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	07/26/2022

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on interview and record review, the facility failed to ensure Advance Directives were in place for two facility residents reviewed for Advance Directives (Residents (R)16 and R60), resulting in the potential for the wishes of the residents not being honored. Findings: R16 Review of the Minimum Data Set (MDS) dated [DATE] reflected R16 was originally admitted to the facility [DATE] with diagnosis that included: History of Stroke, Dementia, and diabetes Mellitus. The Brief Interview for Mental Status (BIMS) score reflected a score of 3 out of 15 which indicated R16 was severely cognitively impaired. Review of the Electronic Medical Record (EMR) for R16 reflected R16 had a legal guardian. Review of the EMR did not reveal an Advance Directive was in place for R16. The medical record reflected a Code Status of CPR. During an interview conducted [DATE] at 2:41 PM, Social Worker (SW) K reported nursing initiates the Advance Directive on admission. SW K reported that social workers act as a double check. SW K reported the Advance Directive gets reviewed at least yearly but is reviewed at Care Conference meetings. During this interview SW K reviewed the EMR of R16 and reported she could not find an Advance Directive. SW K reviewed the notes in the EMR and reported documentation that Advance Directive forms had been mailed to the guardian of R16 in March of 2022, June of 2020, and September of 2019. SW K reported the facility has not received a completed and signed AD back to date. R60 Review of the MDS dated [DATE] reflected R60 was originally admitted to the facility [DATE] and readmitted to the facility [DATE] with diagnoses that included: History of Stroke, Cancer, and Heart Failure. Section C of this MDS titled Cognitive Patterns reflected R60 was severely cognitively impaired. The EMR revealed R60 had a legal guardian. Review of the medical record did not reveal an Advance Directive was in place. The medical record reflected R60 had a code status of full code. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR Progress Notes revealed a Social Worker entry dated [DATE]. The entry reflected an Advance Directive was mailed to patient's representative today for completion. Review of the EMR Progress Notes did not reveal documentation that the completed form was received back by the facility or that the facility attempted any further follow up at Care Conferences.

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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** 39056 Based on interview and record review, the facility failed to notify the physician that a medication was not administered for 2 residents (Resident #21 and #49), resulting in the lack of assessment, monitoring, and documentation and the potential for the worsening of a condition and delay in treatment. Findings: Review of the Fundamentals of Nursing revealed, The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe that the orders are in error, violate agency policy, or are harmful to the patient. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 20717-20719). Elsevier Health Sciences. Kindle Edition. Resident #49 (R49) Review of an Admission Record revealed R49 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes. Review of R49's Physician Order revealed, NovoLOG Solution 100 UNIT/ML (Insulin Aspart) Inject 35 unit subcutaneously three times a day .Give three times daily prior to meals. Hold if blood sugars (less than) 70 and call provider if (greater than) 400. Review of R49's Progress Note for the Electronic Medication Administration Record (EMAR) dated 6/27/22 at 10:41 AM revealed the Novolog was not administered because Too close to previous dose. Review of R49's Progress Notes revealed no documentation that the physician was notified that the ordered medication was not administered. Review of R49's Progress Note for the EMAR dated 7/22/22 at 4:25 PM revealed the Novolog was not administered because Blood glucose 86. (Indicating the insulin was held and the ordered parameters were not followed.) Review of R49's Progress Notes revealed no documentation that the physician was notified that the ordered medication was not administered. Resident #21 (R21) Review of an Admission Record revealed R21 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes. Review of R21's Physician Order revealed, NovoLOG Solution 100 UNIT/ML (Insulin Aspart) Inject 15 unit subcutaneously with meals (No ordered parameters to hold the medication). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R21's Progress Note for the EMAR dated 6/22/22 at 12:43 PM revealed the Novolog was not administered because held insulin as resident refused lunch, sleeping todasy(sic). Review of R21's Progress Notes revealed no documentation that the physician was notified that the ordered medication was not administered. Review of R21's Progress Note for the EMAR dated 6/25/22 at 4:39 PM revealed the Novolog was not administered because of a blood sugar of 86. Review of R21's Progress Notes revealed no documentation that the physician was notified that the ordered medication was not administered. Review of R21's Progress Note for the EMAR dated 7/6/22 at 8:05 AM revealed the Novolog was not administered because of a blood sugar of 94. Review of R21's Progress Notes revealed no documentation that the physician was notified that the ordered medication was not administered. During an interview on 07/20/22 at 12:40 PM, Director of Nursing (DON) reported that the if a medication is being held without parameters the physician should be notified, a new order obtained, and a progress note written. During an interview on 07/21/22 at 11:31 AM, DON reported that nursing staff would be educated on medication administration/errors. DON verified that there was no documentation to verify that the physician was notified or that an order was obtained to hold the insulin for R21 and R49.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on interview and record review, the facility failed to timely and thoroughly investigate and address Resident Council grievance concerns and failed to ensure a caring environment, resulting in unmet care needs, frustration, and the potential for loss of self-worth for an elderly and vulnerable population that rely on staff for their physical and psychosocial needs. Findings; Review of the Resident Council Minutes from the meeting conducted March 30, 2022, reflected, New Business that listed resident complaints of Call light response at night - 3rd shift, Staff loud at night (plus) early morning, Rude staff answering lights - late 2nd (shift) (plus) 3rd (shift). Review of the Resident Council Minutes for April 2022 reflected, Old business -Review of Previous Meeting, Outstanding Issues and Resident Council Departmental Response Forms. The documentation reflected the Old Business to include, Call light Response (at) 3rd (shift) ongoing - all halls, Staff too loud (at) 3rd shift, Staff rude (at) night - ongoing - all halls. The Resident Council Minutes did not reflect any facility response to these concerns that were raised at the March Resident Council meeting or was any update documented that these concerns were being addressed. However, the April Resident Council minutes did reflect that Resident Rights were reviewed. Specific Resident Rights documented as reviewed were, Right to a Dignified Existence and Quality of life is maintained or improved. Review of the Resident Council Minutes for the meeting conducted May 25, 2022, reflected, Old Business of Staff approach - ongoing- grievance. The documentation of the Resident Council Minutes did not reflect that any update to the Resident Council's concerns was provided or that the facility had been taken any action to immediately address the concerns raised by facility residents to include Staff rude, Staff too loud, and Call light response during 3rd shift. Review of the Resident Council Minutes for the meeting conducted 6/29/22 did not reflected any documentation of the issues first raised by the facility residents 3/30/22 and were documented as ongoing in subsequent Resident Council Minutes. The Minimum Data Set (MDS) dated [DATE] for Resident (R)21 was reviewed. The MDS reflected R21 was originally admitted to the facility 9/14/18 with diagnoses that included: History of Stroke, Hemiparesis (weakness to one side of the body), and Parkinson's Disease (a degenerative disorder of the central nervous system). Review of the Brief Interview for Mental Status (BIMS) evaluation reflected a score of 15 out of 15 which indicated the Resident was cognitively intact. The MDS reflected R21 required extensive assistance with toileting and personal hygiene. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted 7/20/22 at 3:51 PM, R21 reported that he is the Resident Council President. R21 reported that he and other residents continue to have concerns with rude staff, loud staff during the night, and long call light response during 3rd shift. R21 reported that when night staff do respond to the call light the staff are, real nasty, like you're bothering them, and indicated staff will harshly say, what do you want?. R21 reported that once he was left on the toilet for an extended period. R21 reported that he continues to hear the same complaints from residents on all halls on the Resident Council and outside of the Resident Council. R21 reported he is often a night owl and will be in the halls. R21 reported he has observed staff gathered at the nurse's station playing on the phones and talking rude. R21 reported that the night staff are loud. R21 reported he had been told that the facility is working on it but it's not really any better. On 7/20/22 at 4:05 PM an interview was conducted with Activities Director (AD) E. AD E reported that she is the staff member that documents the Resident Council Minutes every month. AD E reported that if an issue is not resolved the following month, she will complete a grievance form and submit it to the Nursing Home Administrator (NHA). AD E reported that she filed a grievance on 5/25/22 regarding the issues the Resident Council has raised concerning the facility night staff which were first documented two months prior. The facility document titled Grievance and Satisfaction Form was reviewed. The directions at the top of the form revealed, Complete this form to report instances of grievance or satisfaction. This form will be used to document the instance and record follow up action taken, and resolution obtained. Use additional paper if needed. The top of the form is dated 5/25/22 and completed and signed by AD E. The form reflects that the information was received from Resident Council and the Grievance is described as Call light response - all halls (and) all shifts, staff noise level 3rd shift. The Grievance and Satisfaction Form did not reflect the ongoing resident concern of Rude staff. The form reflected it was received by the NHA and assigned to Nursing on 5/25/22. The Investigation section of the Grievance and Satisfaction form reflected nursing had entered the facility during the night (date unknown) to review call light response and noise level. The Resolution section of the form reflected, staff education provided regarding policy and procedure for call lights. Ongoing audits continue. The undated Resolution is signed by the Director of Nursing (DON). The Resolution signed by the DON did not reflect that the resident concerns of Rude staff and staff noise levels were addressed. On 7/20/22 at 1:48 PM an interview was conducted with the DON regarding the concerns of call light, staff rudeness, and staff noise on the night shift raised by the Resident Council. The DON reported that staff education on call lights and Resident Rights was rolled out recently. This week. The DON reported that there is a nursing supervisor that works the night shift but did not say how this supervisor could not know about the concerns of the residents or how night nursing supervision allowed the issue to rise to the level currently being addressed. The DON was asked if she had talked with any of the night staff about the complaints. The DON reported that staff had told her the concerns were not as severe as what had been reported by residents. The DON did not indicate that any resident interviews were conducted to investigate how severe and pervasive the complaints were throughout the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Copies of the documentation of the education and the call light audits completed in response to the grievance were provided by the DON. Review of the documentation reflected that the call light audits began on 7/19/22, the second day of the Annual Recertification Survey and approximately sixteen weeks from when the issues were first presented by the Resident Council to the facility. Review of the audit sheets reflected nineteen instances when call light responses was reviewed with eighteen of those instances occurring between 8:17 AM and 10:17 PM with one instance reviewed at 12:30 AM. The policy provided by the facility titled Policy / Procedure - Nursing Administration, Section: Resident Rights, Subject: Grievances, Updated 5/2/19 was reviewed. The document reflected, Policy: It is the policy of this facility to investigate all grievances registered by, or on behalf of a resident without the threat of reprisal in any form. The policy reflected, Procedure: .5. The Administrator or designee .shall confer with persons involved in the incident and other relevant persons and within three to seven days shall provide a written explanation .of findings and proposed remedies to the complainant and aggrieved party . 6. During the investigation, the facility will put in place immediate action to prevent potential violation of resident's rights. The policy further reflected that a written grievance would include the steps taken to investigate . The Process outlined by the facility policy reflected that, The Administrator should actively participate in the investigation and resolution but may delegate portions . This indicates that the NHA is providing oversight to the process. The facility policy reflects that the Administrator or designee .will make contact with the concerned party within 24 hours of being made aware of the grievance . The facility policy reflects a five-step process utilizing the acronym REACH (Recognize, Examine, Action, Conclusion, Happy Customers) to ensure a strong grievance process is in place. The facility policy reflected that the investigation must determine the root cause and that failure to accurately determine the root cause will inevitably affect satisfactory resolution of the grievance. Review of the job description for Certified Nurse Aide (CNA) provided by the facility, last revised 1/1/2020, reflected a summary that the CNA plays a critical role in providing superior customer service and nursing care to all Residents. Principal Duties and Responsibilities: in the facility job description include: Must answer call lights promptly and courteously, Fully understands all aspects of resident's rights, .interacts with (residents) in a manner that displays warmth, respect, and promotes a caring environment. Review of the job description provided by the facility for Charge Nurse - RN/ LPN last revised 1/1/2020, reflected in the Position Summary that the nurse ensures Residents receive quality care 24 hours a day. The job description reflects Principal Duties and Responsibilities to include: Monitor and assist CNA's, Know and support facility philosophy, standards, policies, procedures, must answer call lights ., treating Residents with dignity and respect, reporting suspected abuse or neglect and serve as a unit role model. While no direct allegation of abuse was documented by the facility review of the facility policy on Abuse and Neglect (last revised 6/17/19) reflects a definition of Neglect as . the failure to provide necessary and adequate (medical, personal, or psychological) care. The Abuse policy revealed Examples of Neglect which included, Ignoring call lights or cries for help. The Abuse policy continues with a list under the heading of Resident perceptions of abuse and/or neglect. This list included, 1. Being ignored or minimized .4. Staff not responding quickly when assistance is necessary, including poor response to call lights. As of survey exit no additions documentation was provided. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Council Minutes, the interview with the Resident Council President, and the documentation of the actions taken by the facility reveal widespread delay in responding to ongoing resident concerns of possible unmet care needs, possible violation of Resident Rights, and possible failure to perform duties and responsibilities. The demonstrated failure to follow the facility Grievance policy resulted in an incomplete investigation and no resolution to date of the issues first raised by residents as documented 3/30/22 in the Resident Council Minutes.

