asked if the facility did a root cause analysis of R1's fall and circumstances surrounding the fall. Both stated the follow up portion of the fall investigation was not completed and therefore nothing more could be provided for review. The UM, LPN A stated that contributing factors to the fall were identified as combative behaviors with care which can change by the minute. When asked what the facility's expectation was for staff who are attempting to provide care to a combative resident, and the DON stated we educate on how to handle residents with behaviors and do not expect staff to provide care until the behavior subsides. The DON stated it's not good for the resident nor the staff. Both agreed that the staff should ensure the resident is safe and then reapproach. The UM, LPN A stated the care plan was changed from a 1-person physical assist to 2 person assist. When asked if there were any changes or education for the staff regarding behavior management, both stated, no. According to the care plans there were no updates regarding behavior management. R2 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R2 admitted to the facility on [DATE] with diagnosis of (but not limited to) Dementia (short- and long-term memory impairment), heart failure, and chronic kidney disease. Brief Interview for Mental Status (BIMS) reflected a score of 3 out of 15 which represented R2 had severe cognitive impairment. R2 required extensive staff assistance all activities of daily living. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview and observation on 3/15/23 at 11:08 AM, R2 was seated on the side of his bed, dressed in a t-shirt and a brief. R2 had dressing to his feet and was wearing oxygen. The Surveyor attempted to interview R2, but he was unable to answer any specific questions. The care plan for Mobility dated 1/19/23 was reviewed and reflected the following intervention that included (but not limited to), The resident is totally dependent on 2 staff for transferring. Date initiated: 1/19/23. The care plan for Falls dated 1/19/23 was reviewed and reflected the following interventions that included (but not limited to), Be sure call light is within reach, provide cueing and reminders for use as appropriate due to level of cognition. Date initiated: 1/19/23. Floor mat on floor next to bed when in bed. Date initiated: 1/23/23. Follow facility fall protocol. Dated initiated: 1/19/23. Frequent rounding and offering toileting throughout the night. Date initiated: 3/6/23 . During an interview and record review on 3/16/23 at 1:40 PM, R2's progress notes, neurological checks, post fall documents, care plans and 72-hour post fall documentation was reviewed from 1/21/23 - 3/1/23, with the DON and UM, LPN A. UM, LPN A stated that after a fall occurs the nurses will do Alert Charting each shift for 72 hours following the fall to assess and monitor for latent signs, symptoms and injuries of the fall. UM, LPN A stated the nurses are aware of which residents to chart on because it is kept in the Alert Charting Binder. R2 sustained 5 falls in a 5 1/2 week period and the following is a timeline according to the documents provided for review: #1 - 1/21/23 at 6:20 AM, R2 was observed on the floor, beside his bed. R2 was not able to answer any questions related to the fall and had no initial injuries. The immediate intervention was to lower the bed and provide nonskid socks. #2 - 1/22/23 at 3:00 AM, R2 was observed on the floor and R2 was not able to answer questions regarding the fall. There was no indication that ROM was assessed according to the fall report. The root cause was not identified, the immediate action was left blank and there was no indication of the 72-hour follow-up monitoring in the progress notes. Both the DON and UM, LPN A confirmed there were missing documents and assessments. #3 - 2/6/23 at 7:00 AM, R2 was observed on the floor next to the bed. R2 stated, I slipped off the bed. R2 was alert but confused and sustained an abrasion to the top of the scalp. The report reflected a sleep log was initiated but neither the DON nor UM, LPN A could locate it for review. There was no 72-hour follow-up monitoring documented for 2/8/23 and 2/9/23 to review. #4 - 2/12/23 at 10:30 AM, R2 was observed on the floor and stated he was trying to get out. No new interventions were added to the care plan and there was no 72-hour follow-up monitoring documented for 2/13/23, 2/24/23, and 2/15/23 to review. #5 - 3/1/23 at 4:11 AM, R2 was observed on the floor beside of the bed. R2 was confused and unable to answer questions regarding the fall. There was no root cause identified, no immediate intervention identified, no documented notification of the doctor or the Resident Representative, and no documented 72-hour follow-up monitoring in the progress notes for 3/2/23, 3/3/23 and 3/4/23. The intervention of frequent rounding and offering toileting throughout the night was added to the care plan 5 days later, on 3/6/23. Both the DON and the UM, LPN A identified that the required documentation for falls is not being completed by the staff and stated they would be doing further education on that. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/15/23 at 11:12 AM, when asked which residents on her assignment were identified as high risk for falls, RN L identified two other residents and did not identify R2 as high risk. During an interview on 3/15/23 at 11:20 AM, CNA M and CNA N were asked which residents on their assignment were high risk for falls and both identified three residents on the hall and did not identify R2 as high risk. R3 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R3 admitted to the facility on [DATE] with a readmitted [DATE] with diagnosis of (but not limited to) schizoaffective disorder (hearing voices), obsessive compulsive behavior, and muscle weakness. Brief Interview for Mental Status (BIMS) reflected a score of 0 out of 15 which represented R3 had severe cognitive impairment. R3 required extensive staff assistance all activities of daily living. During an interview and observation on 3/15/23 at 11:25 AM, R3 was reclined in his bed under the blankets. R3 verbalized that he is hard of hearing. R3 had sutures to his right eyebrow and the bridge of his nose. R3 reported that he fell and hurt himself. When asked specific questions regarding the falls, R3 was not able to answer. There was no visible call light noted and when R3 was asked if he had one, R3 pointed to the wall behind him and stated, Back there. The call light cord extended from the wall and lead up under the blankets. R3 was unable to locate it after being cued that it was under his blanket. The care plan for Falls dated 1/3/23 reflected the following interventions of, Be sure call light is within reach, provide cueing and reminders for use as appropriate due to level of cognition. Date initiated: 1/3/23. Medication review r/t (related to) increase ADLs (activities of daily living) needs. Date initiated: 2/24/23 . Anticipate and meet resident's needs. Date created 3/14/23. During an interview and record review on 3/16/23 at 1:40 PM, all fall related documentation was reviewed with the DON and UM, LPN A for R3's falls from 1/19/23 to 3/7/23. The following is a timeline: #1 - 1/19/23 at 6:30 PM, R3 was observed crawling on the floor in the hall. R3 stated that he had fallen out of bed trying to get away from the voices. UM, LPN A stated she recalled R3 being extremely fearful and unable to manage, so R3 was subsequently sent to the ER and returned on 1/21/23. #2 - 2/23/23 at 11:45 AM, R3 was observed on the floor, flat on his back. R3 sustained a laceration to the right scalp that measured 1.8 cm x 0.4 cm x 0.3 that required a visit to the ER to close it. R3 was unable to answer questions regarding the fall. There was no root cause identified on the fall report and UM, LPN A was unable to locate the documentation for review. There was no 72-hour documentation and monitoring to review for 2/24/23 the day after the fall with injury. UM, LPN A confirmed there was no monitoring of for 2/24/23 located in the progress notes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	#3 - 3/7/23 at 4:29 PM, R3 was observed by staff leaning forward in his wheelchair and fell on to the floor. R3 sustained a laceration to the right eyebrow and the nose. R3 was sent to ER to have the wounds sutured and returned the same day. UM, LPN A confirmed by searching the progress notes that no 72-hour follow-up and monitoring was done for 3/8/23, 3/9/23 or 3/10. The DON stated the root cause was the resident leaning forward in the wheelchair, possibly sleeping and stated the facility implemented a high back wheelchair to be used. This intervention was not located on the care plan, so the DON added it during this interview. During an interview on 3/15/23 at 11:33 AM, when asked which residents on her assignment were high risk for falls, RN O pulled out her report sheet and identified two residents that were marked high risk for falls and did not identify R3 as high risk.

