STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235132	A. Building B. Wing	06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake Numbers MI00118232 and MI00120441 Based on observation, interview and record review, the facility failed to ensure staff-to-resident communication was conducted in a dignified manner for two residents (Resident #18 and Resident #32) of two residents reviewed for staff-to-resident interactions, resulting in staff speaking to Resident #32 in an undignified manner and belittling and demeaning written documentation of staff verbal communication and directions to Resident #18. Findings include: Resident #18: Review of intake documentation for Resident #18 detailed that on 1/21/21, (Resident #18) voiced complaint that (Certified Nursing Assistant O) told them not to touch their colostomy device because it would cause it to leak. Resident believes this was verbal abuse . and does not want (Nursing Assistant O) for a caregiver again . Record review revealed Resident #18 was discharged home from the facility on 4/8/21. An interview was attempted to be completed with Resident #18 via phone on 5/27/21 at 2:50 PM. A message was left with return phone number. Record review revealed Resident #18 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included gastrointestinal hemorrhage and gastrointestinal fistula (opening in the stomach or intestines that allows contents to leak), gastrostomy (surgically placed opening through the abdomen wall to the stomach for food), and colostomy (surgically created opening in the abdomen wall to allow for the passage of bowel contents). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to perform all Activities of Daily Living (ADLs). The MDS further indicated the Resident displayed verbal behaviors towards others one to three days and rejected care four to six days. On 5/28/21 at 7:45 AM and 7:50 AM, Nursing Assistant O was contacted, via phone, at both numbers provided by the facility. A voicemail message was left with a return number. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress note documentation in Resident #18's medical record revealed the following: -1/20/21: Social Services . Care conference held in resident's room. SW (Social Worker), RD (Registered Dietician), CTRS (Certified Therapeutic Recreation Specialist) and Aid (Nursing Assistant) in attendance . Resident discussed that they would like to go home if they can get feeding tube removed. SW discussed resident getting agitated with staff and (Resident #18) stated that it happens when asking for pain meds. Reminded (Resident) that it is appropriate ask for and not demand them. Aide reported no concerns at this time . -1/24/21: General Progress Note . Resident requested to get ileostomy bag emptied. CNA didn't know how to empty . Nurse finished her job and went in to empty it. In the meantime, Resident called nurses station complaining they had waited 45 minutes. This was exaggerated. Explained to resident I have 19 patients . Then resident c/o (complain of) soiled towel. Nurse replaced towel. Then resident requested lights to be turned out. Lights turned out. Resident looks for things to complain about. (Authored by Licensed Practical Nurse (LPN) P) -1/27/21: Social Services . Resident continues to upset with staff and will yell and scream. Resident reports that he is leaving AMA (Against Medical Advice) . Review of assessment documentation in Resident #18's medical record revealed a Behavioral Symptoms assessment dated [DATE]. The assessment detailed, Identified Behavioral Symptom: Verbal Aggression . Agitation, irritability or hyperactivity . Seriousness of the Behavioral Symptom . immediate intervention required: No; Symptoms interfere with medical care: No; Disruptive: No; Distressing to self and/or others: No . Nature of the Behavioral Disturbance . Purposeful . Additional Factors That May Contribute to Behavior . Pain . Additional Comments: Resident became upset and verbally aggressive towards staff when asking for pain medication. No other documentation was noted in the Resident's medical record related to behaviors. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with LPN P on 5/28/21 at 9:48 AM. When queried regarding Resident #18, LPN P revealed they had cared for the Resident when they were in the facility. With further inquiry regarding the Resident, LPN P revealed the Resident wanted to care for their colostomy themselves and stated, Didn't want anyone to help. (Resident #18) was kind of a mess. When queried regarding behaviors, LPN P stated, (Resident #18) He would have little complaints, but I think when you are like that you are just angry at the world. LPN P continued, I really didn't have any problems with (the Resident) other than they would occasionally refuse. When queried regarding the General Progress Note they authored on 1/24/21, LPN P stated, (Resident #18) would exaggerate the time of everything. Their colostomy would not stop leaking. (Resident #18) would complain like that and exaggerate the time. When asked about the Resident's colostomy, LPN P stated, We were changing the bag four to five times a day. (Resident #18) was complaining all the time. With further inquiry regarding the Resident's complaints and what actions were taken by the facility, LPN P revealed the Resident would request their pain medication before they were able to have if and be mad because they were not able to receive it. LPN P then stated, I am sure it was raw. It (colostomy) leaked all the time. LPN P was then asked if nursing staff are expected to document in the medical record if there is a concern, such as leaking with a colostomy, and replied, Should be documented in the progress notes if it is leaking or changed. When queried regarding the rationale for telling Resident #18 they had 19 patients, LPN P revealed they did have 19 patients. When queried regarding the note detailing the towel was changed because the Resident was complaining, LPN P disclosed that was the reason they changed the towel. LPN P revealed the towel was always wet and Resident #18 was complaining about it. When asked if providing clean linens and supplies was a nursing responsibility, LPN P revealed it was. Review of Resident #18's active care plans, prior to 1/19/21 revealed a care plan entitled, At risk for behavior symptoms r/t (related to) (Blank) . (Created and Initiated: 12/23/20). The care plan included the intervention, Use consistent approaches when providing care (Initiated: 12/23/20). On 1/19/21, the care plan was revised and entitled, At risk for behavior symptoms r/t pain. Pt (patient) becomes verbally abusive and argumentative towards staff (Revised: 1/19/21). Revised/updated care plan interventions included: - Like to watch the news (Created and Initiated: 1/19/21 - Like to watch football- [NAME] (Created and Initiated: 1/19/21) - Offer to put on TV shows - horror movies (Created and Initiated: 1/19/21) - Redirect when is verbally agitation (Created and Initiated: 1/19/21) Resident #18 was attempted to be contacted via phone again on 6/2/21 at 8:15 AM. A voicemail message was left with return number. An interview was completed with Social Worker C on 6/3/21 at 10:00 AM. The Social Services progress note dated 1/20/21 was reviewed with Social Worker C at this time. When queried if Residents have a right to demand and/or request items including pain medication, Social Worker C replied, Absolutely. With further inquiry, Social Worker C revealed it is demeaning to tell Residents how they can speak and stated, Definitely better ways to do it. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) and acting Administrator on 6/3/21 at 11:40 AM. When queried regarding documentation in Resident #18's medical record indicating they were told they were unable to demand pain medications and documentation authored by LPN P, the both the DON and acting Administrator revealed it is not appropriate for staff to tell Residents how they are able to make requests. The DON stated, I think the wording was poor and indicated they were working with staff to improve documentation. At this time, the acting Administrator stated, People document how they talk. 37666 Resident #32: An interview with Confidential Person AA, on 6/2/21 at 1:23 PM provided, He (Resident #32) told me an aide (CNA Z) was abrupt and rough with him. He said the aide said, The other shift should have changed you. I shouldn't have to do it. I called and talked to someone. The Director of Nursing called me back and took care of it. Then the aide came into his room and said, Thanks for getting me in trouble. On 6/2/21 at 2:30 PM, Resident #32 was observed lying in bed watching TV. He was alert and oriented x 3 and readily conversed with this surveyor. Resident #32 described an incident that had occurred about 1-week prior involving Certified Nursing Assistant (CNA) Z. The resident said the aide had worked with him previously and he had not had any issues with her. On this day, she complained to him about changing his brief, because she felt that the previous shift should have changed it prior to the next shift arriving; Resident #32 said the aide was rough with him when she turned him with care. Resident #32 said there are supposed to be 2 staff members assisting him with care and CNA Z had not taken care of him since he reported the incident. A record review of the Face Sheet and Minimum Data Set (MDS) assessment, indicated Resident #32 was admitted to the facility on [DATE] with diagnoses: history of a brain bleed, right and left-sided weakness, diabetes, depression, anxiety and hypertension. The MDS assessment dated [DATE] revealed the resident had moderate cognitive loss and needed 2-person assistance with bed mobility, transfers, hygiene, bathing and toileting. A review of the Care Plans for Resident #32 identified the following: ADL (activities of daily living) Self care deficit . dated initiated 1/22/2016 and revised 5/20/2021, with Interventions: 2-person extensive assist for showers, bed mobility and incontinence care, dated 7/20/2017 and revised 11/15/2017. Possible cognitive loss . date initiated 1/27/2016 and revised 5/20/2021, with Interventions: Approach/speak in a calm, positive/reassuring manner, date initiated 1/27/2016. Difficulty communicating . date initiated 1/22/2016 and revised 5/20/2021, with Interventions: Provide reassurance and patience when communicating . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 6/2/21 at 5:00 PM revealed, she said the resident reported to a (Confidential Person) than (CNA Z) came in his room and complained that she had to change his brief and told him the other shift should have done it. The DON said the aide was placed off work during the investigation and received a written reprimand and education related to customer service. An interview with CNA Z on 6/3/21 at 11:39 AM, I went in his room and he said he needed to be changed. He said 'I had my light on and nobody came in.' I said, I guess I have to do that. I asked him why the shift before didn't clean him up. Sometimes the residents are drenched. We get a little aggravated. The CNA was asked how many staff were supposed to assist the resident with care and said, I guess there is supposed to be 2, but we are always short-staffed. Centers for Medicare and Medicaid Services (CMS), Your Rights and Protections as a Nursing Home Resident, dated 2021 provided, . At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to: Be Treated with Respect: Your have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation pertains to Intake Number MI00120206 Based on observation, interview and record review, the facility failed to obtain informed consent prior to administering a Covid-19 vaccination for one resident (Resident #26) of three residents reviewed for vaccinations from a total sample of thirty-five residents, resulting in Resident #26 receiving a Covid-19 vaccination against her Guardian's wishes. Findings Include: Resident #26: A record review of the Face Sheet and most recent Minimum Data Set (MDS) assessment indicated Resident #26 was admitted to the facility on [DATE] with diagnoses: Parkinson's Disease, bilateral cataracts, Dementia, peripheral neuropathy and arthritis. The MDS assessment indicate the resident had Moderate cognitive impairment with a Brief Interview for Mental Status score (BIMS) of 11 out of 15. The resident required assistance with all care. Further review revealed Resident #26 had a Legal Guardian to assist in making care decisions for the resident. An interview with Confidential Person BB, on 5/26/21 at 11:55 AM They called me a couple times and asked me if I wanted her vaccinated for Covid and I said, No. I didn't find out until about May 17th (2021) that she had the Covid vaccination on May 14th (2021). Someone called me and said she was doing Ok, and then someone else called and said it was their fault and what could they do to make it better. I said there was nothing. A review of the Immunizations tab for Resident #26 indicated there were 2 entries for the Covid-19 vaccinations: Doses 1 and 2. Both entries had a Consent Refused next to them. Neither entry was dated. A review of the Physician orders did not reveal an order to receive the Covid-19 vaccination or monitoring for signs and symptoms of Adverse reactions. A review of the Medication Administration Records (MARS) for May 2021 did not identify that the resident received a Covid-19 vaccination in May 2021. A review of the progress notes, including nurses notes and physician notes had no mention of the resident receiving the Covid-19 vaccination, contact of the Guardian or monitoring of potential adverse reaction/signs or symptoms. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/26/21 at 12:55 PM, during an interview with the Director of Nursing (DON), she was asked if Resident #26 received the Covid-19 vaccination and stated, The (local) Health Department came in on May 14th, 2021 and I gave them a list of residents to receive the Covid Vaccination. She was not on it, but her roommate was. When we went in the room for them to vaccinate her roommate, (Resident #26) asked for the vaccination, without thinking, I told her she could have one and she was vaccinated. She was so happy. She said she would be able to see her grandchildren. The Health Department obtained the consent from her. During the same interview, the Director of Nursing said she later recalled the resident had a Guardian and he was contacted. The DON was asked why there was no documentation in the resident's medical record to indicate that she had received a vaccination, as this needed to be closely monitored and she said it wasn't documented that she received it, but the facility was monitoring her temperature and for signs and symptoms of Covid-19. Discussed with the DON that signs and symptoms of an adverse reaction can be different than signs and symptoms of Covid-19, including a reaction at the injection site. The DON said the facility audited all residents to ensure no one else received the vaccination without informed consent and enacted a new process to ensure that this would not happen again. Centers for Medicare and Medicaid Services, Resident Rights, Your Rights and Protections as a Nursing Home Resident, dated 2021 .At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to: To be fully informed about your total health status in a language you understand; To be fully informed about your medical condition, prescription, and over-the-counter Drugs .; To participate in the decisions that affects your care . This also applies to the responsible party who is assisting to ensure the resident receives appropriate care.

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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** 37666 This Citation pertains to Intake Number MI00115237 Based on interview and record review, the facility failed to notify the resident's responsible party with a change of condition and when the resident was transferred to the hospital for one resident (Resident #5) of three residents reviewed for a change of condition, resulting in Resident #5 transferring to the hospital without notification of the responsible party to make them aware of a serious decline in condition and transfer to the emergency room . Findings Include: Resident #5: A record review of the Face Sheet and Minimum Data Set (MDS) assessment for Resident #5, indicated an admission to the facility on [DATE] with diagnoses: Mild intellectual disabilities, diabetes, Epilepsy, depression, Morbid Obesity, heart failure, atrial fibrillation and COPD. The MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15 indicating severe cognitive impairment. The resident needed assistance with all care. A review of the Census tab in the resident's electronic medical record (EMR) revealed the resident transferred to the hospital on 9/2/20 with readmission on 9/9/20 and transferred to the hospital again on 9/29/20 with no return. An interview with Confidential Person CC on 6/3/21 at 11:54 PM provided, My son was there since the beginning of 2020. He had an appointment with the Heart doctor on 9/22/20. When he came back, they said he was dehydrated. I said why didn't he go to the hospital. I said, 'Are you trying to kill him?' They never sent him to the hospital. I would go to the window to see him, every day. He wasn't the same. All of a sudden it looked like there was something wrong. He was just looking around like he was having a seizure. I told them; most of the time the door was closed. I kept calling. He was not getting better. He was confused. They didn't pay attention to me. I called on 9/29/21 at 8:49 AM, 5:04 PM. I kept trying to call and couldn't get through: 5:56 PM, 5:57 PM, 5:58 PM, 6:21 PM, 7:04 PM, 8:10 PM, 8:11 PM, 9:25 PM 9:28 PM, 9:32 PM. Then at 9:47 PM (the hospital) called me and said, Your son is here. Did (the facility) call you? You need to get up here. He is real bad. They said he was suffering. At 6:20 PM the next evening he passed away. The (facility) never called me. It was the hospital that called. A review of the progress notes for Resident #5 revealed the following: 9/26/21 at 11:16 PM, Resident visiting with his mother earlier. Complains of pain in arms and legs . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/27/21 at 10:49 PM, . He ate breakfast but refused lunch . 9/28/21 There were no documented progress notes of the resident's condition. The notes and assessments go from 9/27/21 at 11:32 PM to the next note at 9/29/20 at 3:10 AM; greater than 24 hours later. 9/29/21 at 6:55 AM, Resident (fasting blood sugar) 1 hour after lunch meal, 44. Resident was still responsive. Had oral glucose. Blood sugar at 51. Glucagon administered. Blood sugar at 62. Resident not answering verbally slurring words. Per (Nurse Practitioner) orders 2nd Glucagon administered. Blood sugar at 95; after then 116. Resident completely responsive. (Blood pressure) low. IV fluids ordered at this time for altered mental status. The next note dated 9/29/21 at 9:22 AM is a respiratory assessment with no additional comments or findings. The next note dated 9/29/21 at 2:20 PM, . During assessment resident was noted to be fatigued and falling asleep during conversation. Glucose level checked and noted to be 44 (low). Glucagon administered-glucose recheck after 15 minutes 51 . Physician updated. The next note is dated 9/30/21 at 12:09 AM, . Cena (Certified Nursing Assistant) notified me at about 6:45 PM that she couldn't get resident to respond to her when she was trying to feed him. When I entered room, resident's neck was hyper extended, eyes staring straight ahead . started having rhythmic movement of head for about 20-30 seconds, then stopped. Repeated this about 6 times . seizure-like . Decision made to send resident to hospital for further evaluation and treatment. Message left with resident's mother to call here . The note on 9/30/21 at 12:09 AM was written about 5 hours after the resident had a serious change of condition. There was no mention of what time a message was left for the resident's mother. There was no documented 2nd attempt to contact her. There was no documentation of attempts to contact the resident's mother (responsible party) with each of the episodes of a very low blood sugar. There was also no attempt to contact the resident's responsible party when he began to skip meals, which could lead to low blood sugar, as he was diabetic and received Insulin. An interview with the Director of Nursing (DON) on 6/2/21 at 3:00 PM related to the resident's change of condition and lack of notification to the responsible party provided, Our policy noting change of condition, includes increased monitoring, notify the doctor and responsible party; leave a message if not available, call again if no return call. A review of the resident's Care Plans provided the following: The resident has an alteration in neurological status . history of seizures, date initiated 2/11/2020, with Interventions: Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments, date initiated 2/11/2020. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Change in Condition, dated 11/2016 Purpose: To provide Guidance in the identification of clinical changes that may constitute a change in condition and require intervention and notifications. Note: CMS requires, A facility must immediately inform the resident; consult with the resident's physician and notify, consistent with his or her authority, the resident representatives when there is . A significant change in the resident's physician, mental or psychosocial status (that is a deterioration in health .) . A decision to transfer or discharge the resident from the facility .