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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** 38659 Based on observation, interview, and record review, the facility failed to implement the comprehensive Care Plan for four residents (Residents (R)6, R17, R7, R38), resulting in anxiety with self-injurious behavior, the potential for aspiration of liquid nutrition and the potential for infection from an ill-maintained assistive breathing device and the potential for all facility residents to not have their comprehensive Care Plans implemented preventing them from reaching their highest level of function. Findings: R 6 Review of R6's face sheet dated 7/19/22 revealed they are a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: dementia, anxiety, heart failure and residual schizophrenia. R6 was not her own responsible party. On 07/18/22 at 10:50 AM, R6 was viewed in her room, she was staring blankly in a darkened room and sitting in her wheelchair. R6 had multiple sores on both sides of her face. They did not appear to be fresh, they were scabbed over and not bleeding. Blood was not observed on her hands, or bed sheets. R6 was asked what happened on face and she stated I'm not sure, maybe I dug at it with a screwdriver or something. On 07/18/22 at 12:20 PM, R6 was observed being assisted by staff D with her lunch tray after she put on her call light. On 7/19/22 at 11:30 AM, R6 was viewed in her room, laying in bed and awake. On 07/19/22 at 11:40 AM, an interview was completed with CNA (certified nursing assistant) C about R6's facial wounds. CNA C stated she has wounds that will heal up and then dig at them again. CNA C thought they put cream on them at times, but R6 often refuses. CNA C was not sure when the current wounds started. CNA C was also working on R6's hall the previous day. She could not recall if R6 had wounds at that time. On 07/19/22 at 11:42 AM an interview was completed with UM (unit manager) A. UM A stated, the last she knew the wounds on R6's face were healed. R6 has wounds intermittently on her face, it is anxiety related and R6 will dig and pick at her face. UM A stated interventions include activities such as giving her cardboard to tear or corn on the cob to pick at. The wound nurse practitioner will come in Thursdays for wound rounds and UM A rounds with them. R6 did not have any facial wounds as of last Thursday. Other interventions for R6 include topical creams, but they are not always tolerated. UM A stated that staff should put a skin note in if there was a new injury and she was not aware of a new injury or injuries to R6's face. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	On 07/19/22 at 04:10 PM, R6 was viewed in her wheelchair sitting in a darkened room with the door open. There were still no activities viewed in her room, she was viewed talking to herself and stated she was just talking to the pictures on the floor. On 07/20/22 at 09:16 AM, R6 was viewed in her darkened room, sitting in her wheelchair picking at her face. R6 said she just finished breakfast. A stuffed cat was viewed on the bed, the resident was not touching the cat. No other activities were viewed. On 07/20/22 at 09:29 AM an interview was completed with Activities Director (AD) E in reference to R6. AD E stated R6 is usually pleasant with staff, but never wants to come to group activities. AD E stated R6 likes tactile activities, like tearing cardboard and picking at corn cobs. Activities staff do involve R6 in some one on one activities with her roommate as well. AD E was asked what activities R6 has been provided this week. AD E stated she thought R6 was tearing up a tissue box at some point this week, but was unsure of any other activities. AD E stated no one has talked to her this week to reach out to R6 more with activities, but that she and 3 other activities staff round to get residents to group activities and offer individual activities. AD E stated R6 is usually in her chair in her room, she is very particular about having clutter or extra things in the room, so when bringing things they have to round back shortly to make sure she is done. AD E stated it is charted under tasks when staff round or do activities. It was discussed that not many activities or attempts to engage in activities are in R6's chart. AD E was informed R6 was recently doing some self injury behaviors again and staff had expressed that more activities would be explored. AD E reiterated that no one has reached out this week to do more things with R6, but will make sure the activities staff round more with her. On 07/20/22 at 11:52 AM, an interview was completed with UM A regarding R6. UM A stated she did not get a chance to talk to activities staff yesterday, but did talk to them now. UM A stated she personally did get R6 some cardboard to tear yesterday. Review of R6's care plan revealed a focus area with a last revised dated on 3/5/22 of an open lesion to R6's supra pubic regions and resident noted aggressively scratching that area when agitated. There is no note of facial lesions. Interventions included: Activities providing extra activities for tactile stimulation as tolerated. Another focus area with a last revised date of 1/11/22 revealed a history of skin injuries with an intervention that included observe skin daily with care activities. Report any changes in coloration, integrity, etc to nurse. An additional care area with the last revised date of 3/14/20 related to psychosocial well-being included interventions such as: provide in room activities of choice, as able. R6's care plan also noted she needed assistance with ADL (activities of daily living), such as transfers from the bed to wheelchair, toileting and personal hygiene, thus staff should be regularly interacting with her. Review of R6's kardex revealed the following under the section Activities: provide her with materials for individual activities as desired. The resident likes the following independent activities: watching TV (talk shows), tearing cardboard, visiting with staff, special snacks and Provide in room activities of choice, as able. Review of R6's activities log revealed, limited activities were logged in the last 30 days. Review of R6's activity log for July revealed no activities offered to R6 on 7/2, 7/3, 7/4, 7/11, 7/13, 7/15, 7/16 and 7/17/22. Other days had 1-2 activities offered. On 7/20/22 there were 8 activities offered. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of R6's skin assessment for 7/19/22 revealed 5 facial scabs measuring 1.4x0.7x0.1, 1x0.2x0.1, 1.5x0.5x0.1, 0.3x0.2x0.1 and 0.7x0.5x0.1 centimeters. Review of wound notes with encounter date of 7/14/22 revealed no active wounds. Past history of wounds are documented and included an abdominal wound, which had recently healed. There was a note from 12/9/2021 that referred to facial wounds due to R6 picking at her skin. Review of R6's progress notes revealed no recent mention of facial wounds prior to 7/19/22. A note on 7/19/22 at 12:04 PM by social services revealed: SS provided follow-up visit this morning. Resident was observed tearing cardboard and had a big smile on her face this morning. She told SS she was shredding cardboard which has been a preferred intervention of hers to avoid or minimize picking at her face. Resident noted that activities had just seen her and was bringing more cardboard for her to rip pieces from. Resident became frustrated when SS began asking her about picking at her face. To avoid more frustration, SS praised her for engaging in ripping cardboard and encouraged her to continue as this is something she voices enjoyment doing. Will continue to follow-up and offer support as needed or requested. A late entry general progress note was added on 7/20/22 and dated 7/19/22 at 10:54 AM: Resident provided with cardboard and cardstock for shredding by this nurse until able to be reviewed by activities director. Resident thankful for activity. An event note from 7/19/22 at 1:06 PM revealed: Nurse entered room and noticed 5 areas on residents face that were scabbed over, 2 areas noted on her left cheek, 1 on her nose, 1 on her chin and 1 on her right cheek. See skin obs for measurements. Resident states she picked at the skin on her face. Head to toe assessment completed, no additional self inflicted areas noted at this time. No c/o pain from resident. VS stable and at baseline. UM, DPOA, BCS and physician notified. Activities to assess for a tactile distraction for resident. A general progress note from 7/20/22 at 10:56 AM revealed: Discussed with Activities Director need to increase tactile activities for resident. Activities Director states she is aware and has provided items to her today and plans to assess further. A recreational services note on 7/20/22 at 12:10 PM revealed: Activities visited with Resident today to assess life enrichment options and preferences. Resident had pleasant affect and was sitting at her table waiting for lunch. Activities brought in multiple independent/tactile activities, per residents' preference. Resident initially refused most items in preference for cardboard to tear, but upon re-approach with basket to keep items in, accepted paper, cardboard, sensory putty, and coloring supplies. Resident refused offer to create a collage with ripped paper, both independently or with staff, as well as refused offer to go outside this afternoon. Historically, Resident has grown frustrated with keeping these items in her room for prolonged periods of time, so was reassured AD would follow up this afternoon. Resident expressed thankfulness at the end of today's visit. Activities will continue to monitor and encourage appropriate engagement. R17 Review of R17's face sheet dated 7/20/22 revealed they are a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Huntington's disease, muscle wasting and atrophy, cognitive communication deficit and adult failure to thrive. R17 was not her own responsible party. Review of R17's orders in their electronic medical records revealed an active order with a start date of 06/04/21: Elevate HOB (head of bed) 30-45 degrees during all feeding and flushes. Review of R17's care plan revealed a focus area of tube feeding. Interventions included: Keep HOB elevated 45 degrees during and thirty minutes after tube feed. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	On 07/20/22 at 09:20 AM, R17 was viewed in bed with their tube feed running, the head of the bed was at slight angle, but the resident's feet were also up, so they appeared to be laying flat. At 9:25 AM, UM A was asked to come to R17's room and note if there were any concerns. UM A stated his bed was not in the right position and confirmed his tube feed was running. UM A stated his bed is tilted at about 15 degrees, but it should be 30-45 degrees. UM A put the tube feeding on hold and went to get another staff member to assist with repositioning the resident. 31771 R7 Review of the Minimum Data Set (MDS) dated [DATE] reflected R7 was admitted to the facility 11/21/07 with diagnosis that included Traumatic Brain Dysfunction. Section K of this MDS titled Swallow/Nutrition Status revealed R7 received nutrition through a feeding tube. Review of the Doctor's Orders reflected directions for the administration of liquid nutrition through an enteral feeding. These directions included that the head of the bed was to be elevated at least 30 degrees during all feedings and flushes. Review of the Care Plan for R7 reflected the head of the bed was to be elevated 30 to 45 degrees during and 30 minutes after tube feedings. On 7/19/22 at 9:31 AM, R7 was observed in her bed with a tube feeding in progress by way of a pump at 70 cubic centimeters (cc) per hour. The head of the bed was observed to be raised approximately 30 degrees. However, the body of R7 was observed to be lower in the bed and with the Resident lying almost flat. On 7/20/22 at 9:15 AM, R7 was again observed to be positioned lower in the bed so that only the shoulders and head were against the head of the bed with the rest of the body flat. A tube feeding was in progress by way of a pump at 70 cc per hour. On 7/20/22 at 9:19 AM, Registered Nurse (RN) F was summoned to the room and asked if R7 was positioned correctly to be receiving nutrition through her feeding tube. RN F acknowledged that R7 was not positioned correctly to be receiving nutrition through her feeding tube. RN F suspended the infusion of liquid nutrition until the Resident could be moved to a position that prevented the risk aspiration of the liquid nutrition. R38 Review of the Minimum Data Set (MDS) dated [DATE] revealed R38 was admitted to the facility 6/17/21 with diagnoses that included Heart Failure and Respiratory Failure. On 7/18/22 at 10:49 AM, R38 was observed in bed wearing a nasal Continuous Positive Airway Pressure (CPAP) mask which was attached to an operating CPAP machine. The nasal CPAP mask appeared well used and was yellowing. R38 reported she did not know if her CPAP mask was ever cleaned. On 7/20/22 at 8:45 AM, R38 was observed in bed wearing the nasal CPAP mask. The CPAP mask appeared yellowing and soiled with debris encrusted on the inner side of the mask. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the Care Plan for R38 reflected a Care Plan focus topic of Resident has altered respiratory functioning and/or difficulty breathing (related to) Sleep Apnea. The altered respiratory Care Plan reflected an Intervention of Clean CPAP/BiPAP mask weekly created on 1/9/22 and revised on 6/20/22. An additional Intervention reflected Licensed staff to assist with management of CPAP machine, initiated on 6/3/22. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) did not reveal any current procedure in place for cleaning or maintaining the CPAP device of R38. No documentation was found in the MAR or TAR that reflected the CPAP mask was being cleaned weekly. Review of the EMR Progress Notes from 4/23/22 to 7/19/22 did not reveal any documentation that the CPAP used by R38 had been cleaned or maintained weekly. On 7/20/22 at 1:48 PM, the Director of Nursing (DON) was informed of the soiled CPAP mask being used by R38. The DON was informed that no documentation was found that the CPAP being used by R38 was cleaned weekly as directed by the facility Care Plan. The DON was asked to provide any documentation regarding these concerns. As of survey exit no further documentation was provided by the facility.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on observation, interview, and record review, the facility failed to follow professional standards of nursing practice for physician notification of a change in condition and medication administration for 9 Residents (#43, #36, #14, #21, #11, #9, #6, #28, #8, #34, and #60) reviewed for medication administration, resulting in the withholding of a medication without a physicians order, incorrect insulin administration, late medication administration, inaccurate controlled substance documentation and the potential for affected residents not maintaining or achieving their highest practical physical well-being. Findings: Review of the Fundamentals of Nursing revealed, The health care provider is responsible to provide accurate, complete, and understandable medication orders .also responsible for documenting any preassessment data required of certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of warfarin, before giving the medication. After administering a medication, immediately document which medication was given on a patient ' s MAR per agency policy to verify that it was given as ordered. Inaccurate documentation, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about patient care. For example, errors in documentation about insulin often result in negative patient outcomes. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 609). Elsevier Health Sciences. Kindle Edition. Review of the Fundamentals of Nursing revealed, Professional standards such as Nursing: Scope and Standards of Practice (ANA, 2010) .apply to the activity of medication administration. To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these six rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 39307-39313). Elsevier Health Sciences. Kindle Edition. Review of the Fundamentals of Nursing revealed, Timely entries are essential in a patient's ongoing care. Delays in documentation lead to unsafe patient care. To increase accuracy and decrease unnecessary duplication, many health care agencies keep records or computers near a patient's bedside to facilitate immediate documentation of information as it is collected. Document the following activities or findings at the time of occurrence .Administration of medications and treatments . [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 24182-24192). Elsevier Health Resident #43 (R43) Review of a an Admission Record revealed R43 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease and respiratory failure. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R43's Medication Administration Record revealed that R43 was to receive the following medications at 7:30 AM: Aripiprazole 15mg Cholecalciferol Tablet 2000 UNIT DULoxetine HCl Capsule Delayed Release Sprinkle 30 MG Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG Allopurinol Tablet 100 MG Polyethylene Glycol 3350 Powder Give 17 gram Potassium Chloride ER Tablet This medication was ordered to be administered again at 12:00 PM Turmeric Oral Capsule 500 MG (ordered for 7:00 AM) HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (ordered for 8:00 AM) On 7/19/22 at 10:30 AM, R43 had not received the above ordered medications. Resident #36 (R36) Review of an Admission Record revealed R36 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: epilepsy. Review of R36's Medication Administration Record revealed that R43 was to receive the following medications at 7:30 AM: Aspirin Tablet Chewable 81 MG Ferrous Sulfate Tablet 325 MG Lasix Tablet 20 MG Losartan Potassium Tablet 25 MG Acetaminophen Extra Strength Tablet 500 MG (2 tablets) This medication was ordered to be administered again at 11:00 AM. Gabapentin Tablet 600 MG (ordered for 8:00 AM) On 7/19/22 at 10:30 AM, R36 had not received the above ordered medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/19/22 at 10:33 AM, Licensed Practical Nurse (LPN) I had 2 preset medication cups setting on the top of her medication cart with multiple pills in each cup. LPN I then brought both medication cups into R43 and R36's room to administer the medication. (Note: the medications for R43 and R36 were administered outside of the nursing standard of practice of 1 hour before and 1 hour after the ordered time). Review of R43 and R36's Progress Notes revealed no documentation that the physician was notified of the late medication administration/medication error. During an observation on 07/19/22 at 12:24 PM, LPN I had 3 preset medication cups setting on the top of her medication cart with multiple pills in each cup. LPN I then stacked the medication cups and left her medication cart to administer the medications. Resident #14 (R14) Review of an Admission Record revealed R14 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension and heart failure. Review of R14's Physician Order revealed, Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for HTN Hold for SBP (systolic blood pressure) less than 120. This medication was ordered to be administered at 7:30 AM. Review of R14's Physician Order revealed, Norvasc Tablet 5 MG (amLODIPine Besylate) Give 5 mg by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold if: (systolic blood pressure less than 100 and diastolic blood pressure less than 60 or pulse less than 55). Review of R14's Blood Pressure Summary and Pulse Summary revealed that for the month of July, R14's Pulse and Blood pressure were not assessed daily and had not been assessed the following days: 6/26/22, 7/11/22, 7/12/22, 7/13/22, 7/14/22, 7/16/22, and 7/17/22. (Indicating the 2 blood pressure medications were not administered according to the physician ordered parameters). Resident #21 (R21) Review of an Admission Record revealed R21 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke. Review of R21's Physician Order revealed, Lisinopril Tablet 30 MG Give 1 tablet by mouth one time a day for HTN (hypertension) hold for SBP less than 120. Review of R21's Medication Administration Record revealed that on 7/19/22 R21's blood pressure was 115/50 and the blood pressure medication Lisinopril was administered outside of the ordered parameters. Resident #11 (R11) Review of an Admission Record revealed R11 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: chronic obstructive pulmonary disease. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R11's Medication Administration Record revealed, Gabapentin Capsule 100 MG Give 1 capsule by mouth every 8 hours for diabetic neuropathy. The medication was documented as administered on 7/19/22 for the 8:00 AM dose. Review of R11's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/19/22 at 10:00 AM the gabapentin was not signed out as being administered. Resident #9 (R9) Review of an Admission Record revealed R9 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes. Review of R9's Medication Administration Record revealed, Gabapentin Capsule 400 MG Give 1 capsule by mouth every morning and at bedtime for neuropathy. The medication was documented as administered on 7/19/22 for the 7:30 AM dose. Review of R9's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/19/22 at 10:00 AM the gabapentin was not signed out as being administered. Resident #6 (R6) Review of an Admission Record revealed R6 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: Dementia with behavioral disturbances. Review of R6's Medication Administration Record revealed, Xanax Tablet 0.25 MG (ALPRAZolam) Give 1 tablet by mouth two times a day. The medication was documented as administered on 7/19/22 for the 7:30 AM dose. Review of R6's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/19/22 at 10:00 AM the alprazolam was not signed out as being administered. Resident #28 (R28) Review of an Admission Record revealed R28 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease. Review of R28's Medication Administration Record revealed, Neurontin Capsule 300 MG (Gabapentin) Give 1 capsule by mouth two times a day. The medication was documented as administered on 7/19/22 for the 7:30 AM dose. Review of R28's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/19/22 at 10:00 AM the gabapentin was not signed out as being administered. Resident #8 (R8) Review of an Admission Record revealed R8 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: respiratory failure. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R8's Medication Administration Record revealed, Lacosamide Tablet 200 MG Give 1 tablet by mouth two times a day. The medication was documented as administered on 7/19/22 for the 7:30 AM dose. Review of R8's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/19/22 at 10:00 AM the Lacosamide was not signed out as being administered. Resident #34 (R34) Review of an Admission Record revealed R34 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes. Review of R34's Medication Administration Record revealed, Gabapentin Capsule 100 MG Give 1 capsule by mouth three times a day. The medication was documented as administered on 7/19/22 for the 7:30 AM dose. Review of R34's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/19/22 at 10:00 AM the gabapentin was not signed out as being administered. During an interview on 07/19/22 at 10:15 AM, LPN I reported that she did not sign out controlled substances for residents until she was done administering all medications on the unit in order to save time. LPN I reported that she was aware that controlled substances were to be signed out along with the date and time at the time the controlled substance was pulled/administered. LPN I reported that she would document the time the controlled substances were administered for all the residents that received controlled substances at one time. During an observation on 07/19/22 at 10:08 AM, LPN I was preparing an insulin pen. LPN I did not place a needle on the pen, dialed up the insulin to the ordered amount, and then placed the needle on the end of the pen. The insulin pen was not primed prior to the administration into the resident. 31771 During the Medication Administration Task an observation and interview were conducted on 7/20/22 at 8:58 AM with Registered Nurse (RN) F. RN F was observed to prepare a NovoLog FlexPen for the administration of 10 units of NovoLog to Resident (R)39 but did not prime the needle. Upon administration of the Novolog insulin to R39 RN F was observed to immediately withdraw the pen from the injection site. RN F did not hold the Novolog FlexPen to the injection site following administration. On return to the medication cart RN F was asked about the administration. RN F reported there was no need to prime the pen. RN F was asked about holding the Novolog pen to the injection site at the time of administration. RN F stated what would be the point?. RN F held up the Novolog FlexPen and reported once you push it to there, showing the point where the plunger would be at the bottom, it can't go any further. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The manufacturers package insert for the Novolog FlexPen was reviewed. Review of the section titled Instructions for use. Steps B and C address attaching a new disposable needle. Step D reflects, Giving the airshot before each injection. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:. The Instructions for use section continues with step E, turn the dose selector to select (two) units, F. Hold your Novolog FlexPen with your needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. keep the needle pointing upward, press the push-button all the way in. The dose selector returns to (zero). A drop of insulin should appear at the tip of the needle. The Instruction for use section precedes to Giving the injection, step I. Insert the needle into your skin. Inject the dose by pressing the push-button all the way in until the (zero) lines up with the pointer. Step J. Keep the needle in the skin for at least (six) seconds and keep pushing the push-button pressed all the way in until the needle has been pulled out from the skin. This will make sure that the full dose has been given. In summary the manufacturers package insert directs the priming a new disposable needle with two units of insulin. Then, when administering the Doctor Ordered dose, hold the Novolog FlexPen to the injection site for at least six seconds to ensure the full dose has been given. RN F was not observed to have followed the manufacturer's instructions for administration of the Novolog insulin to R39. RN F was not observed to have primed the Novolog FlexPen before administration and was not observed to hold the Novolog FlexPen for six seconds at the end of administration. RN F acknowledged that the manufacturers instructions were not followed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38659 Based on observation, interview, and record review, the facility failed to provide daily meaningful activities for R6, resulting in self-injuring behavior and the potential for further injuries, increased depression, boredom, and lack of meaning/quality of life: Findings include: R 6 Review of R6's face sheet dated 7/19/22 revealed they are a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: dementia, anxiety, heart failure and residual schizophrenia. R6 was not her own responsible party. On 07/18/22 at 10:50 AM, R6 was viewed in her room, she was staring blankly in a darkened room and sitting in her wheelchair. R6 had multiple sores on both sides of her face. They did not appear to be fresh, they were scabbed over and not bleeding. Blood was not observed on her hands, or bed sheets. R6 was asked what happened on face and she stated I'm not sure, maybe I dug at it with a screwdriver or something. On 07/18/22 at 12:20 PM, R6 was observed being assisted by staff D with her lunch tray after she put on her call light. On 7/19/22 at 11:30 AM, R6 was viewed in her room, laying in bed and awake. On 07/19/22 at 11:40 AM, an interview was completed with CNA (certified nursing assistant) C about R6's facial wounds. CNA C stated she has wounds that will heal up and then dig at them again. CNA C thought they put cream on them at times, but R6 often refuses. CNA C was not sure when the current wounds started. CNA C was also working on R6's hall the previous day. She could not recall if R6 had wounds at that time. On 07/19/22 at 11:42 AM an interview was completed with UM (unit manager) A. UM A stated, the last she knew the wounds on R6's face were healed. R6 has wounds intermittently on her face, it is anxiety related and R6 will dig and pick at her face. UM A stated interventions include activities such as giving her cardboard to tear or corn on the cob to pick at. The wound nurse practitioner will come in Thursdays for wound rounds and UM A rounds with them. R6 did not have any facial wounds as of last Thursday. Other interventions for R6 include topical creams, but they are not always tolerated. UM A stated that staff should put a skin note in if there was a new injury and she was not aware of a new injury or injuries to R6's face. On 07/19/22 at 04:10 PM, R6 was viewed in her wheelchair sitting in a darkened room with the door open. There were still no activities viewed in her room, she was viewed talking to herself and stated she was just talking to the pictures on the floor. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/20/22 at 09:16 AM, R6 was viewed in her darkened room, sitting in her wheelchair picking at her face. R6 said she just finished breakfast. A stuffed cat was viewed on the bed, the resident was not touching the cat. No other activities were viewed. On 07/20/22 at 09:29 AM an interview was completed with Activities Director (AD) E in reference to R6. AD E stated R6 is usually pleasant with staff, but never wants to come to group activities. AD E stated R6 likes tactile activities, like tearing cardboard and picking at corn cobs. Activities staff do involve R6 in some one on one activities with her roommate as well. AD E was asked what activities R6 has been provided this week. AD E stated she thought R6 was tearing up a tissue box at some point this week, but was unsure of any other activities. AD E stated no one has talked to her this week to reach out to R6 more with activities, but that she and 3 other activities staff round to get residents to group activities and offer individual activities. AD E stated R6 is usually in her chair in her room, she is very particular about having clutter or extra things in the room, so when bringing things they have to round back shortly to make sure she is done. AD E stated it is charted under tasks when staff round or do activities. It was discussed that not many activities or attempts to engage in activities are in R6's chart. AD E was informed R6 was recently doing some self injury behaviors again and staff had expressed that more activities would be explored. AD E reiterated that no one has reached out this week to do more things with R6, but will make sure the activities staff round more with her. On 07/20/22 at 11:52 AM, an interview was completed with UM A regarding R6. UM A stated she did not get a chance to talk to activities staff yesterday, but did talk to them now. UM A stated she personally did get R6 some cardboard to tear yesterday. Review of R6's care plan revealed a focus area with a last revised dated on 3/5/22 of an open lesion to R6's supra pubic regions and resident noted aggressively scratching that area when agitated. There is no note of facial lesions. Interventions included: Activities providing extra activities for tactile stimulation as tolerated. Another focus area with a last revised date of 1/11/22 revealed a history of skin injuries with an intervention that included observe skin daily with care activities. Report any changes in coloration, integrity, etc to nurse. An additional care area with the last revised date of 3/14/20 related to psychosocial well-being included interventions such as: provide in room activities of choice, as able. R6's care plan also noted she needed assistance with ADL (activities of daily living), such as transfers from the bed to wheelchair, toileting and personal hygiene, thus staff should be regularly interacting with her. Review of R6's kardex revealed the following under the section Activities: provide her with materials for individual activities as desired. The resident likes the following independent activities: watching TV (talk shows), tearing cardboard, visiting with staff, special snacks and Provide in room activities of choice, as able. Review of R6's activities log revealed, limited activities were logged in the last 30 days. Review of R6's activity log for July revealed no activities offered to R6 on 7/2, 7/3, 7/4, 7/11, 7/13, 7/15, 7/16 and 7/17/22. Other days had 1-2 activities offered. On 7/20/22 there were 8 activities offered. Review of R6's skin assessment for 7/19/22 revealed 5 facial scabs measuring 1.4x0.7x0.1, 1x0.2x0.1, 1.5x0.5x0.1, 0.3x0.2x0.1 and 0.7x0.5x0.1 centimeters. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of wound notes with encounter date of 7/14/22 revealed no active wounds. Past history of wounds are documented and included an abdominal wound, which had recently healed. There was a note from 12/9/2021 that referred to facial wounds due to R6 picking at her skin. Review of R6's progress notes revealed no recent mention of facial wounds prior to 7/19/22. A note on 7/19/22 at 12:04 PM by social services revealed: SS provided follow-up visit this morning. Resident was observed tearing cardboard and had a big smile on her face this morning. She told SS she was shredding cardboard which has been a preferred intervention of hers to avoid or minimize picking at her face. Resident noted that activities had just seen her and was bringing more cardboard for her to rip pieces from. Resident became frustrated when SS began asking her about picking at her face. To avoid more frustration, SS praised her for engaging in ripping cardboard and encouraged her to continue as this is something she voices enjoyment doing. Will continue to follow-up and offer support as needed or requested. A late entry general progress note was added on 7/20/22 and dated 7/19/22 at 10:54 AM: Resident provided with cardboard and cardstock for shredding by this nurse until able to be reviewed by activities director. Resident thankful for activity. An event note from 7/19/22 at 1:06 PM revealed: Nurse entered room and noticed 5 areas on residents face that were scabbed over, 2 areas noted on her left cheek, 1 on her nose, 1 on her chin and 1 on her right cheek. See skin obs for measurements. Resident states she picked at the skin on her face. Head to toe assessment completed, no additional self inflicted areas noted at this time. No c/o pain from resident. VS stable and at baseline. UM, DPOA, BCS and physician notified. Activities to assess for a tactile distraction for resident. A general progress note from 7/20/22 at 10:56 AM revealed: Discussed with Activities Director need to increase tactile activities for resident. Activities Director states she is aware and has provided items to her today and plans to assess further. A recreational services note on 7/20/22 at 12:10 PM revealed: Activities visited with Resident today to assess life enrichment options and preferences. Resident had pleasant affect and was sitting at her table waiting for lunch. Activities brought in multiple independent/tactile activities, per residents' preference. Resident initially refused most items in preference for cardboard to tear, but upon re-approach with basket to keep items in, accepted paper, cardboard, sensory putty, and coloring supplies. Resident refused offer to create a collage with ripped paper, both independently or with staff, as well as refused offer to go outside this afternoon. Historically, Resident has grown frustrated with keeping these items in her room for prolonged periods of time, so was reassured AD would follow up this afternoon. Resident expressed thankfulness at the end of today's visit. Activities will continue to monitor and encourage appropriate engagement.