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F 0697 Level of Harm - 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** 31197 This citation pertains to intake number MI00134976 and MI00135157. Based on observation, interview, and record review, the facility failed to accurately assess a new onset of swelling with pain and monitor pain for 1 resident, Resident #1 (R1) reviewed for pain management. This deficient practice resulted in R1 sustaining prolonged sever pain and suffering when the extent and origin of a new onset of left hip swelling and increased pain was not thoroughly assessed caused a delay in treatment and surgery to occur. Findings include: R1 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of (but not limited to) Alzheimer's/Dementia (short- and long-term memory impairment), stroke with left sided weakness, osteoarthritic, and a left femur (leg) fracture with surgical repair. Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which represented R1 had severe cognitive impairment. R1 required extensive staff assistance of 1-2 with all activities of daily living. According to the Pain Care Plan dated 9/22/18 last revised on 6/11/19 reflected a focus area of pain related to stroke residual pain. The Pain Care Plan had just two interventions listed. -The resident's pain is aggravated by sitting to long on coccyx. Last revised on 9/22/18. -The resident's pain is alleviated/relieved by repositioning often. Last revised on 9/22/18. According to the February Medication Administration Record (MAR) reflected the following as needed pain medications given on 2/22/23: -Norco Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 0.5 tablet by mouth every 8 hours as needed for pain. On 2/22/23 it was signed out at 9:49 AM by Registered Nurse (RN) B for a pain level of 5 (moderate) and once more at 8:36 PM by Licensed Practical Nurse (LPN) C for a pain level of 5. -Acetaminophen Tablet 325 MG, give 2 tablets by mouth every 4 hours as needed for General Discomfort. There were no doses signed out as given on 2/22/23. Record review of the X-ray order for a 2 View Left Hip and Pelvis Dx (diagnosis) Pain Created by (name of RN B) on 2/22/23 at 1408 (2:08 PM) Revised by (name of RN B) on 2/22/23 at 1408 (2:08 PM) Signed by (name of Provider) on 2/22/23 at 17:47 (5:47 PM) (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/14/23 at approximately 2:20 PM, CNA F stated she worked on 2/22/23 from 2:00 PM to 10:00 PM and was assigned to R1. CNA F stated the previous shift reported that R1 repeatedly asked to go to the bathroom and had increased behaviors. CNA F stated that approximately 2:15 PM, she observed R1 in her room by the closet doors, seated in her wheelchair. CNA F stated that R1 was visibly upset and swinging her arms about. CNA F stated that R1 grabbed her shirt and when she attempted to back up away from R1, R1 slid forward out of the wheelchair. CNA F stated that R1 had her bottom off the wheelchair seat, her left leg caught up in the footrest behind her and her right foot forward. CNA F stated she called out for help and CNA G entered the room. CNA F stated together they lifted R1 off the floor and back into the wheelchair, pushed the wheelchair over to the bed and then transferred R1 into bed. CNA F stated that R1 remained upset and combative with the CNA F and CNA G. CNA F stated she did not report the fall/incident to R1's nurse. CNA F stated that she did not know that was considered a fall and did not report the incident until she was interviewed by the NHA on 2/27/23. A record review the progress note dated 2/26/23 at 1:50 PM, entered late for 2/22/23 (4 days later) at 2:44 PM, written by RN B was reviewed. The note reflected, Late Entry: Note Text: CNA notified nurse that resident was having pain to her left hip. Resident would not allow CNA to get her out of bed d/t (due to) the pain she was having. Nurse assessed bilateral hips. Minimal swelling noted to the left side compared to the right. Nurse administered PRN pain medication at that time and notified on call physician of findings NP ordered an x-ray to be completed for her left hip and pelvis. Nurse faxed order over to (name of company) Diagnostics. During a telephone interview on 3/15/23 at 11:55 AM, this surveyor read the progress note written RN B on 2/26/23 to her. When asked why the progress was entered on 2/26/23 for an assessment done on 2/22/23 (4 days later), RN B stated she worked 6:00 AM - 6:00 PM on 2/26/23 and it was her first day back after being off. RN B stated she heard from other staff members that R1 had sustained a fractured hip and was hospitalized . When asked if R1's ROM (range of motion) was assessed, RN B stated, No, not unless it's indicated. She (R1) would barely let me touch it. RN B stated she medicated R1 with Norco, but the MAR reflected that Norco was signed out at 9:49 AM and rated the pain at a 5 for moderate pain. This was inconsistent with RN B statement that R1 would barely