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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** 39056 This citation pertains to intake #: MI00126341 Based on observation, interview, and record review, the facility failed to prevent facility acquired pressure ulcers and provide pressure ulcer preventative care consistent with professional standards of practice for 1 Resident (Resident #4) reviewed for the risk of and/or the development of pressure injuries, resulting in the development of an avoidable pressure ulcer and the potential for skin breakdown and overall deterioration in health status. Findings include: Review of the facility policy Skin Monitoring and Management-Pressure Ulcer adopted on 7/11/18 revealed, A resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition or other factors demonstrate that a developed pressure ulcer was unavoidable; and A resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new, unavoidable sores from developing . PREVENTION In order to prevent the development of skin breakdown or prevent existing pressure ulcers from worsening, nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan .B. Monitor impact of interventions and modify interventions as appropriate based on any identified changes in condition. C. Reposition the resident. D. Use pressure relieving/reducing and redistributing devices (including but not limited to low air loss mattresses, wedges, pillows, etc.) . Review of the Fundamental of Nursing revealed, Repositioning (turning) patients is a consistent element of evidence-based pressure injury prevention (EPUAP, NPIAP, PPPIA, 2019a). The twofold aim of repositioning should be to reduce or relieve pressure at the interface between bony prominence and support surface (bed or chair) and to limit the amount of time the tissue is exposed to pressure (Maklebust and [NAME], 2016) .A standard turning interval of 1.5 to 2 hours does not always prevent pressure injury development; repositioning intervals are based on patient assessment. Some patients may need more frequent position changes, while other patients can tolerate every-2-hour position changes without tissue injury. When repositioning, use positioning devices to protect bony prominence's (WOCN, 2016). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1255). Elsevier Health Sciences. Kindle Edition. Resident #4 (R4) Review of an Admission Record revealed R4 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: multiple sclerosis. Review of a Minimum Data Set (MDS) assessment for R4, with a reference date of 7/4/22 revealed a Brief Interview for Mental Status (BIMS) score of 99, out of a total possible score of 15, which indicated R4 was severely cognitively impaired. Review of the Functional Status revealed that R4 required extensive 2 person physical assist for bed mobility, transferring, dressing, toileting, and personal hygiene. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R4's Care Plan revealed, (R4) has actual impairment to skin integrity r/t (related to) Stage 4 pressure sore to Sacrum. Risk factors/contributing dx (diagnosis) include MS (multiple sclerosis), spinal stenosis, anemia, expressive language disorder, wheelchair bound, decrease mobility, and multiple contractures. Date Initiated: 07/18/2021 .reposition with cares as resident allows revised 6/17/2022 .Resident needs pressure reduction interventions: alternating pressure mattress Date Initiated: 07/22/2021. (No intervention was noted for the frequency of repositioning on the Care Plan or Kardex). During an interview on 07/18/22 at 2:46 PM, Family Member (FM) G reported that R4 had recently been diagnosed with MRSA (antibiotic resistive infection). FM G reported that R4 had been diagnosed with a pressure ulcer while a resident at the facility and it had recently worsened. FM G reported that R4 was unable to reposition herself and relied on staff to provide care and ensure care planned interventions were in place to prevent the development and worsening of a pressure ulcer. During an observation on 07/19/22 at 7:47 AM, R4 was in bed on her back with no pressure reducing devices in place to offload pressure on R4's buttocks. During an observation on 07/19/22 at 8:25 AM, R4 was in bed on her back with no pressure reducing devices in place to offload pressure on R4's buttocks. During an observation on 07/19/22 at 9:43 AM, R4 was in bed on her back with no pressure reducing devices in place to offload pressure on R4's buttocks. During an observation on 07/19/22 at 10:53 AM, R4 was in bed on her back with no pressure reducing devices in place to offload pressure on R4's buttocks. During an observation and interview on 07/19/22 11:28 AM, R4 was in bed on her back with no pressure reducing devices in place to offload pressure on R4's buttocks. At that time Registered Nurse (RN) F was entering the room to provide wound care. RN F reported that R4 was to be repositioned at least every 2 hours to prevent the worsening of the pressure ulcer. R4 had stool in her brief and her coccyx/sacral wound had a measurable depth, was macerated around the edges, and had noted drainage. R4's wound was approximately the size of the diameter of a golf ball. Review of R4's Skin/Wound Evaluation dated 6/17/22 revealed, Wound evaluation completed. Resident wound type is Pressure. Wound location is Sacrum. Wound measurements are: Area - 0.9 cm2, Length - 1.6 cm, Width - 0.9 cm, Depth - 0.1 cm. Review of R4's Skin/Wound Evaluation dated 6/30/22 revealed, Sacrum Type of Skin change/Impairment:: Pressure - stage 4 Measurement(s):: 4 x 4.8 x 0.3cm. (Indicating the worsening of the facility acquired pressure ulcer). Review of the Wound Care Provider note dated 6/30/22 revealed, (name omitted) RN was present during the visit today requested I see patient to reassess the area that she has on her sacrum. She is on an APM (pressure reducing mattress) but it was turned off so it was completely flat . Review of R4's Skin/Wound Evaluation dated 7/7/22 revealed, Sacrum Type of Skin Change/Impairment:: Pressure - Stage 4 Measurement(s):: 3 x 3.6 x 0.3cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R4's Skin/Wound Evaluation dated 7/14/22 revealed, Sacrum Type of Skin Change/Impairment:: Pressure - stage 4 infection present Measurement(s):: 2.8 x 3.5 x 0.3cm (Indicating the worsening of the facility acquired pressure ulcer due to a new infection). Review of the Wound Care Provider note dated 7/14/22 revealed, (Licensed Practical Nurse/Wound Care Nurse LPN/WCN A) was present during the visit today request I see patient to reassess the area that she has on her sacrum. I spoke with (LPN/WCN A) earlier this week. She had the culture done on the sacrum on 7/7/2022 and it was sent to the nursing home on 7/12/2022. It showed heavy growth of Proteus Mirabilis, heavy growth Enterococcus, MRSA, and Klebsiella pneumoniae. Her PCP (primary care provider) put her on Bactim DS (antibiotic) twice daily. I added gentamicin cream to the wound . During an interview on 7/20/22 at 2:20 PM, LPN/WCN A reported that the culture was obtained and the antibiotic started for R4 due to the significant and sudden worsening of the wound on her coccyx. LPN/WCN A reported that R4's sacral wound was nearly healed and then opened significantly.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 This citation pertains to Intake # MI00128917 Past Non- Compliance was determined appropriate by the state agency for this citation. Plan outlined below. Based on observation, interview, and record review, the facility failed to ensure resident safety during care for one resident (Resident (R)16), resulting in a fall and the potential for falls for all facility residents that require staff assistance for care and transfers. Findings: The Minimum Data Set (MDS) dated [DATE] reflected R16 admitted to the facility 9/29/17 with diagnoses that included History of Stroke and Dementia. Section G, titled Functional Status, indicated R16 was non-ambulatory and required the assistance of two staff for bed mobility and transfers. The MDS reflected R16 had no falls since he was admitted to the facility. Review of the facility document titled Incident # 905, Client (R16), Type/Nature of Incident: Observed on floor. The document reflected, 5/22/22, (Certified Nurse Aide (CNA)) taking care of resident stated she rolled him over and she did not have 2 care takers in the room with him at all times. Education provided. Review of the Electronic Medical Record (EMR) Progress Notes for R16 revealed documentation dated 5/22/22 at 1:40 AM that a CNA reported resident was on floor. The entry reflected the nurse found the Resident was lying face down. R16 was evaluated and Neuros (neurological checks to assess for possible head injury) were began, . Immediate intervention was to call on-call physician to obtain orders ., long term interventions is to have staff read the Kardex (a quick reference summary of resident care needs) before providing care, and always provide care with two people at all times. Review of the EMR Progress Note of 5/22/22 at 1:41 AM reflected, On-call physician notified. New orders obtained to send resident to (hospital emergency room) for evaluation. Review of the EMR Progress Note of 5/22/22 at 1:42 AM reflected, Second (Certified Nurse Aide (CNA)) stated that she was changing the resident's brief while rolling him he began to resist and then the resident fell off the bed. Review of the hospital documentation for R16 dated 5/22/22 at 1:58 AM reflected R16 was evaluated in the emergency room for, Abrasion of knee, bilateral (both knees). And Musculoskeletal: Positive for arthralgias (joint pain), back pain, and neck pain. And Neurological: Positive for headaches. Review of the Care Plan for R16 reflected a Focus of (R16) has limited physical mobility (related to) Weakness and cognitive defects initiated 6/22/19. An intervention for the Focus reflected. Bed Mobility: two assist, initiated 3/15/21 and revised 3/22/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan for R16 reflected a Focus of Resident has an (Activities of Daily Living) deficit (related to) Activity intolerance, Confusion, Dementia, Fatigue, Hemiplegia (weakness to one side of the body), Limited Mobility, Stroke, initiated 1/23/22. An intervention for this Focus area reflected Two staff in room with care, initiated on 1/23/22. Review of the Kardex for R16 reflected, Two staff in room with care. And Bathing/Showering: two assist, and Bed Mobility: two assist. On 7/18/22 at 9:29 AM an observation and interview were conducted with R16 in his room. R16 reported that he remembered the fall out of bed and that he was being provided care when the fall occurred. On 7/19/22 at 1:35 PM a telephone interview was conducted with Licensed Practical Nurse (LPN) J. LPN J reported she was the nurse on duty in the early morning hours of 5/22/22 when R16 fell out of bed. LPN J reported she was summoned to the Resident's room where she observed R16 on the floor. LPN J reported R16 was complaining that his back hurt and he had pain in his upper and lower extremities. LPN J indicated that one CNA was providing care when two staff are required for R16. LPN J reported that R16 would not have fallen if the CNA had followed the Kardex On 7/20/22 at 1:48 PM an interview was conducted with the Director of Nursing (DON) regarding the fall of R16. The DON reported that the CNA made a mistake and did not follow the Kardex for R16. The DON reported that, We recognized that we had a problem and indicated training had been completed on following the direction of the Care Plan and the direction of the Kardex. The DON reported that audits were conducted, and were ongoing, for staff compliance to the Care Plan and Kardex training. On 7/20/22 the surveyor verified the following interventions were put in place and were effective. -The facility policy on Care Plans was reviewed. - All licensed and certified staff were trained on Updating Care Plan and following the Kardex. - The DON/ Designee had completed audits on all shifts to verify ongoing Care Plan compliance. During this survey observations were conducted, staff were interviewed, and facility documents were reviewed which verified the proceeding interventions were completed prior to this Annual Recertification Survey and no continuing issues related to this citation were noted. A determination of past non-compliance was approved by the state agency as of 7/14/22. .

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to monitor and follow up on reported skin concerns for 1 resident with a colostomy (Resident #), resulting in the potential for unassessed pain, skin breakdown, and infection. Findings: Resident #19 (R19) Review of an Admission Record revealed R19 was a [AGE] year old male, last admitted to the facility on [DATE], with pertinent diagnoses of Alzheimer's and colon cancer and obstruction requiring a colostomy. During an observation on 07/18/22 at 2:49 PM, the skin around R19's colostomy wafer (a plastic apparatus that adhered to the skin, fits over the colostomy opening (stoma), and holds the pouch that collects stool) was noted to be red. During an observation on 07/19/22 at 10:10 AM, R19's colostomy wafer had pulled away from the skin at the 3 o ' clock position and stool collected on the skin and on R19's pants. During an observation on 07/19/22 at 11;37 AM, Certified Nurse Aide (CNA) O showered R19, provided colostomy care at the time of the shower, and noted that the skin surroundings the ostomy opening and under the adhesive wafer was red and had a small open area. During an interview at the time of the observation, CNA O stated that the procedure for reporting skin concerns is 2 step: complete a skin/shower monitoring checklist and report the concern verbally to the nurse on duty. During an interview on 07/20/22 at 10:02 AM, Licensed Practical Nurse (LPN) I indicated that an aide had reported skin concerns related to R19 following the shower yesterday. LPN I stated: (1) that CNA O said it was red, (2) that CNA O had filled out a shower sheet for R19 and that (LPN I) had signed off on the form, (3) that (LPN I) did not assess the skin concern for R19 because the area was always red and that (LPN I stopped charting on it because it was status quo for R19. A review on 07/20/2022 at 8:42 AM of R19's Progress Notes-View All reflected the last nursing progress note had been entered into R19's chart on 6/28/22 at 2:26 PM and noted stoma area hernia protruding today. Ostomy changed after cleaning BM (bowel movement) off the entire area, red under wafer. Review of a facility Policy/Procedure Colostomy and Ileostomy Care, adopted 07/11/2018, revealed the following: It is the policy of this facility that colostomy and ileostomy care will be provided for residents unless contraindicated by physician .#17 Notify physician of signs and symptoms of impaired skin integrity, changes in appearance of the stoma, signs and symptoms of infection or other complications .#18 Document all appropriate information in medical record.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38659 Based on observation, interviews, and record review, the facility failed to ensure proper positioning of 2 Residents receiving tube feedings (R17 and R7), of 4 Residents reviewed for tube feedings, resulting in the potential of impaired breathing due to aspiration of liquid nutrition. Findings include: Review of facility provided policy with the subject Enteral Nutrition-Resident Care and an adopted date of 7/11/18 revealed procedures which included: General monitoring of nursing care should include: 1. Head of bed should be elevated at a 30 - 45-degree angle during feeding and for at least one (1) hour after feeding is completed to prevent gastric reflux and possible aspiration . R17 Review of R17's face sheet dated 7/20/22 revealed they are a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Huntington's disease, muscle wasting and atrophy, cognitive communication deficit and adult failure to thrive. R17 was not his own responsible party. Review of R17's orders in their electronic medical records revealed an active order with a start date of 06/04/21: Elevate HOB (head of bed) 30-45 degrees during all feeding and flushes. Review of R17's care plan revealed a focus area of tube feeding. Interventions included: Keep HOB elevated 45 degrees during and thirty minutes after tube feed. On 07/20/22 at 09:20 AM R17 was viewed in bed with their tube feed running, the head of the bed was at slight angle, but the resident's feet were also up, so they appeared to be laying flat. At 9:25 AM, UM A was asked to come to R17's room and note if there were any concerns. UM A stated his bed was not in the right position and confirmed his tube feed was running. UM A stated his bed is tilted at about 15 degrees, but it should be 30-45 degrees. UM A put the tube feeding on hold and went to get another staff member to assist with repositioning the resident. 31771 R7 Review of the Minimum Data Set (MDS) dated [DATE] reflected R7 was admitted to the facility 11/21/07 with diagnosis that included Traumatic Brain Dysfunction. Section K of this MDS titled Swallow/Nutrition Status revealed R7 received nutrition through a feeding tube. Review of the Doctor's Orders reflected directions for the administration of liquid nutrition through an enteral feeding. These directions included that the head of the bed was to be elevated at least 30 degrees during all feedings and flushes. Review of the Care Plan for R7 reflected the head of the bed was to be elevated 30 to 45 degrees during and 30 minutes after tube feedings. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Fundamentals of Nursing revealed, Enteral Feedings .Each time the head of the bed is lowered below 30 degrees (e.g., for hygiene care, dressing changes, moving the patient), the nurse pauses a patient's feeding to prevent aspiration .To reduce the risk for aspiration, nurses follow several practices, such as keeping the head of bed elevated at 30 to 45 degrees, reducing the use of sedatives, assessing placement of the enteral access device and tolerance to the enteral feeding every 4 hours, and ensuring adequate bowel function ([NAME] and [NAME], 2018). Patients diagnosed with pancreatitis, gastric outlet obstruction .[NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1121). Elsevier Health Sciences. Kindle Edition. On 7/19/22 at 9:31 AM R7 was observed in her bed with a tube feeding in progress by way of a pump at 70 cubic centimeters (cc) per hour. The head of the bed was observed to be raised approximately 30 degrees. However, the body of R7 was observed to be lower in the bed and with the Resident lying almost flat. On 7/20/22 at 9:15 AM in the room of R7 a tube feeding was in progress for the Resident. The head of the bed was observed to be greater than thirty degrees. However, R7 was positioned lower in the bed so that only the shoulders and head were against the head of the bed with the rest of the body flat. On 7/20/22 at 9:19 AM Registered Nurse (RN) F was summoned to the room and asked if R7 was positioned correctly to be receiving nutrition through her feeding tube. RN F acknowledged that R7 was not positioned correctly to be receiving nutrition through her feeding tube. RN F suspended the infusion of liquid nutrition until the Resident could be moved to a position that prevented the risk aspiration of the liquid nutrition.

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Skld Muskegon	1061 W Hackley Ave Muskegon, MI 49441

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to monitor oxygen administration for 2 residents (Resident #38 and Resident #13), resulting in undated oxygen tubing, an empty oxygen tank, and uncleaned oxygen delivery apparatuses. Findings include: 38659 Resident #13 (R13) Review of R13's face sheet dated 7/19/22 revealed they are an [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: Alzheimer's disease and Chronic Obstructive Pulmonary Disease (COPD). R13's most recent MDS (Minimum Data Set) assessment revealed a BIMS (Brief Interview for Mental Status) of 14/15, revealing she was cognitively intact. On 07/18/22 at 10:57 AM during an interview in her room, it was observed R13's oxygen tubing was undated. R13 was asked about their oxygen tubing and she stated this set of tubing was changed recently, but generally staff don't change it very often, much less than I am used to. R13 stated before the most recent change, her tubing had turned yellow and one of her visitors drew staff's attention to it. R13 could not say specifically how long she had been using the tubing that turned yellow, but it had been in use a pretty long time, too long. R13 stated when she was at home the tubing was replaced regularly, but staff are so busy it is not happening in the facility. Review of R13's MAR/TAR (medication administration record/treatment administration record) revealed an order oxygen equipment management- change out, date & label all tubing/bags/set ups .clean filter and wipe down machine every night shift every Sun for cleaning routine. 31771 Resident #38 R38 Review of the Minimum Data Set (MDS) dated [DATE] revealed R38 was admitted to the facility 6/17/21 with diagnoses that included Heart Failure and Respiratory Failure. Section O of the MDS titled Special Treatments and Programs reflected R38 was receiving oxygen therapy, while a resident at the facility. Review of the Electronic Medical Record (EMR) Face Sheet revealed an additional diagnosis of dependence on supplemental oxygen. On 7/18/22 an observation was conducted in the room of R38. R38 was asleep in bed wearing a nasal Continuous Positive Airway Pressure (CPAP) mask which was attached to an operating CPAP machine. Next to the bed was a wheelchair with an oxygen tank in a holder attached to the wheelchair. It was observed that the oxygen tank gauge read that the tank was empty. Undated oxygen tubing was observed to be coiled in a circle and was hung over a handle on the wheelchair and was not stored in a plastic bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/22 at 10:49 AM R38 was awake but remained in bed with nasal CPAP mask in place. The nasal CPAP mask appeared well used and was yellowing. R38 reported she did not know if her CPAP mask was ever cleaned. On 7/20/22 at 8:45 AM R38 was observed in bed wearing the nasal CPAP mask. The CPAP mask appeared yellowing and soiled with debris encrusted on the inner side of the mask. It was noted that the wheelchair oxygen tank and previously noted undated oxygen tubing remained in place coiled and hung over the wheelchair handle. Review of the Care Plan for R38 reflected a Care Plan focus topic of Resident has altered respiratory functioning and/or difficulty breathing (related to) Sleep Apnea. Although the medical record and MDS did not reflect a diagnosis of Sleep Apnea the Care Plan did address that R38 chooses to use old CPAP mask. The altered respiratory Care Plan reflected an Intervention of Clean CPAP/BiPAP mask weekly created on 1/9/22 and revised on 6/20/22. An additional Intervention reflected Licensed staff to assist with management of CPAP machine, initiated on 6/3/22. Further review of altered respiratory Care Plan did not reveal an intervention regarding oxygen administration. Review of the entire Care Plan did not reveal any current Care Plan Focus or other interventions under any heading regarding oxygen administration. On 7/20/22 at 10:00 AM a review was conducted of the Doctor's Orders for R38. This review did not reveal any current Doctor's Orders for any oxygen or oxygen devices, to include the use of a CPAP. The Doctor's Orders did not reveal any Orders for the care and maintenance of the CPAP device of R38. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) did not reveal any current procedure in place for cleaning or maintaining the CPAP device of R38. No documentation was found in the MAR or TAR that reflected the CPAP mask was being cleaned weekly. Review of the EMR Progress Notes from 4/23/22 to 7/19/22 did not reveal any documentation that the CPAP used by R38 had been cleaned or maintained weekly. On 7/20/22 at 1:48 PM the Director of Nursing (DON) was informed of the soiled CPAP mask being used by R38. The DON was informed that no Doctor's Order was found in the EMR for oxygen administration or for the use of oxygen devices to include the CPAP device currently being used by R38. The DON was informed of the oxygen tubing coiled and hung on the wheelchair handle, the empty oxygen tank on the wheelchair, and that no documentation was found that the CPAP being used by R38 was cleaned weekly as directed by the facility Care Plan. The DON was asked to provide any documentation regarding these concerns. On 7/19/22 at 12:59 PM a Request for Records email was sent to the Nursing Home Administrator (NHA). This email included requests for policies and procedures related to, Oxygen Storage, Oxygen devices (tubing, nebulizer machines, CPAP machines, oxygen concentrators). The facility provided one oxygen policy titled, Policy/ Procedure - Nursing Clinical Subject: Oxygen Administration, Adopted 7/11/2018. On review this policy revealed a section titled, Procedure. This section reflected 1. Verify physician order, which indicated that a physician order was required to have available and provide to facility residents oxygen and oxygen delivery devices and accessories. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As of survey exit no further documentation was provided by the facility.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to ensure staff providing direct patient care had an active unrestricted nursing license and able to practice in the State of Michigan. This deficient practice resulted in an immediate jeopardy beginning on 5/11/22 when Unlicensed Staff B, acting with the authority of a licensed nurse, provided nursing care to residents and subsequently dispensed controlled substances in error for 4 Residents (#21, #30, 49, and #5). Additionally, the facility failed to ensure licensed nursing staff were competent and trained to perform their duties (medication administration) resulting in significant medication errors for 6 Residents (#21, #20, #25, #21, #43, and #36) and the potential for serious harm, injury, and/or death. Findings: Review of the Licensing and Regulatory Affairs license search for Unlicensed Staff B revealed that beginning on 5/11/22 the Licensed Practical Nurse license was suspended. Review of Unlicensed Staff B's Time Sheet revealed she worked the following shifts after the suspension of her license: 5/13/22 on the 300-400 unit 5/16/22 on the 400-500 unit 5/17/22 on the 300-400 unit 5/20/22 on the 400-500 unit 5/23/22 on the 200 unit (night shift) 5/26/22 on the 200 unit (night shift) 5/27/22 on the 200 unit (night shift) 5/31/22 on the 400-500 unit 6/1/22 on the 300-400 unit 6/2/22 on the 300-400 unit 6/6/22 on the 400-500 unit (night shift) 6/10/22 unknown unit (night shift) 6/13/22 on the 200 unit (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6/18/22 on the 300 unit 7/3/22 on the 200 unit 7/7/22 on the 400-500 unit During an interview on 07/21/2022 at 2:31 PM, Unlicensed Staff B reported that she was aware that her license had been under review/probation for an incident involving her failure to administer a blood thinner causing a resident to become subtherapeutic as well as falsely charting that the blood thinner had been administered. Unlicensed Staff B reported that she had been on probation ever since the incident. Unlicensed Staff B reported that she did not notify the staffing agency at the time of her hire that her nursing license was in a probationary period. Unlicensed Staff B reported that she was not aware that her nursing license had been suspended but reported that she had not paid the required fees to ensure she was in compliance with the Board of Nursing. Resident #21 (R21) Review of an Admission Record revealed R21 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke. Review of R21's Physician Order revealed, Neurontin Capsule 400 MG (Gabapentin) Give 1 capsule by mouth two times a day (to be administered at 7:30 AM and 1:00 PM and Neurontin Capsule 400 MG (Gabapentin) Give 2 capsule by mouth at bedtime (to be administered at 8:00 PM). Review of R21's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/7/22 the gabapentin was administered as follows: *7/7/22 1 400 mg capsule at 8:00 AM *7/7/22 1 400 mg capsule at 1:00 PM *7/7/22 1 400 mg capsule at 4:00 PM *7/7/22 2 400 mg capsule at 10:00 PM Indicating R21 received an extra dose of gabapentin 400mg by Unlicensed Staff B on that date. Resident #30 (R30) Review of an Admission Record revealed R30 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke. Review of R30's Physician Order revealed, HYDROcodone-Acetaminophen Tablet 7.5-325 MG (Norco) Give 1 tablet by mouth four times a day (To be administered at 7:30 AM, 12:00 AM, 4:00 PM, and 8:00 PM). Review of R30's Controlled Drug Receipt/Record/Disposition Form revealed that on 6/2/22 the Norco was administered as follows: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	*6/2/22 1 tablet at 2:00 PM *6/2/22 1 tablet at 4:00 PM Indicating R30 received 2 doses of narcotic medication 2 hours apart by Unlicensed Staff B. Review of R30's Physician Order revealed, Diazepam (valium) 2mg 1 tablet by mouth 3 times a