let me touch it. No other pain medication was signed out as given until 8:36 PM (11 hours later). When asked why the progress note and the X-ray order were done after 2 PM when the Norco was given at 9:49 AM, RN B stated she was behind in her charting. When asked if she reassessed R1 during the remainder of her shift and RN B stated, Nothing more on my shift. When asked why R1's Resident Representative was not notified to of the new onset of joint swelling with increase in pain and to obtain permission for the X-ray, RN B stated, I wasn't thinking about that at the time, and you don't need permission to order an X-ray. When asked about the assessment finding that R1 wouldn't allow you to touch her, why the X-ray wasn't ordered STAT instead of routine, RN B stated, That's the way the doctor ordered it. When asked if the new onset of swelling and pain along with the pending X-ray was reported in the shift-to-shift report with LPN C on 2/26/23 at 6:00 PM, RN B stated, Yes. During a telephone interview on 3/14/23 at 5:50 PM, LPN C stated that she was assigned to R1's care from 6:00 PM on 2/22/23 until 6:00 AM on 2/23/23. LPN C stated that she was unaware of R1's new hip swelling, increased pain, and X-ray order. LPN C stated that she did not recall that R1's change in condition was reported to her in the shift-to-shift report and had she known she would have specifically assessed R1 for that. LPN C stated that no X-rays were taken during her shift. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 3/15/23 at 1:45 PM, CNA H stated that she worked from 10:00 PM on 2/22/23 until 6:00 AM on 2/23/23 and was assigned to R1. CNA H stated that R1 complained about her left leg hurting and she noticed an abrasion on R1's left knee. CNA H stated that she assumed R1 hit her knee on the TV that swings out from the wall over the bed on a long extending bracket. According to the February MAR, no pain medication was provided on the night shift. During an interview on 3/14/23 at 2:35 PM, LPN D stated she worked the day shift 2/23/23 and started at 6:00 AM. LPN D stated that early in the shift CNA I reported that R1 had pain and refused to get up. LPN D stated she went to assess her right away. LPN D stated, I saw her (R1) leg inverted, jacked up, and swollen. I called the doctor and sent her to ER about 9:30 AM. When asked what R1's pain level was, LPN D stated that she did not attempt ROM and rated R1's pain a 10 on 10 pain scale which was severe. LPN D stated it took 4 people to lift R1 onto the EMS cart when they arrived and R1 really cried out when then moved her. During an observation and interview on 3/15/23 at 12:15 PM, CNA I and CNA J reposition R1 in bed. R1 had visible discomfort with repositioning with mild facial grimacing noted. R1 had noted surgical wounds in different stages of healing on her left leg and an abrasion to the left knee approximately 2 cm x 1 cm. CNA I stated that she was assigned to R1 the morning of 2/23/23 when R1 was transferred to the hospital. CNA I stated that she knew right away that something was wrong with R1's hip from just looking at it, it was protruding and red. CNA I stated that she went to get the nurse right away. CNA I stated, I noticed a bandaid on her left knee that was new so, I pulled it back to see what was under it. According to the Femur X-ray dated 2/23/23 at 1:22 PM reflected, Impression 1. Displaced comminuted left intertrochanteric fracture . According to the Wound Summary in the hospital records dated 2/23/23 reflected an abrasion to the anterior (front) knee that was covered with a bandaid upon arrival from the facility. According to the Fixation Left Hip IM Nail (L) Operative Noted dated 2/23/23 at 3:35 PM reflected, Based on the tension required for reduction with traction, I suspect the fracture is greater than 24 hours. It may coincide with the abrasion noted on her left knee in terms of timing. During an interview and record review on 3/16/23 at 1:40 PM, the Director of Nursing and the Unit Manager, LPN A was asked about RN B's note that was a Late Entry on 2/26/23 for a pain assessment on 2/22/23 at 2:44 PM. Both the DON and UM, LPN A stated they were dissatisfied with RN B's note. Both agreed that the X-ray should have been ordered STAT and a call placed to R1's Resident Representative for notification and permission. UM, LPN A stated the nurse should always notify the manager or DON when ordering an X-ray, so no one is caught off guard. When asked if an assessment of increased joint swelling and pain should include a ROM assessment, both said yes and indicated it was their expectation to rate the pain level and do follow-up assessment regarding the pain.