day. Review of R30's R21's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/7/22 the valium was administered as follows: *7/7/22 1 tablet at 10:00 AM Indicating Unlicensed Staff B did not administer R30 his morning dose of valium. Resident #49 (R49) Review of an Admission Record revealed R49 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: fibromyalgia. Review of R49's Physician Order revealed, Gabapentin 300 MG 1 capsule by mouth three times a day (to be administered at 7:30 AM, 1:00 PM, and 8:00 PM) Review of R49's Controlled Drug Receipt/Record/Disposition Form revealed that on 6/13/22 the gabapentin was administered as follow: *6/13/22 1 capsule at 7:30 AM *6/13/22 1 capsule at 6:00 PM Indicating the 2nd dose of gabapentin was administered late by Unlicensed Staff B. Resident #5 (R5) Review of an Admission Record revealed R5 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes. Review of R5's Physician Order revealed, Gabapentin 300 MG 1 capsule by mouth three times a day. Review of R5's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/7/22 the gabapentin was administered as follows: *7/7/22 1 capsule at 10:00 AM Indicating the morning dose of gabapentin was not administered by Unlicensed Staff B. Resident #51 (R51) (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of an Admission Record revealed R51 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: left femur fracture. Review of R51's Physician Order revealed, LORazepam Tablet 0.5 MG Give 1 tablet by mouth every 8 hours (To be administered at 12:00 AM, 8:00 AM, and 4:00 PM). Review of R51's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/16/22 the lorazepam was administered as follows: *7/16/22 1 tablet at 12:00 AM *7/16/22 1 tablet at 4:00 PM Indicating R51 did not receive a dose of Ativan on 7/16/22 from Licensed Practical Nurse (LPN) H. Resident #20 (R20) Review of an Admission Record revealed R20 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia with behavioral disturbance. Review of R20's Physician Order revealed, LORazepam 0.5 MG 1 tablet by mouth one time a day. Review of R20's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/17/22 the lorazepam was not administered by LPN H. Resident #25 (R25) Review of an Admission Record revealed R25 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke. Review of R25's Physician Order revealed, traMADol t50MG 1 tablet by mouth two times a day. Review of R25's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/17/22 the tramadol was administered as follows: *7/17/22 1 tablet at 7:52 PM Indicating R25 did not receive a dose of tramadol from LPN H the morning of 7/17/22. Resident #21 (R21) Review of an Admission Record revealed R21 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke. Review of R21's Physician Order revealed, Norco Tablet 7.5-325 MG (HYDROcodone-Acetaminophen) Give 1 tablet by mouth four times a day (to be administered at 7:30 AM, 12:00 PM, 4:00 PM, and 8:00 PM). (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of R21's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/8/22 the Norco 7.5/325 mg was administered as follows: *7/8/22 1 tablet at 12:00 PM *7/8/22 1 tablet at 4:00 PM *7/8/22 1 tablet at 9:10 PM Indicating R21 did not receive the 7:30 AM dose of the medication from LPN H. Review of R21's Physician Order revealed, Neurontin Capsule 400 MG (Gabapentin) Give 1 capsule by mouth two times a day (to be administered at 7:30 AM and 1:00 PM and Neurontin Capsule 400 MG (Gabapentin) Give 2 capsule by mouth at bedtime (to be administered at 8:00 PM). Review of R21's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/8/22 the gabapentin was administered as follows: *7/8/22 1 400 mg capsule at 8:10 AM *7/8/22 2 400 mg capsule at 9:10 PM Indicating R21 did not receive the 1:00 PM dose of the medication from LPN H. Resident #43 (R43) Review of an Admission Record revealed R43 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease and respiratory failure. Review of R43's Physician Order revealed, HYDROcodone-Acetaminophen (Norco) Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth two times a day. Review of R43's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/19/22 the Norco was administered as follows: *7/19/22 1 tablet at 6:30 AM (was not documented as administered as a PRN medication on the MAR.) *7/19/22 1 tablet at 10:00 AM Indicating R43 received doses of Norco 3.5 hours apart. Review of R43's Medication Administration Record on 7/19/22 at 10:30 AM revealed there was no documentation that LPN I had administered the 8:00 AM dose of norco (Indicating late controlled substance administration). Important to note that the MAR and observation indicated the Norco had not been administered as of 7/19/22 at 10:30 AM, review of the documentation on the Controlled Drug Receipt/Record/Disposition Form obtained on 7/19/22 at 2:48 PM revealed documentation that the norco was administered on 7/19/22 at 10:00 AM resulting in inaccurate controlled substance administration and/or inaccurate controlled substance documentation. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #36 (R36) Review of an Admission Record revealed R36 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: epilepsy. Review of R36's Physician Order revealed Gabapentin Tablet 600 MG Give 600 mg by mouth every 8 hours related to EPILEPSY (To be administered at 8:00 AM. 4:00 PM, and 12:00 AM). Review of R36's Medication Administration Record on 7/19/22 at 10:30 AM revealed there was no documentation that R36 had received the 8:00 AM dose of gabapentin (Indicating late/missed controlled substance administration). During an observation on 07/19/22 at 10:33 AM, Licensed Practical Nurse (LPN) I had 2 preset medication cups setting on the top of her medication cart with multiple pills in each cup. LPN I then brought both medication cups into R43 and R36's room to administer the medication. (Note: the medications for R43 and R36 were administered outside of the nursing standard of practice of 1 hour before and 1 hour after the ordered time). During an interview on 7/21/22 at 2:03 PM, Nursing Home Administrator reported that she was not notified from the staffing agency nor Unlicensed Staff B that her nursing license was suspended as of 5/11/22. NHA reported that Unlicensed Staff B was immediately removed from the schedule and reported that her last date worked was 7/7/22. During an interview on 7/19/22 at 4:10 PM, Director of Nursing (DON) reported that LPN H had been hired on 6/9/22 and had orientation with the facility nursing staff. DON reported that LPN H would be receiving additional 1:1 orientation and education due to the ongoing medication errors identified during the survey. During an interview on 7/25/22 at 11:05 AM, Nursing Home Administrator reported that all resident's narcotic sheets were being reviewed for errors. No additional documentation regarding medication errors was produced prior to survey exit on 7/26/22. On 7/25/22 the Nursing Home Administrator was verbally notified and received written notification of the immediate jeopardy that was identified on 7/25/22 due to the facility's failure to ensure staff providing direct patient care had an active unrestricted nursing license and were able to practice in the State of Michigan. A written plan for removal for the immediate jeopardy was received on 7/26/22 and the following was verified on 7/26/22: (Facility) is providing the following information to demonstrate that the immediacy of the cited deficiency F726 has been removed. Response to Cited Areas: No specific residents were identified in the IJ Notice. All residents are at a potential risk. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Staff member B worked a total of 13 shifts from 5/13/22 to 7/7/22, this was confirmed on 7/21/22. Unlicensed staff B was confirmed to not have worked at the facility after 7/7/22. Unlicensed staff B will not pick up any future shifts at the facility. On 7/21/22 a call was placed to the staffing agency for unlicensed staff B, notifying the agency of the findings and that the individual was not eligible to work. All licensed staff employed or contracted, professional licenses were validated on 7/21/22 to be active and unencumbered to work in the State of Michigan. Other Residents at Potential Risk: A 100% audit was started on 7/25/22 by the facility nurse management team The audit consisted of verification of all current resident to ensure medications, including narcotics and treatments were administered/completed as ordered by the attending physician At this time 10 out of 66 residents have been identified concerns with medication/treatment administration. On 7/25/22, the facility pulled the 24-hour report for the 13 identified shifts staff B worked to identify if any residents experienced a change in condition or any negative outcomes. 0 out of 10 had identified concerns with a change in condition or negative outcome. A 100% audit was completed on 7/21/22 by the facility administrative staff to validate all professional staff, whether employed directly by the facility or through agency contracts have license that are active and unencumbered. 0 out of 34 had identified concerns with their license. On 7/22/22 a review was completed of the Health Disciplinary Action Reports, published by the State of Michigan's Licensing and Regulatory Affairs ([NAME]) department for the month of July to ensure facility professional staff, employed and contracted, did not have any pending action. 0 out of 34 had identified pending actions on their license. Process Implemented to prevent further incidence: On 7/22/22, the Human Capitol Partner was educated on pulling the Health Disciplinary Action Reports, published by the State of Michigan's Licensing and Regulatory Affairs ([NAME]) department weekly to ensure facility professional staff, employed and contracted, did not have any pending action. The Administrator and Regional Nurse Consultant have reviewed the Controlled Drugs, Administration of Drugs, and Medication Errors policies and deemed they meet clinical and regulatory standards. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 7/25/22, the facility-initiated education for licensed nurses to ensure the necessary skills and competencies for administration of medications including controlled medications and identifying and reporting a medication error. Licensed nurses who have not received the education will be removed from the schedule until the education is completed. As of 7/26/22, 2 out of 3 facility nurse managers have received training. As of 7/26/22, 6 out of 13 facility licensed nurses have received training. As of 7/26/22, 3 out of 18 agency licensed nurses have received training. Monitoring: The Administrator and/ or designee will conduct random audits monthly times 3 months or until substantial compliance has been maintained to ensure the Health Disciplinary Action Reports published by the State of Michigan [NAME] department has been pulled and any facility professional staff employed and contracted with pending actions have been identified with appropriate follow up. The Director of Nursing and/ or designee will conduct random audits on 5 staff competencies weekly times 4 weeks, then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the necessary skills for administration of medications including controlled medications and identifying and reporting a medication error. The medical director was notified of these findings on 7/25/22. The pharmacist consultant was notified of these findings on 7/25/22. All findings will be forwarded to the QA committee and will provide further guidance as needed. The facility alleges that the immediacy with the deficient practice has been removed on July 26, 2022. Although the immediate jeopardy was removed on 7/26/22, the facility remained out of compliance at a scope of widespread and severity of likelihood of harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency.

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	07/26/2022

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on observation, interview, and record review, the facility failed to 1). provide controlled substance oversight, 2). ensure facility nursing staff administering the medications were licensed and competent, and 3.) keep residents free from significant medication errors by following the physician order for the administration of controlled substances for 11 residents (#21, #30, #15, #49, #5, #26, #51, #25, #20, #43, and #36) reviewed for medication administration. This deficient practice resulted in an immediate jeopardy when, beginning on 5/9/22, facility staff failed to provide proper administration of controlled substances and promptly notify the physician of medication errors. This deficient practice resulted in missed doses of controlled substances, additional doses of controlled substances, incorrect time for the administration of controlled substances and placed all residents residing in the facility at risk for serious harm, injury and/or death. Findings: Resident #21 (R21) Review of an Admission Record revealed R21 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke. Review of R21's Physician Order revealed, Neurontin Capsule 400 MG (Gabapentin) Give 1 capsule by mouth two times a day (to be administered at 7:30 AM and 1:00 PM and Neurontin Capsule 400 MG (Gabapentin) Give 2 capsule by mouth at bedtime (to be administered at 8:00 PM). Review of R21's Controlled Drug Receipt/Record/Disposition Form revealed that on 5/9/22 the gabapentin was administered as follows: *5/9/22 1 400 mg capsule at 8:30 AM *5/9/22 1 400 mg capsule at 12:00 PM *5/9/22 1 400 mg capsule at 1:00 PM *5/9/22 2 400 mg capsule at 7:20 PM Indicating R21 received an extra dose of Neurontin 400mg on that date. Review of R21's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/7/22 the gabapentin was administered as follows: *7/7/22 1 400 mg capsule at 8:00 AM *7/7/22 1 400 mg capsule at 1:00 PM *7/7/22 1 400 mg capsule at 4:00 PM (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	*7/7/22 2 400 mg capsule at 10:00 PM Indicating R21 received an extra dose of Neurontin 400mg by Unlicensed Staff B on that date. Review of R21's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/8/22 the gabapentin was administered as follows: *7/8/22 1 400 mg capsule at 8:10 AM *7/8/22 2 400 mg capsule at 9:10 PM Indicating R21 did not receive the 1:00 PM dose of gabapentin. Review of R21's Physician Order revealed, Norco Tablet 7.5-325 MG (HYDROcodone-Acetaminophen) Give 1 tablet by mouth four times a day (to be administered at 7:30 AM, 12:00 PM, 4:00 PM, and 8:00 PM). Review of R21's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/6/22 the Norco 7.5/325 mg did not have a signature indicating which licensed nurse administered the medication for the dose administered at 8:00 AM, 1:00 PM, or 4:00 PM. Review of R21's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/8/22 the Norco 7.5/325 mg was administered as follows: *7/8/22 1 tablet at 12:00 PM *7/8/22 1 tablet at 4:00 PM *7/8/22 1 tablet at 9:10 PM Indicating R21 did not receive the 7:30 AM dose of the medication. Review of R21's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/9/22 the Norco 7.5/325 mg was administered as follows: *7/9/22 1 tablet at 10:00 AM *7/9/22 1 tablet at 11:30 AM Indicating R21 received a dose of the narcotic medication 1.5 hours after the previous dose. Review of R21's Electronic Health Record revealed no documentation that the physician was notified of the medication errors at that time. Resident #30 (R30) Review of an Admission Record revealed R30 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of R30's Physician Order revealed, HYDROcodone-Acetaminophen Tablet 7.5-325 MG (Norco) Give 1 tablet by mouth four times a day (To be administered at 7:30 AM, 12:00 AM, 4:00 PM, and 8:00 PM). Review of R30's Controlled Drug Receipt/Record/Disposition Form revealed that on 6/2/22 the Norco was administered as follows: *6/2/22 1 tablet at 2:00 PM *6/2/22 1 tablet at 4:00 PM Indicating R30 received 2 doses of narcotic medication 2 hours apart by Unlicensed Staff B. Review of R30's Physician Order revealed, Diazepam (valium) 2mg 1 tablet by mouth 3 times a day. Review of R30's R21's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/7/22 the valium was administered as follows: *7/7/22 1 tablet at 10:00 AM Indicating Unlicensed Staff B did not administer R30 his morning dose of valium Review of R30's Electronic Health Record revealed no documentation that the physician was notified of the medication errors at that time. Resident #15 (R15) Review of an Admission Record revealed R15 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: kidney disease and heart failure. Review of R15's Physician Order revealed, TraMADol HCl Tablet 50 MG Give 1 tablet by mouth three times a day (To be administered at 7:30 AM, 1:00 PM, and 8:00 PM). Review of R15's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/2/22 the tramadol was administered as follow: *7/2/22 1 tablet at 10:15 AM *7/2/22 1 tablet at 2:15 PM Indicating R15 received 2 doses of the controlled substance 4 hours apart and did not receive the 3rd dose. Review of R15's Electronic Health Record revealed no documentation that the physician was notified of the medication errors at that time. Resident #49 (R49) (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of an Admission Record revealed R49 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: fibromyalgia. Review of R49's Physician Order revealed, Gabapentin 300 MG 1 capsule by mouth three times a day (to be administered at 7:30 AM, 1:00 PM, and 8:00 PM) Review of R49's Controlled Drug Receipt/Record/Disposition Form revealed that on 5/27/22 the gabapentin was administered as follows: *5/27/22 1 capsule at 7:00 AM *5/27/22 1 capsule at 12:00 PM Indicating the 3rd dose of gabapentin was not administered. Review of R49's Controlled Drug Receipt/Record/Disposition Form revealed that on 6/10/22 the gabapentin was administered as follows: *6/10/22 1 capsule at 8:00 AM *6/10/22 1 capsule at 1:00 PM Indicating the 3rd dose of gabapentin was not administered. Review of R49's Physician Order revealed, Gabapentin 300 MG 1 capsule by mouth three times a day (to be administered at 7:30 AM, 1:00 PM, and 8:00 PM) Review of R49's Controlled Drug Receipt/Record/Disposition Form revealed that on 6/13/22 the gabapentin was administered as follow: *6/13/22 1 capsule at 7:30 AM *6/13/22 1 capsule at 6:00 PM Indicating the 2nd dose of gabapentin was administered late by Unlicensed Staff B. Review of R49's Controlled Drug Receipt/Record/Disposition Form revealed that on 6/26/22 the gabapentin was administered as follows: *6/26/22 1 capsule at 7:00 AM *6/26/22 1 capsule at 12:30 PM Indicating the 3rd dose of gabapentin was not administered. Review of R49's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/1/22 the gabapentin was administered as follows: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	*7/1/22 1 capsule at 7:00 AM *7/1/22 1 capsule at 12:30 PM Indicating the 3rd dose of gabapentin was not administered. Review of R49's Electronic Health Record revealed no documentation that the physician was notified of the medication errors at that time. Resident #5 (R5) Review of an Admission Record revealed R5 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes. Review of R5's Physician Order revealed, Gabapentin 300 MG 1 capsule by mouth three times a day. Review of R5's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/7/22 the gabapentin was administered as follows: *7/7/22 1 capsule at 10:00 AM Indicating the morning dose of gabapentin was not administered by Unlicensed Staff B. Review of R5's Electronic Health Record revealed no documentation that the physician was notified of the medication error at that time. Resident #26 (R26) Review of an Admission Record revealed R26 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: arm fracture. Review of R26's Physician Order revealed, Pregabalin Capsule 75 MG Give 75 mg by mouth three times a day for pain (To be administered at 7:30 AM, 11:00 AM, and 8:00 PM). Review of R26's Controlled Drug Receipt/Record/Disposition Form revealed that on 6/20/22 the pregabalin was administered as follows: *6/20/22 1 capsule on 6/20 at 7:20 PM Indicating the 7:30 AM dose and the 11:00 AM dose of pregabalin was not administered. During an interview on 7/25/22 at 11:05 AM, Nursing Home Administrator (NHA) reported that R26 was not on LOA (Leave of Absence) at the time the medication was documented as not given for the reason that the resident was not in facility. Review of R26's Electronic Health Record revealed no documentation that the physician was notified of the medication error or that the resident was not in the facility on 6/20/22. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #51 (R51) Review of an Admission Record revealed R51 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: left femur fracture. Review of R51's Physician Order revealed, LORazepam Tablet 0.5 MG Give 1 tablet by mouth every 8 hours (To be administered at 12:00 AM, 8:00 AM, and 4:00 PM). Review of R51's Controlled Drug Receipt/Record/Disposition Form revealed that on 5/17/22 the lorazepam was administered as follows: *5/17/22 1 tablet at 12:00 AM *5/17/22 1 tablet at 9:00 AM *5/17/22 1 tablet at 12:30 PM *5/17/22 1 tablet at 5:00 PM Indicating R51 received an additional dose of Ativan on 5/17/22 Review of R51's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/16/22 the lorazepam was administered as follows: *7/16/22 1 tablet at 12:00 AM *7/16/22 1 tablet at 4:00 PM Indicating R51 did not receive the 8:00 AM dose of Ativan on 7/16/22 from Licensed Practical Nurse (LPN) H Review of R51's Electronic Health Record revealed no documentation that the physician was notified of the medication errors at that time. Resident #25 (R25) Review of an Admission Record revealed R25 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke. Review of R25's Physician Order revealed, traMADol t50MG 1 tablet by mouth two times a day. Review of R25's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/17/22 the tramadol was administered as follows: *7/17/22 1 tablet at 7:52 PM Indicating R25 did not receive a dose of tramadol the morning of 7/17/22. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of R25's Electronic Health Record revealed no documentation that the physician was notified of the medication error at that time. Resident #20 (R20) Review of an Admission Record revealed R20 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia with behavioral disturbance. Review of R20's Physician Order revealed, LORazepam 0.5 MG 1 tablet by mouth one time a day. Review of R20's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/17/22 the lorazepam was not administered. Review of R20's Electronic Health Record revealed no documentation that the physician was notified of the medication error at that time. Resident #43 (R43) Review of an Admission Record revealed R43 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease and respiratory failure. Review of R43's Physician Order revealed, HYDROcodone-Acetaminophen (Norco) Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth two times a day. Review of R43's Controlled Drug Receipt/Record/Disposition Form revealed that on 7/19/22 the Norco was administered as follows: *7/19/22 1 tablet at 6:30 AM *7/19/22 1 tablet at 10:00 AM Indicating R43 received doses of Norco 3.5 hours apart. Review of R43's Medication Administration Record on 7/19/22 at 10:30 AM revealed there was no documentation that R43 had received the 8:00 AM dose of norco (Indicating late controlled substance administration). Important to note that the MAR and observation indicated the Norco had not been administered as of 7/19/22 at 10:30 AM, review of the documentation on the Controlled Drug Receipt/Record/Disposition Form obtained on 7/19/22 at 2:48 PM revealed documentation that the norco was administered on 7/19/22 at 10:00 AM causing inaccurate controlled substance administration/documentation. Review of R43's Electronic Health Record revealed no documentation that the physician was notified of the medication error at that time. Resident #36 (R36) Review of an Admission Record revealed R36 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: epilepsy. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of R36's Physician Order revealed Gabapentin Tablet 600 MG Give 600 mg by mouth every 8 hours related to EPILEPSY (To be administered at 8:00 AM. 4:00 PM, and 12:00 AM). Review of R36's Medication Administration Record on 7/19/22 at 10:30 AM there was no documentation that R36 had received the 8:00 AM dose of gabapentin (Indicating late/missed controlled substance administration). Review of R36's Electronic Health Record revealed no documentation that the physician was notified of the medication error at that time. During an observation on 07/19/22 at 10:33 AM, Licensed Practical Nurse (LPN) I had 2 preset medication cups setting on the top of her medication cart with multiple pills in each cup. LPN I then brought both medication cups into R43 and R36's room to administer the medication. (Note: the medications for R43 and R36 were administered outside of the nursing standard of practice of 1 hour before and 1 hour after the ordered time). During an interview on 7/21/22 at 2:03 PM, Nursing Home Administrator reported that she was not notified from the staffing agency nor Unlicensed Staff B that her nursing license was suspended as of 5/11/22. NHA reported that Unlicensed Staff B was immediately removed from the schedule and reported that her last date worked was 7/7/22. During an interview on 7/19/22 at 4:10 PM, Director of Nursing (DON) reported that LPN H had been hired on 6/9/22 and had orientation with the facility nursing staff. DON reported that LPN H would be receiving additional 1:1 orientation and education due to the ongoing medication errors identified during the survey. During an interview on 7/25/22 at 11:05 AM, Nursing Home Administrator reported that all resident's narcotic sheets were being reviewed for errors. No additional documentation regarding medication errors was produced prior to the survey exit on 7/26/22. On 7/25/22 the Nursing Home Administrator was verbally notified and received written notification of the immediate jeopardy that was identified on 7/25/22 due to the facility's failure to ensure controlled substances were administered according to standard nursing practice. A written plan for removal for the immediate jeopardy was received on 7/26/22 and the following was verified on 7/26/22: (Facility) is providing the following information to demonstrate that the immediacy of the cited deficiency F760 has been removed. Response to Cited Areas: On 7/25/2022, resident's #15, #30, #5, #49, #1, #43, #20, #25, #21 and #51 were interviewed and assessed (which included vital signs and pain assessment) by a facility nurse for adverse effects related to significant medication errors. There were no adverse effects identified. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility completed a Medication Error Report on all 10 identified residents with medication errors. Other Residents at Potential Risk: An audit of all current resident narcotic logs from 7/1/22 to current was initiated on 7/25/22 by the nurse managers, to verify controlled substances were/are administered and documented to standards. There were 10 out of 66 additional residents identified at risk of a medication error. The facility will complete a Medication Error Report on any additional identified medication errors. Process Implemented to prevent further incidence: The Administrator and Regional Nurse Consultant have reviewed the Controlled Drugs, Administration of Drugs, and Medication Errors policies and deemed they meet clinical and regulatory standards. On 7/25/22, training was initiated with the DON and Nurse Managers by the Nurse Consultant on identifying, reporting and follow up on medication error. Nurse managers who have not received the education will be removed from the schedule until the education is completed. As of 7/26/22, 2 out of 3 Nurse Managers have received training. On 7/25/22, the facility-initiated education with the licensed nurses by a nurse manager on administration of Controlled Drugs, Administration of Drugs, and Medication Errors. Licensed nurses who have not received the education will be removed from the schedule until the education is completed. As of 7/26/22, 6 out of 13 facility licensed nurses have received training. As of 7/26/22, 3 out of 18 agency licensed nurses have received training. The consultant pharmacist was informed of the findings on 7/25/22. The pharmacist consultant will review monthly the controlled drugs shift to shift logs and medication administration records for concerns and report their findings to the facility for appropriate follow up. Monitoring: The Director of Nursing and/ or designee will conduct random audits of medication administration on three nurses weekly for 4 weeks, then monthly thereafter for 3 months or until sustained compliance has been achieved to ensure appropriate administration of medication, including controlled medications and medication error are identified and report as applicable. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The medical director was notified of these findings on 7/25/2022 All findings will be forwarded to the QA committee and will provide further guidance as needed. The facility alleges that the immediacy with the deficient practice has been removed on July 26, 2022. Although the immediate jeopardy was removed on 7/26/22, the facility remained out of compliance at a scope of pattern and severity of likelihood of harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37577 Based on observation, interview, and record review, the facility failed to securely store narcotics, monitor refrigerator/medication storage temperatures, and monitor for expired medications in 2 medication storage rooms and 1 medication cart, resulting in the potential for narcotic diversion and reduced medication efficacy. Findings: During an observation on 07/19/22 at 11:41 AM, the medication storage room for the 400/500 halls was not secured. The door to the storage room was not closed tightly, the surveyor walked in to the room and noted that the medication refrigerator was not locked. The medication refrigerator contained a small plastic locked container used to store controlled substances. The shelf that the narcotic storage box was secured to could be pulled out of the refrigerator. Also located in the refrigerator were 3 boxes of Flu vaccines afluria with expiration dates of June 30 2022. The refrigerator temperature documentation log sheet sheet for the 400/500 halls medication storage room had one temperature written in on 7-5-22 during the PM shift. During an observation on 07/19/22 at 12:25 PM, the 200 hall medication storage room's refrigerator temperature log was missing temperature checks for 6 PM shifts in July. Review of the facility Policy/Procedure Medication Access and Storage, adopted 07/11/2018, reflected It is the policy of this facility to store all drugs and biological's in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. 31771 300 Hall Medication Cart On 7/20/22 at approximately 9:15 AM a review of the 300 Hall medication was conducted with Registered Nurse (RN) F. In the top drawer of the cart was noted a Humalog Kwik Pen that had been placed in service for R60. It was observed that the Humalog Kwik Pen did not reveal a date that it had been placed in service. RN F was asked if the insulin pen should have a date on it when it was placed in service. RN F stated, Absolutely It even has a sticker for it (a place that the date could be written). This indicated that the Humalog Pen must be assigned a known start date when it was placed in service. This known start date, evident for all licensed nursing staff to monitor, would indicate when the twenty-eight-day limit had begun, and a discard date could be calculated from that start date. Review of the manufacturer's package insert for the storage and use of the Humalog Kwik pen was reviewed. The manufacturer's package insert reflected the care of In-use Pen to Store the pen you are currently using at room temperature. Throw away the Humalog Pen you are using after twenty-eight days, even if it still has insulin left in it.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to: (a) properly date food and drinks, (b) consistently monitor dish machine temperatures, and (c) correctly thaw chicken, resulting in an increased risk for contaminated food and food borne illness for all residents who received hydration and nutrition from the kitchen. Findings include: During the initial kitchen tour that started at 9:03 AM on 07/18/22, a large tub of chicken soaking in water was observed sitting in the middle sink of the 3-compartment dish sink. During the initial tour at 9:07 AM, an observation inside the left side of the refrigerator designated juice box revealed a pitcher of red juice with no lid and no date. A sticky red substance coated half of the bottom shelf of the left side of the refrigerator. A milk crate on a lower shelf below the pitcher of red juice, held half pint milk cartons that had a red sticky substance on the containers. During the initial kitchen tour on 07/18/22 at 9:12 AM, a plastic container containing corn flakes was labeled as prepared 6/8/22 and use by 7/8/22. During the initial kitchen tour on 07/18/22 the additional following observations were made: (1) Four 1/4 metal pans were stacked after being washed. Moisture was visible in three of the pans. (2) The refrigerator designated cook box contained (a) one 5 pound bag of Queso Rico shredded cheese that was open and had not been dated, (b) a plastic tub with a green lid that appeared to contain some sort of beef soup, did not have a label to identify the food nor a date label, (c) one 5 pound bag of fresh cut salad, opened and no date label, and (d) an open to air package of turkey lunch meat with no date label. (3) The refrigerator designated reach in contained 6 uncovered and undated cups of peaches and 6 uncovered and undated cups of applesauce. (4) Review of the dishwashing/warewashing machine temperature log revealed no temperature had been checked for dinner on 07/17/22. (5) The walk-in refrigerator contained (a) one 25-pound box of Markon First Crop Fresh Tomatoes and many of the tomatoes had brown marks and were soft and squishy, (b) one box of Markon Chopped Collard Greens that did not have a received date marked, and (c) one box of Queen [NAME] heads of lettuce that did not have a received date marked. (6) The walk-in freezer contained (a) one box of Banquet Beef Pot Pies that sat under the condenser and had ice formation on the lid and the lid of the box was discolored by an unknown liquid, and (b) three stacked 9 x 11' tin pans also sat under the condenser and contained an unidentified frozen food. The pans were not labeled or dated, and the lids were not secured, and ice formation was observed around the edges of the food. (7) The dry storage room contained: (a) one large plastic bin labeled as corn starch and use by date of 09/08/21. The bin contained two open bags of flour. (b) An 8-quart plastic container of flour, with an unsealed lid and no date, sat on the bottom shelf of a metal rack, and (c) one opened and undated loaf of bread, two opened and undated packages of buns, and none of the bread was marked with received dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the last observation of the initial kitchen tour at 9:55 AM, the tub of chicken in the 3-compartment dish sink now had room temperature water running in it from the faucet. The faucet and handle were leaking, and the water dripped from the handles and faucet into the tub of chicken. During an observation at the same time, dietary cook L stated that the chicken was being thawed for immediate use. The dietician and kitchen manager were not available for the initial tour. During a revisit to the kitchen on 07/19/22 at 7:30 AM the following observations were made: (1) In the refrigerator designated juice box and on the right side sat two pitchers of yellow juice without lids or use by dates. (2) The refrigerator designated reach-in contained 4 uncovered and undated cups of applesauce and 2 uncovered and undated cups of peaches, as well as an uncovered small bowl of salad and one cup of uncovered pudding. During an interview at the time of the tour, with dietician N, it was noted that if they are left- overs, they should be covered and dated. (3) The plastic bin of corn flakes labeled use by 07/08/22, remained on the shelf near the food prep area. (4) Review of the dishwash/warewash machine temperature log reflected no temperatures were checked for lunch or dinner on 07/18/22. (5) The dry storage room contained: (a) one large plastic bin labeled as corn starch and use by date of 09/08/21. The bin contained two open bags of flour. (b) An 8-quart plastic container of flour, with an unsealed lid and no date, remained on the bottom shelf of a metal rack, and (c) now two opened and undated loafs of bread, two opened and undated packages of buns-one were not tied off and open to air, and none of the bread was marked with received dates. Dietician N indicated that when bread products are opened, they should be tied off and dated, and that the containers of flour should be dated. During the revisit to the kitchen on 07/19/22 at 8:00 AM, Kitchen Manager M arrived and reviewed the above listed findings. Additionally, a new observation in the walk-in refrigerator was made of a box of fish, being thawed for use that day, sat uncovered and unprotected, and was near a cooling unit. During a revisit to the kitchen on 07/20/22 at 8:00 AM, the following was observed: (1) The left side of the refrigerator designated as juice box contained the uncovered and undated pitcher of red juice. (2) The red sticky substance still coated half of the bottom shelf of the left side of the juice Box refrigerator. (3) The walk-in refrigerator contained a gallon of milk with expiration date 07/19/22, and (4) In dry storage area, two packages of bread products were opened and not labeled or dated. Review of the facility Policy/Procedure Food Receiving and Storage, adopted 07/11/2018, reflected the following: It is the policy of this facility that foods shall be received and stored in a manner that complies with safe food handling practices .(1) Food Services, or other designated staff, will maintain clean food storage areas at all times .(7) Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date) and .(8) All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date).

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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** 38659 This citation refers in part to MI0012914 Based on interview and record review, the facility failed to maintain complete and accurate medical records for 2 residents (R11 and R6), and had an incomplete and inaccurate facility reported incident (R11), resulting in inaccurate and incomplete medical records, the potential for providers not having an accurate picture of the residents condition and facility reported incidents not having complete and accurate information. Findings include: R 6 Review of R6's face sheet dated 7/19/22 revealed they are a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: dementia, anxiety, heart failure and residual schizophrenia. R6 was not her own responsible party. On 07/18/22 at 10:50 AM R6 was viewed in her room, she was staring blankly in a darkened room and sitting in her wheelchair. R6 had multiple sores on both sides of her face. They did not appear to be fresh, they were scabbed over and not bleeding. Blood was not observed on her hands, or bed sheets. R6 was asked what happened on face and she stated I'm not sure, maybe I dug at it with a screwdriver or something. On 07/18/22 at 12:20 PM R6 was observed being assisted by staff D with her lunch tray after she put on her call light. On 7/19/22 at 11:30 AM, R6 was viewed in her room, laying in bed and awake. On 07/19/22 at 11:40 AM, an interview was completed with CNA (certified nursing assistant) C about R6's facial wounds. CNA C stated she has wounds that will heal up and then dig at them again. CNA C thought they put cream on them at times, but R6 often refuses. CNA C was not sure when the current wounds started. CNA C was also working on R6's hall the previous day. She could not recall if R6 had wounds at that time. On 07/19/22 at 11:42 AM an interview was completed with UM (unit manager) A. UM A stated, the last she knew the wounds on R6's face were healed. R6 has wounds intermittently on her face, it is anxiety related and R6 will dig and pick at her face. UM A stated interventions include activities such as giving her cardboard to tear or corn on the cob to pick at. The wound nurse practitioner will come in Thursdays for wound rounds and UM A rounds with them. R6 did not have any facial wounds as of last Thursday. Other interventions for R6 include topical creams, but they are not always tolerated. UM A stated that staff should put a skin note in if there was a new injury and she was not aware of a new injury or injuries to R6's face. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/19/22 at 04:10 PM R6 was viewed in her wheelchair sitting in a darkened room with the door open. There were still no activities viewed in her room, she was viewed talking to herself and stated she was just talking to the pictures on the floor. On 07/20/22 at 09:16 AM R6 was viewed in her darkened room, sitting in her wheelchair picking at her face. R6 said she just finished breakfast. A stuffed cat was viewed on the bed, the resident was not touching the cat. No other activities were viewed. On 07/20/22 at 09:29 AM an interview was completed with Activities Director (AD) E in reference to R6. AD E stated R6 is usually pleasant with staff, but never wants to come to group activities. AD E stated R6 likes tactile activities, like tearing cardboard and picking at corn cobs. Activities staff do involve R6 in some one on one activities with her roommate as well. AD E was asked what activities R6 has been provided this week. AD E stated she thought R6 was tearing up a tissue box at some point this week, but was unsure of any other activities. AD E stated no one has talked to her this week to reach out to R6 more with activities, but that she and 3 other activities staff round to get residents to group activities and offer individual activities. AD E stated R6 is usually in her chair in her room, she is very particular about having clutter or extra things in the room, so when bringing things they have to round back shortly to make sure she is done. AD E stated it is charted under tasks when staff round or do activities. It was discussed that not many activities or attempts to engage in activities are in R6's chart. AD E was informed R6 was recently doing some self injury behaviors again and staff had expressed that more activities would be explored. AD E reiterated that no one has reached out this week to do more things with R6, but will make sure the activities staff round more with her. On 07/20/22 at 11:52 AM, an interview was completed with UM A regarding R6. UM A stated she did not get a chance to talk to activities staff yesterday, but did talk to them now. UM A stated she personally did get R6 some cardboard to tear yesterday. Review of R6's care plan revealed a focus area with a last revised dated on 3/5/22 of an open lesion to R6's supra pubic regions and resident noted aggressively scratching that area when agitated. There is no note of facial lesions. Interventions included: Activities providing extra activities for tactile stimulation as tolerated. Another focus area with a last revised date of 1/11/22 revealed a history of skin injuries with an intervention that included observe skin daily with care activities. Report any changes in coloration, integrity, etc to nurse. An additional care area with the last revised date of 3/14/20 related to psychosocial well-being included interventions such as: provide in room activities of choice, as able. R6's care plan also noted she needed assistance with ADL (activities of daily living), such as transfers from the bed to wheelchair, toileting and personal hygiene, thus staff should be regularly interacting with her. Review of R6's kardex revealed the following under the section Activities: provide her with materials for individual activities as desired. The resident likes the following independent activities: watching TV (talk shows), tearing cardboard, visiting with staff, special snacks and Provide in room activities of choice, as able. Review of R6's activities log revealed, limited activities were logged in the last 30 days. Review of R6's activity log for July revealed no activities offered to R6 on 7/2, 7/3, 7/4, 7/11, 7/13, 7/15, 7/16 and 7/17/22. Other days had 1-2 activities offered. On 7/20/22 there were 8 activities offered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R6's skin assessment for 7/19/22 revealed 5 facial scabs measuring 1.4x0.7x0.1, 1x0.2x0.1, 1.5x0.5x0.1, 0.3x0.2x0.1 and 0.7x0.5x0.1 centimeters. Review of wound notes with encounter date of 7/14/22 revealed no active wounds. Past history of wounds are documented and included an abdominal wound, which had recently healed. There was a note from 12/9/2021 that referred to facial wounds due to R6 picking at her skin. Review of R6's progress notes revealed no recent mention of facial wounds prior to 7/19/22. A note on 7/19/22 at 12:04 PM by social services revealed: SS provided follow-up visit this morning. Resident was observed tearing cardboard and had a big smile on her face this morning. She told SS she was shredding cardboard which has been a preferred intervention of hers to avoid or minimize picking at her face. Resident noted that activities had just seen her and was bringing more cardboard for her to rip pieces from. Resident became frustrated when SS began asking her about picking at her face. To avoid more frustration, SS praised her for engaging in ripping cardboard and encouraged her to continue as this is something she voices enjoyment doing. Will continue to follow-up and offer support as needed or requested. A late entry general progress note was added on 7/20/22 and dated 7/19/22 at 10:54 AM: Resident provided with cardboard and cardstock for shredding by this nurse until able to be reviewed by activities director. Resident thankful for activity. An event note from 7/19/22 at 1:06 PM revealed: Nurse entered room and noticed 5 areas on residents face that were scabbed over, 2 areas noted on her left cheek, 1 on her nose, 1 on her chin and 1 on her right cheek. See skin obs for measurements. Resident states she picked at the skin on her face. Head to toe assessment completed, no additional self inflicted areas noted at this time. No c/o pain from resident. VS stable and at baseline. UM, DPOA, BCS and physician notified. Activities to assess for a tactile distraction for resident. A general progress note from 7/20/22 at 10:56 AM revealed: Discussed with Activities Director need to increase tactile activities for resident. Activities Director states she is aware and has provided items to her today and plans to assess further. A recreational services note on 7/20/22 at 12:10 PM revealed: Activities visited with Resident today to assess life enrichment options and preferences. Resident had pleasant affect and was sitting at her table waiting for lunch. Activities brought in multiple independent/tactile activities, per residents' preference. Resident initially refused most items in preference for cardboard to tear, but upon re-approach with basket to keep items in, accepted paper, cardboard, sensory putty, and coloring supplies. Resident refused offer to create a collage with ripped paper, both independently or with staff, as well as refused offer to go outside this afternoon. Historically, Resident has grown frustrated with keeping these items in her room for prolonged periods of time, so was reassured AD would follow up this afternoon. Resident expressed thankfulness at the end of today's visit. Activities will continue to monitor and encourage appropriate engagement. R11 Review of R11's face sheet dated 7/20/22 revealed they are a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: dementia, hemiplegia and hemiparesis (paralysis and weakness on one side of the body), bipolar disorder, depression and Chronic Obstructive Pulmonary Disease (COPD). Review of facility reported incident with final investigation submitted 6/1/2022 regarding R11 being allegedly called a name by a visitor revealed the incident was documented to be discovered on 5/24/2022 at 9:16 AM, there was no date or time the incident occurred entered. The provided investigation summary did not include any dates or times. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R11's progress notes revealed only a social services note on 5/25/2022 for a follow-up visit regarding the resident alleging that a visitor called her a name this week. There was no other note to document the alleged incident or when the allegation was received. The facility provided a working investigation file. The facility summary word document had no date or time of that the resident told staff of the incident and no date or time that the incident allegedly occurred. It was noted that it was reported about 30 minutes after the visitor left. Included in the facility file was a Grievance and Satisfaction Form dated 5/23/22 with no time filled in. Under the Administrator Notification section, the Director of Nursing (DON) was documented to have received the form on 5/23/22. Also included in the facility file were staff interviews. Some staff interviews noted an incident date of 5/23/22 and some were documented with an incident date of 5/24/22. During an interview of 07/20/22 at 10:56 AM with the DON, the incident with R1 was discussed. The discrepancies with the incident dates was discussed. The DON looked over the files and stated the incident occurred on 5/23/22 but they were notified on 5/24/22, the next day. The DON stated if there is a conflict or confusion in the dates, that is why. The DON agreed that the dates should match and there should be times noted. The DON was also informed nothing is noted in the resident progress notes. The DON stated it was not noted because I don't believe anything actually occurred. The DON was asked if it would it be important to note behavior where the resident makes allegations, she replied: I suppose so.