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation pertains to Intake Number MI00120213. Based on interview and record review, the facility failed to operationalize policies and procedures to ensure a thorough and comprehensive investigation was completed for an allegation of abuse and unusual occurrence for two residents (Resident #27 and Resident #35) of twenty-four residents reviewed for abuse, resulting in a lack of investigation, lack of staff interviews, and the potential for inaccurate investigation results and unidentified events/abuse. Findings include: Review of intake documentation detailed, (Resident #27) states that police forcefully placed them in their wheelchair repeatedly. Record review revealed Resident #27 was admitted to the facility on [DATE] with diagnoses which included Cardiovascular Accident (CVA-stroke) with resulting hemiplegia and hemiparalysis (one sided paralysis), and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the Resident was cognitively intact, required supervision to perform all Activities of Daily Living (ADLs), and displayed rejection of care behaviors one to three days. Review of Resident #27's care plans revealed a care plan entitled, At risk for behavior symptoms. Resident has confusion and behaviors . Resident will become overly concerned with and involved in roommates' care. Resident will attempt to and will barricade self in room. Resident will call police r/t (related to) believing/perceiving rights are being violated r/t having staff monitoring watching over them (Created: 4/12/21; Initiated: 5/13/21; Revised: 5/20/21). The care plan included the intervention, Reassure resident care is being provided for roommate (Initiated: 5/18/21) Review of progress note documentation in Resident #27's medical record revealed the following: -5/12/21 at 5:13 PM: General Progress Note . At approx. 3:30 pm today resident came out of room yelling and swearing, stating that the staff here were ignorant and G-- D--- Imbeciles . Supervisor, social work and resident's nurse made aware. 5/12/21 at 6:57 PM: Social Services . SW (Social Worker) heard resident in the hall yelling at staff. SW sat with resident and discussed behavior. Resident states that only yells at staff when feels that needs to . 5/17/21 at 9:48 PM: General Progress Note . Notice Resident is becoming aggressive and overly involved in roommates care . Resident continued throughout shift being demanding and waving cane while talking to staff. Administration is aware of residents behavior . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/18/21 at 3:03 AM: General Progress Note . patient noted sitting in w/c (wheelchair) at left side of roommates bed. Requesting that roommate's sheets and brief be changed because they are wet. patient's roommate's sheets checked, and they are wet also noted is incontinent of large amount of urine. Patient demanding and raising voice to this speaker that roommate be changed immediately and refusing to go to own side of bed until they are . -5/18/21 at 11:35 PM: General Progress Note . DON (Director of Nursing) received a call from floor nursing staff stating that this resident was holding the door closed to prevent staff from entering the room. Resident has a roommate that requires assistance and resident is preventing staff from entering the room. DON instructed staff to go down to the room while I was on the phone with them and explain to resident that they will need to open the door so staff can monitor roommate and provide care. By phone this writer could hear the resident say, 'You're not getting in here'. This writer instructed floor nurse to inform the resident that they were creating a potentially dangerous situation for the other resident and if they would not allow staff into the room, they would need to get the police to respond to the building. This writer heard the nurse inform the resident . responded, 'Call the police, you're not coming in'. Floor nurse ended call with this writer to contact the police. -5/19/21 at 00:35 AM: General Progress Note . DON received call from floor nurse stating that police were able to get the door open to the resident's room . refused to move to an alternate room so roommate was moved while police were present. After police left resident requested to be transferred to the emergency room . This writer instructed floor nurse to inform the physician and send resident to the hospital due to continued behaviors that put self, staff, and potentially others at risk. The medical record contained additional documentation of Resident #27's behaviors and behavior monitoring not included in this citation. An interview was conducted with Licensed Practical Nurse (LPN P) on 5/28/21 at 9:48 AM. When queried regarding Resident #27, LPN P stated, I haven't had a problem with (Resident #27) but I know other nurses have. (Resident #27) had a roommate, (Resident #35). They blocked the door, and no one could enter. With further inquiry, LPN P stated, I was on a different unit and tried to get (Resident #27) to open the (room) door but they wouldn't. I think they ended up calling the Police. A review of facility provided investigation revealed the investigation contained the following documentation: -Incident Reports dated 5/18/21 at 11:30 PM and 5/19/21 at 1:00 AM. -Investigation Summary -Statements from Resident #27, Nursing Assistant (CNA S), and Registered Nurse (RN) T -Resident #27's Electronic Medical Record (EMR) progress notes, Medication Administration Record (MAR), MDS, pain and transfer assessment documentation -Paper skin assessment documentation (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incident report dated 5/18/21 at 11:30 PM detailed, Type: Violent behavior . Location of Incident: Patient's Room. Description . Resident would not allow staff into room. Resident sat in front of the door and prevented staff from entering. Resident has a roommate (Resident #35), staff needed to enter room to provide care to the roommate. Unable to redirect or gain entry with verbal coaching from staff . Center Action . Entry to the room was gain with police assistance. Resident was assessed and found to be medically stable however he continued to exhibit verbally aggressive behavior with staff and threatened physical aggression with staff. Resident has not displayed any behaviors that are intentionally trying to harm any resident . believes they are helping the other residents . Incident Cause . Resident did not want to allow staff entry into the room . verbalized to police believe needs to take care of roommate. Resident is retired Fire Chief . alert and oriented x 3 (person, place, and time) . developed a believe that it is their job to make sure staff care for roommate . Resident was taken to the hospital for evaluation. (Resident #35) was moved to an alternate room . Disposition . Resident was sent to the hospital for evaluation of behaviors- Resident returned after a few hours . The incident report dated 5/19/21 at 1:00 AM detailed, Description . Resident states (Police Officer U) was rough with them during a police intervention . Describe cause of incident . Resident was not allowing staff in to care for their roommate. Police had to be called to intervene. Resident tried to get up multiple times, per (Resident #27) the officer told them to sit down but (the Resident) refused. When (Resident #27) did not site down the officer put pressure on their shoulder to get them to sit down . The investigation summary detailed, On 5/19/21, (Resident #27) stated the police entered their room forcefully alone with 'the rest of the mob' and restricted them (to) one corner of the room. (Resident #27) stated one of the officers was nice (Officer V) while the other (Officer U) was more forceful. (Resident #27) stated they tried to stand up from their wheelchair because (Officer U) had blocked them into the corner in a position that was uncomfortable for their leg. When *Resident #27) attempted to stand up, (Officer U) stated 'you are fine' and pushed them back down into the wheelchair (RN T) stated (Resident #27) was 'barricading' the door with themselves and their wheelchair with their roommate also inside . The investigation did not contain the schedule and/or staffing assignments for the date of the occurrence, statements, statements from other residents or staff working when the incident occurred, and/or a police report. Record review revealed Resident #35 was admitted to the facility on [DATE] with diagnoses which included non-traumatic brain dysfunction. dementia, and dysphagia (difficulty swallowing). Review of the MDS assessment dated [DATE] revealed the Resident was rarely/never understood and required extensive to total assistance to perform all ADLs with the exception of eating. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Director of Nursing (DON) on 6/2/21 at 11:48 AM. When queried regarding the incident involving Resident #27 and their roommate, the DON stated, (Resident #35) is the roommate. The DON was asked about Resident #35 including their cognitively ability and psychosocial well-being following the incident and stated, (Resident #35) has a guardian. They had no concerns. When queried if the facility completed a separate investigation concerning Resident #35, the DON revealed they did not and stated, There was no allegation that anything inappropriate was alleged to have been done with (Resident #35). When asked if (Resident #35) would be able to understand and express concerns, the DON revealed the Resident would not. The Don then stated, (Resident #27) felt that they were in charge of caring for (Resident #35). When asked if that was an unusual behavior, the DON revealed the facility was aware the Resident had issues in the past with interpersonal relationships. The DON was then asked what Resident #27 had barricaded the door with and replied, Themselves and their wheelchair. When queried regarding documentation of Resident #27's behavioral changes including increased involvement in Resident #35's care and lack of assessment of the change in behavior leading up to them barricading the door, the DON replied, Could they have done a behavioral assessment? Sure, but I don't know if expressing concern for roommate would be a behavior. When queried regarding a Police report and/or incident number related to the incident, the DON revealed they had not received any information from the department. Staff schedule including assignments for 5/18/21 and 5/19/21 were requested from the DON at this time. On 6/2/21 at 12:15 PM, an interview was completed with Police Staff W. When queried regarding the officers who responded to the incident at the facility involving Resident #27, Staff W revealed Officer V and Officer U were on duty and responded. When queried regarding a report related to the incident, Staff W stated, It is not letting me open it. They are working on it. Staff W continued, They (Officers V and U) were out there twice that night for that Resident. A voicemail was left with return number on the Officer's voicemail. A return call was not received by the conclusion of the survey. An interview was completed with Resident #27 in their room on 6/2/21 at 12:44 PM. When queried if they recalled the Police coming to the facility, Resident #27 specified they did. When asked what occurred, Resident #27 stated, I was worried about my roommate but did not elaborate. When queried if the Police came to the facility because they had physically blocked the door to prevent staff from entering, Resident #27 made eye contact, half smiled, but did not provide a response. When queried regarding their interaction with the Police, Resident #27 stated, They got a little rough with the forceful way they made me get into my wheelchair. Resident #27 was asked how the Police were rough and revealed they made them sit down and instructed them to stay where they were. When asked the reason why the Police wanted them to sit down and not move around, Resident #27 did not respond. Resident #27 was then asked if anyone else was present when the Police were in their room and replied, Yeah, the whole gang (facility staff). When queried why they blocked the door and prevented staff from providing care to their roommate, Resident #27 replied, I just wanted my roommate to get some sleep. When asked why they did not want staff to be able to check on their roommate, Resident #27 did not provide a response and began asking questions about this Surveyor. Review of facility provided schedule and assignment documentation revealed RN T, CNA X, and CNA Y were the staff assigned to care for Resident #27 and Resident #35 on 5/18/21 midnight shift. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the DON on 6/2/21 at 2:40 PM. When queried regarding Resident #27's behavior progression, the DON replied, I think (Resident #27) had a hard time getting acclimated (to facility). When asked about the facility reporting the incident as an allegation of abuse by the Police, the DON stated, They (residents) know what to say- abuse. The DON indicated Resident #27 felt that because they are elderly, they are able to allege elder abuse regardless of their actions towards others and/or police involvement. An interview was conducted with Agency RN T on 6/2/21 at 3:12 PM. When queried if they had worked the midnight shift of 5/18/21 to 5/19/21 at the facility, RN T indicated they had. RN T was then asked if anything out of the ordinary had happened during the shift and revealed they had to call the Police to assist with an incident involving Resident #27. RN T revealed the Resident room door was closed, the door was supposed to be open, and Resident #27 was preventing them from opening it. RN T stated, The aides (CNAs) told me it was supposed to be open. With further inquiry regarding the CNA's telling them the door should be open, RN T stated, The Aides were told by the nurse before that the room door was supposed to be open but (Resident #27) didn't want it open. (Resident #27) said it was bullshit. They were belligerent and swearing. RN T was asked what happened next and indicated they were concerned about Resident #27's roommate (Resident #35). RN T stated, I went back to (the room to) move (Resident #35) along with the aides and called the DON. We called the Police. When queried how Resident #27 had barricaded the door, RN T replied, (Resident #27) was behind the door with feet on the wall. When asked what occurred when the Police arrived, RN T stated, They (Police) forcefully opened the door. It took the two Police to push the door open. When queried what happened after gaining entry to the room, RN T replied, (Resident #27) was hitting at and fighting with them (Police). They (Police) asked me what I wanted to do with (Resident #27). When asked about Resident #27's roommate (Resident #35), RN T stated, I immediately thought of some sort of abuse. It was a fine line for me. RN T was asked to explain and elaborated, It wasn't the first time. How did (Resident #27) know their roommate was wet without touching them? There was a night from the night before that something happened. With further inquiry, RN T stated, (Resident #27) is like a ticking time bomb. When queried if they felt Resident #35 was in danger or if something had happened, RN T replied, I'm not saying (Resident #27) did anything (to Resident #35). I don't know if they did or not, but I was not comfortable with the situation or them being in the same room. When queried regarding any unusual behaviors prior to Resident #27 barricading the door, RN T replied, It started with (Resident #27) being upset when staff would shut the (privacy) curtain to give care (to Resident #35). I thought something was going on. When queried regarding Resident #35 including assessment following the incident, RN T replied, (Resident #35) couldn't answer. At 3:25 PM on 6/2/21, an interview was completed with CNA S. When queried if they were assigned to provide care to Resident #27 or Resident #35 when they worked the midnight shift on 5/18/21, CNA S stated, I was not assigned to that unit, but I heard about the commotion and went over to help. When asked what they observed upon arrival to the unit, CNA S stated, The door was open when I got over there. The Police had (Resident #27) between their bed and the wall. (Resident #27) was yelling (Resident #35) they are taking you away. CNA S revealed they assisted to move Resident #35 out of the room. When asked about Resident #35's well-being during the incident and move, CNA S stated, All (Resident #35) said was, 'Honey, can I go back to bed?'. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the DON on 6/2/21 at 4:15 PM. When asked how Resident #27 was aware Resident #35 had soiled their brief and was wet without touching and/or uncovering them, the DON indicated Resident #35's sheets were wet. When queried regarding Resident #27 not wanting the privacy curtain closed and opening the curtain when staff were providing peri and ADL care to Resident #35, the DON stated, I was not aware. The DON provided the staffing schedule/assignment for 5/18/21 midnight shift at this time. The schedule revealed CNA staff assigned to the hall where Resident #27 and Resident #35 resided were CNA X and CNA Y. On 6/2/21 at 4:35 PM, Resident #35 was observed sitting in a wheelchair, with the TV on, in their room in the facility. When spoke to, Resident #35 would make eye contact and smile but did not provide appropriate and/or meaningful responses when asked questions. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/21 at 7:30 AM, an interview was completed with CNA X. When queried what had occurred on 5/18/21 when they were working, CNA X stated, (Resident #27) got upset about something about somebody trying to take care of (Resident #35). CNA X revealed Resident #27 would not let any staff provide care to Resident #35 and stated, All of a sudden (Resident #27) just barricaded the door. The (RN T) tried to talk to (Resident T) but the next thing I know (Resident #27) was hollering through the door, 'Call the police, police the police'. CNA X was queried what occurred next and indicated the nurse was handling the situation, so they continued to provide care to other residents. When queried regarding Resident #27, CNA X stated, (Resident #27) gets like that a lot. (The Resident) has barricaded the (room) door before. CNA X was queried when regarding Resident #27 had barricaded the door previously and stated, I don't remember when. With further inquiry, CNA X revealed Resident #27 had barricades the door with their wheelchair in the same way they did when the Police were called. CNA X then stated, (Resident #27) will go off on you. They did that the night before last when I worked. I'm used to it (Resident #27's behaviors). When queried if they had observed Resident #27 displaying behaviors towards Resident #35, CNA X replied, I never seen (Resident #27) be mean to (Resident #35) but would say they were (Resident #35's) aid. CNA X continued, If (Resident #27) didn't want you touching (Resident #35), they would go off on you. When queried regarding the privacy curtain when providing care to Resident #35, CNA X stated, (Resident #27) would get up on the side of their bed and get mad, when we would pull the curtain to take care of (Resident #35). CNA X was asked what they meant when they said the Resident would get mad and CNA X revealed, Resident #27 would get an attitude. CNA X then stated, One time, (Resident #27) put their light on and said (Resident #35) was wet. I was there that night. We went down there to change (Resident #35). We didn't say anything to (Resident #27) but we were trying to figure out how (Resident #35) knew they were wet. When queried if there was a urine odor in the room or if Resident #35's bed was saturated or visibly wet, CNA X replied, (Resident #27) would have had to have pulled the covers back. The brief and pull pad were wet. CNA X continued, There was no way (Resident #27) could have known without pulling back the blankets. When asked, CNA X stated, Resident #35) don't never kick or take off their blankets. CNA X then stated, (Resident #35) takes (penis) out of their brief when they are in bed and indicated it made them uncomfortable because Resident #27 had to pull the Resident's blankets off. When asked if they informed the charge nurse about their concerns, CNA X stated, Yes and indicated other staff had also verbalized concerns. When queried regarding the room door, CNA X stated, Door is always supposed to be open. We told (Resident #27) that we need to see (Resident #35) but they always get up and close it. CNA X was then asked when Resident #27's behaviors started and replied, Maybe three weeks to a month. It was weird, really weird. When queried why the Residents were not separated sooner, when the behaviors were first identified, CNA X replied, We (staff) can't figure it out. We can't figure out why they ever moved (Resident #35) in that room in the first place. They should never have been together. When asked what they meant, CNA X indicated the two Residents were not a good fit to be in the same room. CNA X then stated, I don't know why they didn't move (one of the residents) when it all started. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/21 at 8:30 AM, an interview was completed with CNA Y. When queried if they worked midnight shift on 5/18/21, CNA Y stated, No, sometimes they ask me to work afternoons instead. When queried if they had taken care of Resident #27 and/or Resident #35 while working, CNA Y revealed they had. CNA Y stated, I almost got hit twice by (Resident #27's) cane before. When asked about the Resident's room door, CNA Y revealed the door was supposed to be open and stated, (Resident #27) would shut the door in our (staff) faces. With further inquiry, CNA Y stated, I feel like (Resident #27) had an unhealthy relationship with (Resident #35). I even went to the Administrator about it. I felt like (Resident #27) would hurt one of us and I didn't feel it was healthy for (Resident #35's) safety. When queried what prompted them to speak to the Administrator, CNA Y stated, Two nights before (incident), (Resident #27) said (Resident #35) was soaking wet. They were screaming. CNA Y continued, (Resident #27) would have had to uncover (Resident #35) to know they were wet. When asked how wet Resident #35 was, CNA Y replied, We just changed them an hour earlier. CNA Y then stated, (Resident #35) likes to take their privates out (when in bed) and indicated they were concerned because Resident #27 would have had to remove their blanket. With further inquiry regarding behaviors, CNA Y revealed (Resident #27) would try to stop them when they would pull the privacy curtain to provide care to Resident #35. When asked how they would try to stop them, CNA Y stated, (Resident #27) would try to open the curtain. CNA Y continued, I asked the nurse to have (Resident #27) step out a couple of time but (the Resident) would refuse. When asked how long the behaviors had been occurring, CNA Y stated, Around three weeks. When queried why the Residents were not separated earlier, CNA Y stated, That is what I wanted to know when I talked to the Administrator because why was (Resident #27) fishing under (Resident #35's) blanket when they expose themselves? An interview was conducted with Social Worker C on 6/3/21 at 9:35 AM. When queried if they were aware of concerns related to Resident #27's behaviors including behaviors towards Resident #35, Social Worker C revealed facility staff had brought concerns forward to them. Social Worker C revealed they had spoke with Resident #35 on 5/6/21 because Staff said they went in to open the window curtain and (Resident #27) said that it was too bright for (Resident #35) and they couldn't open it. So, I went in to talk to (Resident #35) and (Resident #35) said they liked it open and liked the sunshine. When asked if they spoke to Resident #35 following the incident where Resident #27 barricaded the room door, Social Worker C stated, I did not ask them about their roommate or how they felt about it. They have a hard time with in-depth conversations. I don't know if they could hear me anyway. An interview and review of provided investigation documentation was completed with the covering Administrator on 6/3/21 at 10:40 AM. When queried if an investigation was completed pertaining to Resident #35, the Administrator indicated they would look. After reviewing the provided documentation the covering Administrator stated, There are definitely holes. There has to be another investigation. When queried why facility staff who were assigned to the Residents were not interviewed as part of the investigation, the covering Administrator replied, I don't know, always interview people who are assigned. When queried why the Residents were not separated when the behaviors began and escalated, the covering Administrator replied, There has to be another investigation. When asked how Resident #27 would have known Resident #35 was wet without uncovering them, the covering Administrator was unable to provide an explanation and revealed they would look for additional and/or separate investigation documentation. At 10:55 AM on 6/3/21, the covering Administrator revealed the facility did not have additional investigation documentation and did not complete another investigation. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation has two Deficient Practice Statements: Deficient Practice Statement One: This Citation Pertains to Intake Numbers MI00115183. Based on interview and record review, the facility failed to operationalize policies and procedures to ensure care was provided per healthcare provider recommendations, orders, and standards of practice for one (Resident #1) of one resident reviewed for appropriate care and treatments, resulting in a lack of implementation of wound care treatment, lack of implementation of non-weight bearing status, lack of blood glucose monitoring, potential decline in overall health status, and Resident verbalization of feeling uncared for, neglected, and overall dissatisfaction. Findings Include: Review of intake documentation revealed the facility received a concern from Resident #1's spouse (Witness Q) on 3/16/20. Witness Q voiced concerns voiced concerns that Resident #1 had not received appropriate and necessary medical care in the facility related to blood glucose monitoring, respiratory medication administration, and physical therapy. Witness Q revealed they felt the Resident had been ignored, abused, and neglected. Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, right lower extremity trimalleolar fracture (broken ankle in three different places), left femur fracture, and sarcopenia (progressive skeletal muscle disorder with loss of muscle mass and function). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, required extensive assistance for bed mobility, location, dressing, toileting, and total assistance with transferring. The medical record further revealed Resident #1 was transferred to the hospital on 3/14/20 per family/Resident request on 3/14/20 and did not return to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/21 at 12:55 PM, a phone interview was conducted with Resident #1 and Witness Q. When queried regarding the facility, Witness Q indicated they would let Resident #1 explain what happened. When queried regarding their stay at the facility, Resident #1 revealed they were admitted to the facility right when Covid started. Resident #1 continued, The ambulance took me to that place (facility) and I didn't see anybody (facility staff) until 9:00 PM that night. Resident #1 was asked what time they arrived at the facility and replied, Around 6:00 PM. Resident #1 disclosed when staff entered their room, They (staff) picked the bandage off (surgical wound), put it on the bed, and then stuck it back on my wound. They had long nails and didn't use gloves. When asked if they knew the name of the staff member, Resident #1 revealed they did not and stated, (Nurse) took my bandage off with her long pink nails! Resident #1 revealed the staff member's nails matched her outfit and they had bleach blonde hair. When queried if anyone one else was present in the room at that time, Resident #1 stated, One other one, (they were) not as flashy as the first one. The one with the pick nails took the bandage off and put it back on. Resident #1 was asked about other concerns with care and stated, My meds looked different, so I put them in the napkin and didn't take them. When asked if staff provided education to them regarding what the medications, they were giving them were and how medications made by different manufactures may look different even though they are the same medication, Resident #1 replied, No. They just handed them to me in a cup and said here are your meds. Resident #1 was then asked if any facility staff members had asked them about their concerns, Resident #1 adamantly replied, No. When queried if they were diabetic, Resident #1 revealed they were and stated, They didn't even check it (blood glucose level). Resident #1 was queried if they asked nursing staff about blood glucose monitoring and replied, No, they should know and they were never there. I had to beg for help. I sat in the wheelchair all day long the one day I was there. I just hollered and hollered for help. When queried what happened, Resident #1 revealed a man finally came to help. Resident #1 stated, They didn't know what they were doing, and it hurt me. I was not supposed to put any weight on my leg. Resident #1 revealed the male staff member pivoted them incorrectly causing them to have to put weight on their leg. Resident #1 continued, It was awful. When asked, Resident #1 revealed they just wanted out of there and was happy when they were transferred back to the hospital. Review of Resident #1's documentation in the medical record revealed the following progress notes: -3/12/20 at 7:11 PM: Medical Practitioner Note . Meds reviewed and no new orders. -3/12/20 at 8:54 PM: Patient arrived to facility from Hospital by EMS/ stretcher. Patient has a femur fx (fracture) and right ankle fx with cast in place. Skin alterations noted on admission assessment . All meds entered and reviewed with MD . -3/13/21 at 5:35 PM: Second skin and medication check completed at this time . patient has a cast to right lower ext (extremity) that extends knee down to toes . Skin tear noted to Left inner calf measuring 0.6 cm (centimeter) x 0.5 cm. Second skin tear noted to left leg, below kneecap, measuring 1 cm x 0.5 cm. Swelling noted to LLE. Wound vac placed on left hip/thigh region. Patient has multiple incisions noted. First . left upper thigh, lateral, measuring 12 cm with 7 sutures . Second . left knee, measures 0.3 cm x 1.5 cm. Third is distal to knee and measures 0.5 cm x 1.5 cm. Fourth, is proximal to right knee and measures 2.5 cm x 1.5 cm . Fifth incision is to right upper thigh/lateral aspect, measures 3.5 cm, with no sutures, and bruising noted. Sixth incision is to right lower hip with 5 steri-strips intact and measures 7.5 cm. Left buttocks has a 1 cm x 1 cm healing skin tear . -3/13/20 at 9:16 PM: Resident and physician made aware of medications unable to administer or unavailable in the past 24 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/14/20 at 11:36 AM: Patient's spouse called facility yelling and irate at staff saying somebody scratched patients leg while changing gauze on lower leg along with relaying other complaints from patient . demanded (Resident #1) be sent out to Hospital right now . Patient was offered scheduled meds along with PRN (as needed) pain medication. Patient refused all meds and stated would take them when arrived at the hospital. Patient was pleasant with writer during the transfer process . Review of Resident #1's Admission/Re-Admission Evaluation (Opened: 3/12/20 at 6:56 PM; Locked: 3/12/20 at 11:00 PM) revealed orders were verified with the Resident's health care provider at 7:00 PM and that the Resident had a wound vac in place to their left hip. The assessment did not specify the time Resident #1 arrived at the facility. Documentation pertaining to Resident #1's hospital stay and discharge instructions including hospital medication and treatment documentation were requested from the Director of Nursing (DON) on 5/28/21 at 1:06 PM. The DON provided documentation including Resident #1's facility Medication Administration Record (MAR) and a facility One on one Inservice to Registered Nurse (RN) R. The in-service detailed, Upon admission, all medications available will be given from backup must be administered as ordered . The only documentation from the Resident's hospitalization included was (Hospital) Patient Discharge Instructions, Dated 3/12/21 at 1:52 PM. The discharge instructions included the following instructions for Resident #1's care: - Dulera 100 micrograms (mcg)/5 mcg/actuation Aerosol 2 inhalation inhaled. - ProAir HFA Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate HFA) 2 puff inhale orally two times a day for SOB (Shortness of Breath) - Elevate legs if you have swelling . - Diet . Carbohydrate Controlled- 1800 ADA (American Diabetes Association) . - D/C Provena (name of wound vac and midline intravenous catheter manufacturer) in six days and transition to daily dressing changes . - Activity- Right Lower Extremity: No weight bearing . - Precautions: No crossing legs . - Activity . Activity as Tolerated . Use [NAME] . - Incision Care: Do not touch wound or bandage unless absolutely necessary . Always wash hands before and after touching incision . - Use ice pack 15-20 minutes at a time . - Use incentive spirometer for three to five days after discharge . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's facility MAR, Treatment Administration Record (TAR), and health care provider orders revealed Resident #1 did not receive any medications on 3/12/21. The Resident's Dulera and ProAir HFA inhalers were not administered to the Resident at any time while at the facility. Resident #1 did not have orders in place related to elevating their lower extremities, weight bearing status, walker use, ice pack, cast care, incentive spirometer use, and/or wound vac treatment. The sole wound care treatment order read, Wet-to-dry dressing to left hip. Irrigate with NS, pack with NS (Normal Saline), moistened kerlix, cover with ABD (thick, padded dressing) pad and secure with tape every evening shift for wound care. Resident #1 also had an order in place for a regular diet. The following care plans and interventions, all Initiated and Created: 3/12/20, were noted in Resident #1's medical record: -The resident has altered respiratory status/Difficulty Breathing r/t (related to) (BLANK). Intervention: Administer medication/puffers as ordered . - (Blank) _____ (specify type of skin problem) at (Blank) _____ (specify location) related to: (Blank). Intervention: Administer treatment per physician orders . - Alteration in musculoskeletal status r/t (BLANK). Intervention: Follow MD orders for weight bearing status . - Requires assistance/ potential to restore function for TRANSFERRING from one position to another as evidenced by (BLANK) related to (BLANK). Intervention: Transfer with mechanical lift . Resident #1 did not have a care plan in place related to diabetes mellitus. An interview was completed with the DON on 6/2/21 at 10:00 AM. When queried regarding Resident #1's wound care while at the facility including what treatment the Resident was supposed to have in place, the DON replied, I believe (Resident #1) did not have a wound vac here yet and indicated wet to dry dressings were being completed until a wound vac was available. The DON was then asked why a daily dressing change was not completed and documented on the TAR as ordered but did not provide an explanation. Resident #1's medical record documentation was reviewed with the DON at this time. After review, the DON stated, It looks like (Resident #1) did have a wound vac in place. When queried why there was not an order for the wound vac, the DON stated, There should have been an order. When asked about treatments for the Residents other wounds as well as cast care and monitoring, the DON stated, They were only here like two days. I don't think everything made it in the computer. The DON was then queried regarding Resident #1 having a diagnosis of diabetes mellitus, not having an order to monitor blood glucose levels, and not having a controlled carbohydrate diet ordered, the DON replied, (Resident #1) was on oral meds (for diabetes management). We don't just check (blood glucose levels), the Doctor would have to order it. The DON further revealed that an A1C (hemoglobin A1C- laboratory blood test which identifies average blood sugar level over previous two to three months). When queried regarding Resident #1's non-weight bearing status, the DON reviewed the medical record and stated, I don't see anything specific. There should have been an order and also care planned. Review of facility provided policy/procedure entitled, Glucose Blood Monitoring (Finger Stick Blood Sugar), dated 2014 revealed, Purpose: To monitor blood sugar levels and to observe for complications of altered sugar levels in blood . The policy did not address procedure assessment and monitoring of residents diagnosed with diabetes mellitus. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy/procedure entitled, Skin Practice Guide (Dated 2013) revealed, Alteration in skin integrity: If an alteration in skin integrity is identified on admission, a designated member of the wound team evaluates the status of the wound (ideally within 24-hours of admission) and collaborates . to determine the type of alteration present. Treatment orders are obtained, noted and initiated . If non-pressure related ulcers or other skin alterations, e.g., skin tears, surgical incisions, etc. are identified; a Skin Alteration Record is initiated . Treatment Order Components: Treatment orders are written for each site separately and include but are not limited to: site location; type of skin alteration; cleansing agent, if indicated; primary dressing; secondary dressing; frequency of treatment . Wound Management . 7. Document the presence of any non-removable dressing/ device, (primary) surgical dressing, cast or brace . 37666 Deficient Practice Two This Citation pertains to Intake# MI00115237. Based on interview and record review, the facility failed to assess, monitor and provide timely treatment for one resident (Resident #5) of three residents reviewed for a change of condition from a census of ninety-two residents, resulting in Resident #5 being hospitalized for a decrease in cognition and overall decline in condition. Findings Include: Resident #5: A record review of the Face Sheet and Minimum Data Set (MDS) assessment for Resident #5, indicated an admission to the facility on [DATE] with diagnoses: Mild intellectual disabilities, diabetes, Epilepsy, depression, Morbid Obesity, heart failure, atrial fibrillation and COPD. The MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15 indicating severe cognitive impairment. The resident needed assistance with all care. A review of the Census tab in the resident's electronic medical record (EMR) revealed the resident transferred to the hospital on 9/2/20 with readmission on 9/9/20 and transferred to the hospital again on 9/29/20 with no return. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Confidential Person CC on 6/3/21 at 11:54 PM provided, My son was there since the beginning of 2020. He had an appointment with the Heart doctor on 9/22/20. When he came back, they said he was dehydrated. I said why didn't he go to the hospital. I said, 'Are you trying to kill him?' They never sent him to the hospital. They said, 'Nobody tells us what to do.' I would bring food for him and they wouldn't go down to give it to him. They would say they didn't have time; there wasn't enough staff. I would go to the window to see him, every day. He wasn't the same. All of a sudden it looked like there was something wrong. He was just looking around like he was having a seizure. I told them; most of the time the door was closed. I kept calling. He was not getting better. He was confused. They didn't pay attention to me. I called on 9/29/21 at 8:49 AM, 5:04 PM. I kept trying to call and couldn't get through: 5:56 PM, 5:57 PM, 5:58 PM, 6:21 PM, 7:04 PM, 8:10 PM, 8:11 PM, 9:25 PM 9:28 PM, 9:32 PM. Then at 9:47 PM (the hospital) called me and said, Your son is here. Did (the facility) call you? You need to get up here. He is real bad. They said he was suffering. His body was shutting down. I asked why and they said he had Septic shock. I said doesn't that take a while and they said, Yes. The (facility) never called me. It was the hospital that called. On 10/3/20 he passed away. A review of the progress notes for Resident #5 revealed the following: 9/26/21 at 11:16 PM, Resident visiting with his mother earlier. Complains of pain in arms and legs . 9/27/21 at 10:49 PM, . He ate breakfast but refused lunch . 9/28/21 There were no documented progress notes of the resident's condition or assessments. The notes and assessments go from 9/27/21 at 11:32 PM to the next note at 9/29/20 at 3:10 AM; greater than 24 hours later. 9/29/21 at 6:55 AM, Resident (fasting blood sugar) 1 hour after lunch meal, 44. Resident was still responsive. Had oral glucose. Blood sugar at 51. Glucagon administered. Blood sugar at 62. Resident not answering verbally slurring words. Per (Nurse Practitioner) orders 2nd Glucagon administered. Blood sugar at 95; after then 116. Resident completely responsive. (Blood pressure) low. IV fluids ordered at this time for altered mental status. The next note dated 9/29/21 at 9:22 AM is a respiratory assessment with no additional comments or findings. The next note dated 9/29/21 at 2:20 PM, . During assessment resident was noted to be fatigued and falling asleep during conversation. Glucose level checked and noted to be 44 (low). Glucagon administered-glucose recheck after 15 minutes 51 . Physician updated. The next note is dated 9/30/21 at 12:09 AM, . Cena (Certified Nursing Assistant) notified me at about 6:45 PM (9/29/20) that she couldn't get resident to respond to her when she was trying to feed him. When I entered room, resident's neck was hyper extended, eyes staring straight ahead . started having rhythmic movement of head for about 20-30 seconds, then stopped. Repeated this about 6 times . seizure-like . Decision made to send resident to hospital for further evaluation and treatment. Message left with resident's mother to call here . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The note on 9/30/21 at 12:09 AM was written about 5 hours after the resident had a serious change of condition. A review of the Medication Administration Record (Martar) indicated the resident received a long-acting Insulin Levemir- daily, a short acting Insulin if his blood sugars were high- up to 4 times a day and a pill-Metformin twice a day. The resident had documentation of multiple days of very low blood sugars: A review of the Physician orders revealed the following: Hypodermoclysis Therapy (fluid therapy administered into subcutaneous tissue): Solution: 0.9% sodium chloride; Volume: 1 liter; Rate: 55 ml/hr every shift for supplemental fluids, Start Date 9/22/20 at 2:15 PM and End date 9/23/20; A review of the September 2020 Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated Resident #5 received the 3 liters of Sodium chloride fluids from 9/22/20-9/23/20. There were no orders for laboratory tests to monitor the resident after administration of the fluids. Another order for IV fluids was written on 9/29/20 to begin at 10:15 that night. The resident was already transferred to the hospital. New orders for laboratory tests were written on 9/29/20 and obtained prior to resident discharge. The results were as follows: 9/11/20 at 8:00 PM, 64 9/13/20, 64 9/20/20 and on 9/29/20 with multiple instances of low blood sugar. Per review of the MAR for September 2020, the resident's Insulin and oral Diabetes medication was not held due to low blood sugars. He continued to receive the medications, although he was not eating well and was exhibiting signs and symptoms of low blood sugar. There is one order to administer Glucagon (a medication to increase blood sugar) on 9/12/20 and given at 1:13 AM. 9/29/20 labs: Wbc's 15.9 high (normal 4.5-11.0), Sodium 145 high (normal 136-144), Potassium 5.4 high (normal 3.6-5.1), Bun (shows kidney function) 44 high (normal 8-26), Creatinine (kidney function) 2.74 high (normal 0.61-1.73), Albumin 3.1 low (normal 3.5-5.0 shows protein consumption). The last labs prior to this was 8/13/20 at the facility. Divalproex Sodium tablet Delayed Release 500 mg, Start Date 9/10/20. There was no order for monitoring for adverse effects or documentation to evaluate the effectiveness of the medication. The resident had been identified to have a change of condition and low blood sugars days before he was transferred to the hospital. His family had attempted on multiple occasions to talk to the staff about their concerns that Resident #5 had a change of condition. The facility did not initiate new interventions until the resident could no longer respond to them. He was then transferred to the hospital. A review of the Acute Care Transfer form dated 9/29/20 at 6:43 PM revealed the following: BP 98/55 (low), Pulse 123 (High), Blood Glucose 88, Temperature 97.3, Oxygen saturation 93% (low for the resident), Resident lethargic, continuous seizure activity, low BP, Low Blood sugar. An interview with the Director of Nursing (DON) on 6/2/21 at 3:00 PM related to the resident's change of condition and lack of notification to the responsible party provided, Our policy noting change of condition, includes increased monitoring, notify the doctor and responsible party; leave a message if not available, call again if no return call. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's Care Plans provided the following: Endocrine system related to: Insulin Dependent Diabetes, date initiated 2/11/20 and revised 8/28/20 with Interventions: Obtain glucometer readings and report abnormalities as ordered; Obtain lab results as ordered and notify physician of results; Provide diet per physician orders; Report symptoms of hypoglycemia; weakness, pallor, diaphoresis, vision changes, change in consciousness, all dated 2/11/20. The resident has an alteration in neurological status . history of seizures, date initiated 2/11/2020, with Interventions: If seizure activity occurs, place on side, maintain open airway. Remove obstacles to ensure safe environment, 2/11/20; Obtain vital signs as needed, 2/11/20; report presence of seizure activity. Note duration, characteristic of tonic/clonic movement, level of consciousness, etc.; Monitor/report to MD s/sx of tremors, rigidity, dizziness, changes in level of consciousness, slurred speech, all dated 2/11/20. Renal Insufficiencies related to chronic renal failure, date initiated 2/11/20 and revised 8/28/20, with Interventions: Administer medications per physician orders, 2/11/20 and Diet per physician orders, 2/11/20. The Care Plans were not updated after the resident returned from the Cardiology appointment with identified issues of dehydration. New interventions were not enacted. The resident was not assessed daily, although he had episodes of decreased mentation, poor appetite, and low blood sugars. No laboratory tests were ordered from 8/14/20 to 9/29/20 to aid in monitoring the resident's health status. A review of the facility policy titled, Change in Condition, dated 11/2016 Purpose: To provide Guidance in the identification of clinical changes that may constitute a change in condition and require intervention and notifications .

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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** 37666 This Citation Pertains to Intake Number MI00118857 Based on observation, interview and record review, the facility failed to ensure pressure ulcers were assessed, monitored, wound care was provided and appropriate interventions were in place for two residents (Resident #21 and Resident #22) of three residents reviewed for pressure ulcers, resulting in 1) Resident #21 developing an unstageable facility-acquired pressure ulcer measuring 10.3 cm length x 6.0 cm width x 0 cm depth with 90% yellow and brown slough (fibrinous dead tissue) on the coccyx, that required hospitalization , surgical removal of dead tissue (debridement) and antibiotic treatment; 2) Resident #22 with two Stage 2 pressure ulcers on the right and left buttocks with surrounding Deep Tissue Injury (DTI) did not receive wound care as ordered, because the supplies were not available in the building, which could further lead to worsening of the wound. Findings Include: Resident #21: A review of the Face Sheet and Minimum Data Set (MDS) assessment for Resident #21 indicated an admission on 1/28/21 with diagnoses: Diabetes, heart failure, atrial fibrillation, hypertension, sarcopenia, end stage renal disease, outpatient renal dialysis. The MDS assessment dated [DATE] revealed full cognitive abilities and the need for 2-person assistance with bed mobility, transfer, dressing, hygiene, bathing, and toileting. The resident was discharged on home on 2/18/21. A review of the progress notes revealed the following: A late note dated 2/16/21 at 1:39 PM, . Resident has right and left MASD. Right buttock is 3.1 cm length x 1. 9 cm width x 0.1 cm depth, has scant serosanguinous drainage, no slough, no maceration, and no necrosis. The left buttock measures 0.4 cm x 0.8 cm x 0 cm. There is scant serosanguinous drainage, no slough, no maceration, and no necrosis . Resident has an unstageable pressure ulcer to coccyx. Site measures 10.3 cm x 6.0 cm x 0 cm. It is 90% yellow and brown slough . moderate amount of serosanguinous drainage . A Physician/NP note dated 2/16/21 at 12:15 PM, Due to patient's sarcopenia, debility he requires positioning of body that is not feasible in a regular bed. In frequent need of body positioning to alleviate pain and avoid body breakdown. Bed wedges and pillows have been unsuccessful . The resident's wounds on the buttocks and coccyx were not identified, measured, or treated until they were very large. The resident had documentation of resistance with repositioning due to discomfort and additional interventions were not initiated until the large wounds were observed. A review of the physician orders revealed: 2/15/21 and discontinued 2/16/21: Cleanse coccyx with normal saline, pat dry, apply 1:1 mix of z-guard and A&D, cover with border gauze. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2/15/21: Cleanse bilateral buttocks with normal saline, pat dry, apply 1;1 mix of z-guard and A&D, every night shift. 2/16/21: Cleanse coccyx with normal saline, pat dry, apply Santyl, cover with border foam, every night shift. 2/18/21: Daily Body Audit, every day shift. Woundsource: Assessing Wound Tissue and Drainage Types: Slough versus Purulence: [NAME] Haven MSN, GERO-BC, APRN, CWOCN-AP, dated February 2021, . Tissue Type: Slough, Slough is necrotic tissue that needs to be removed from the wound for healing to take place . necrotic tissue prevents or slows healing . An interview with Confidential Person GG on 5/27/21 at 10:46 AM, revealed, My husband had to be put in (the hospital) and then another nursing home. He had many sores. It's terrible. When he came home on February 18th, (2021) on a Thursday, I didn't know how bad it was. He had a home care nurse come in the next day. It was horrible. The hoecake nurse told me right away he needed to go to the hospital. He was in ICU for 5 days. When he was in the (facility) I couldn't check on him. He was full of sores. They did not tell me about it. He has had multiple surgeries on the sores and antibiotics. It is horrible. On 5/27/21 at 2:40 PM, and interview with the Director of Nursing (DON) provided, He went home. He was dependent with care. I know what his wounds looked like when he left here. Then they called the ambulance to take him to the hospital. She called here and I talked to her. She didn't feel like she could care for him at home. An interview with the Unit Manager F on 5/27/21 at 3:06 PM, He had a foot ulcer. He would refuse incontinence care and developed MASD (Moisture Associated Dermatitis; he started breaking down. We saw him on wound rounds. He would 'Ow, Ow, Ow, with movement. On 2/16/21 we saw he had an unstageable wound to the coccyx- 10.3 cm length x 6.0 cm width x 0 cm depth with 90% slough and a moderate amount of drainage. The wound was first observed by a nurse on 2/14/21. I'm surprised it didn't happen earlier. It progressed quick. We talked to the wife and explained to her about the wounds and treatments. He was discharge about 1:00 PM and she called and wanted to bring him back about 3:00 PM. There was some discussion about it. A review of the Admission/Re-Admission Evaluation (Nursing Assessment) dated 1/28/21 at 11:28 PM revealed, Clinical Evaluation Integumentary (Skin): Skin Integrity Issues Present: Yes; Current skin integrity Issues: Dialysis catheter insertion wound right neck; Chest -dialysis catheter right upper chest; Right antecubital- blister right forearm; dry skin over majority of body; left toes- healed blister top of foot; left ankle inner-dried wound, open to air. A review of the Care Plans for Resident #21 provided: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At risk for alteration in skin integrity related to generalized weakness . date initiated and created 1/28/21 and revision 3/2/21 (discontinued) with Interventions: Administer treatments as ordered (1/29/21); Barrier cream to peri area/buttocks as needed (1/29/21); Encourage to reposition as needed; use assistive devices as needed (1/28/21); Observe skin condition with ADL (activities of daily living) care daily, report abnormalities (1/29/21) Pressure redistributing device on bed/chair (1/28/21); Provide preventive skin care routinely and prn (1/28/21). Resident has unstageable pressure ulcer to coccyx . date initiated/created 2/17/21 with Interventions: Administer treatment per physician orders (2/17/21); Daily body audit (2/17/21); Incontinence management (2/17/21). Bilateral buttocks MASD, date created/initiated 2/17/21 with Interventions: Administer treatments per physician orders; Encourage and assist as needed to turn and reposition . Follow up care with physician as ordered; Report evidence of infection . all dated 2/17/21. Resident #22: A review of the Face Sheet and Minimum Data Set (MDS) assessment indicated Resident #22 was admitted to the facility on [DATE] with diagnoses: Psychotic disorder, depression, history of brain tumor, acute kidney failure, hypertension, atrial fibrillation, and pain. On 5/27/21 at 11:00 AM, Resident #22 was observed lying in bed watching TV. Upon interview, the resident said he had a sore and pointed to his buttocks. He said he was supposed to have a dressing change for the wound. On 5/27/21 at 1:00 PM, Nurse's F and FF were observed at the wound care cart on the back Central hall. Nurse FF said they did not have the wound ointment ordered Santyl (used for debriding/removal of dead tissue from the wound) for the wound on the resident's coccyx/buttocks area, We can't find it and it's not in the med room. The nurses were asked how often the dressing was ordered to be changed and Nurse FF said, Daily and we got a new order from the doctor, so we can change it. Nurse FF said she rounded weekly with the Wound Care Nurse and assisted her when she saw each resident's wound. On 5/27/21 at 1:05 PM, Nurse's F and FF entered the room and assisted the resident with bowel care in preparation of the dressing change. After Nurse FF completed the care tasks and rewashed her hands and changed into clean gloves, she removed the old dressing from the resident's coccyx and buttocks areas, and it was dated 5/25/21. The buttocks and coccyx areas were scaly, red, raw with 2 open areas, one on each right and left buttock. The entire area was large, but the 2 open areas were each small. Nurse F was asked again how often the dressing was to be changed and she said, Daily. She said the resident was supposed to have a wound ointment Santyl (used to remove dead tissue from the wound), but because they didn't have it they were going to cleanse the wound with normal saline and apply a boarder foam dressing one time and then the wound ointment would be in. The ointment was ordered on 5/25/21- two days prior and had not arrived. The dressing had not been changed on 5/26/21 as ordered and was not going to receive the ordered treatment on 5/27/21 either. A review of the physician orders indicated the following: 5/11/21 ordered and 5/25/21 discontinued: Cleanse left buttock with Normal Saline, pat dry, apply A&D, cover with border gauze. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/25/21 ordered and 5/27/21 discontinued: Santyl Ointment, apply to left buttock topically daily. The right buttock had a new order on 5/25/21: Cleanse right buttock with Normal saline, pat dry, apply z-guard (ointment) with A&D, cover with border gauze, every day shift. A review of a progress note dated 5/25/21 at 2:27 PM revealed, Resident was seen on weekly wound rounds with wound NP (Nurse Practitioner). Resident has a left buttock Stage II pressure ulcer. The site measures 0. 6 cm length x 0.5 cm width x 0.2 cm depth. There is scant serosanguinous drainage . 100 % slough (yellow fibrinous dead tissue) . The right buttock Stage II has a small amount of serosanguinous drainage. Site measures 1.5 cm x 0.1 cm x 0 cm . A wound note dated 5/19/21 at 1: 28 PM, provided . Resident has a left buttock Stage II pressure ulcer. The site measures 6.5 cm x 5.0 cm x 0.1 cm. There is scant serosanguinous drainage, no malodor, no necrosis, no slough. There are scattered areas of discoloration resembling a DTI (Deep tissue injury). Surrounding skin is dry and friable . The left buttock wound had developed the dead tissue/slough between 5/19/21 and 5/25/21. The National Pressure Injury Advisory Panel; February 13, 2020 NPIAP Staging for lightly pigmented skin . Stage 2 Pressure Injury . Granulation tissue, slough and eschar are not present . Stage 3 Pressure Injury: . Sough and/or eschar may be visible . If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury . A review of the Care Plans for Resident #22 provided: Coccyx shearing, at increased risk for breakdown, date initiated 4/13/21 and revised 5/14/21 with Interventions: Administer treatment per physician orders, date initiated 4/13/21. Resident has a Stage II pressure ulcer to the left buttock, date initiated 5/5/21 and revised 5/14/21 with Interventions: Administer treatment per physician orders (5/5/21); Daily body audit (5/5/21); Incontinence management (5/5/21). Resident has a Stage II pressure ulcer to the right buttock, date initiated 5/5/21 and revised 5/14/21 with Interventions: Administer treatment as ordered (5/5/21); Incontinence management (5/5/21). On 5/27/21 at 2:55 PM, the Director of Nursing (DON) was interviewed about the lack of necessary wound supplies to complete Resident #22's left buttock dressing to promote wound healing. The DON said the ointment had not been received, but the nurses had followed up on it today and it would be available by the next day. It would not be available until 3 days after it was ordered. Reviewed with the DON that the old dressing on the resident's wounds was dated 5/25/21- 2 days prior and she said, I heard about that. They should be changing the dressing as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy titled, Skin Practice Guide, dated 2013 provided, . International NPUAP (National Pressure Ulcer Advisory Panel) -EPUAP Pressure Ulcer Definition; A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or in combination with shear . Management Strategies: Moisture and Incontinence Management: Moist skin is more vulnerable to injury. Moisture may be the result of incontinence . Proper cleansing of the skin and application of protective skin products assist in protecting the skin . wound management also includes: wound documentation; dressing selection . Dressing selection is based upon: wound type; tissue type . treatment goals .Dressing changes are performed using non-sterile, clean techniques unless otherwise ordered by the attending physician . adhere to principles of infection control- separate clean and dirty . documentation- completion of the treatments are documented on the (TAR) immediately after being performed; dressing are dated and initialed .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation pertains to Intake Numbers MI00115237, MI00116444, and MI00120441 Based on observation, interview and record review the facility failed to ensure that there was adequate staff to meets the needs of the residents, for five residents (Resident #5, Resident #14, Resident #22, Resident #31 and Resident #32) of five residents reviewed for staffing and potentially effecting all residents, resulting in staff verbalizations of being unable to adequately provide care, residents waiting for assistance with fluids and activities of daily living (ADL's); leading to feelings of frustration and shame for Resident's #'s 22, 31 and 32. Findings Include: On 6/3/21 at 11:20 AM, during an interview with the Staffing and Scheduling Coordinator HH related to staffing, she confirmed the facility had 1 Certified Nursing Assistant (CNA) on the 2nd shift East hall on 6/2/21 on the for approximately 38 residents. On multiple days during the survey including 5/26/21 and 5/28/21 there was only 1 CNA on the Medbridge skilled nursing hall for approximately 15-19 residents on the day shift. She said the facility should have 8 CNAs for the facility on the 1st and 2nd shift: 3 on the East hall, 3 on the Central hall and 2 aides on the Medbridge hall. United States Department of Labor, Occupational Safety and Health Administration: Long Work Hours, Extended or Irregular Shifts, and Worker Fatigue: .Long work hours may increase the risk of injuries and accidents and can contribute to poor health and worker fatigue. Studies show that long work hours can result in increased levels of stress . Centers for Disease Control and Prevention (CDC), Coronavirus Disease 2019 (Covid-19), Strategies to Mitigate Healthcare Personnel Staffing Shortages, Updated July 17, 2020: . Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care . Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including communicating with HCP about actions the facility is taking to address shortages and maintain patient and HCP safety . Resident #5: A record review of the Face Sheet and Minimum Data Set (MDS) assessment for Resident #5, indicated an admission to the facility on [DATE] with diagnoses: Mild intellectual disabilities, diabetes, Epilepsy, depression, Morbid Obesity, heart failure, atrial fibrillation and COPD. The MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15 indicating severe cognitive impairment. The resident needed assistance with all care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with Confidential Person CC on 6/3/21 at 11:54 PM provided, My son was there since the beginning of 2020. He had an appointment with the Heart doctor on 9/22/20. When he came back, they said he was dehydrated. I said why didn't he go to the hospital. I said, 'Are you trying to kill him?' They never sent him to the hospital. They said, 'Nobody tells us what to do.' I would bring food for him and they wouldn't go down to give it to him. They would say they didn't have time; there wasn't enough staff. I would go to the window to see him, every day. He wasn't the same. All of a sudden it looked like there was something wrong. He was just looking around like he was having a seizure. I told them; most of the time the door was closed. I kept calling. He was not getting better. He was confused. They didn't pay attention to me. I called on 9/29/21 at 8:49 AM, 5:04 PM. I kept trying to call and couldn't get through: 5:56 PM, 5:57 PM, 5:58 PM, 6:21 PM, 7:04 PM, 8:10 PM, 8:11 PM, 9:25 PM 9:28 PM, 9:32 PM. Then at 9:47 PM (the hospital) called me and said, Your son is here. Did (the facility) call you? You need to get up here. He is real bad. They said he was suffering. His body was shutting down. I asked why and they said he had Septic shock. I said doesn't that take a while and they said, Yes. The (facility) never called me. It was the hospital that called. On 10/3/20 he passed away. Resident #14: A record review of the Face Sheet and MDS assessment for Resident #14 indicated an original admission of 1/27/17 and discharge of 4/11/21, with diagnoses: History of an anoxic brain injury, history of seizures and a myocardial infarction, anxiety, heart disease, hypertension, and a tracheostomy. The MDS assessment dated [DATE] revealed Resident #14 had a memory problem and needed extensive to total assistance with all care and needed 2-person assistance with bed mobility, dressing, hygiene, bathing, and toileting. A review of the Care Plan titled, ADL (Activities of daily living) self-care deficit ;resident requires total care related to physical limitations secondary to brain anoxia, seizures, history of MI with cardiac arrest, quadriparesis with contracture and arthritis, date initiated 11/1/2017 and revised 4/12/21 (after discharge), with Interventions: Assist: Transfer using mechanical lift;2-person assistance, dated 11/1/2017. On 5/28/21 at 9:42 AM, Hospital Case Manager HH was interviewed and said the facility refused to readmit Resident #14 after sending the resident to the hospital for a change of condition. Case Manager HH said the resident had been admitted to the hospital on several prior occasions and then the facility readmitted the resident. After the resident was transferred to the hospital on April 11, 2011, the facility refused to take him back and the resident was still in the hospital. The Case Manager stated, He needs to be suctioned every 4 hours and they said they don't have the staff to suction him. When I talked to the (Prior Administrator), she said there were staffing issues. An interview with the Director of Nursing (DON) on 6/2/21 at 9:55 AM related to Resident #14 revealed the resident had a history of a tracheostomy, then it was removed and replaced. He was unstable with many secretions and respiratory infections. Reviewed staffing with the DON and she said the resident was usually on the Medbridge skilled unit with 1 nurse and 1-2 CNA's. An interview with the Prior Administrator on 6/2/21 at 11:00 AM about Resident #14 provided, I would need staffing to take him. He has many health issues. Resident #22: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Face Sheet and Minimum Data Set (MDS) assessment indicated Resident #22 was admitted to the facility on [DATE] with diagnoses: Psychotic disorder, depression, history of brain tumor, acute kidney failure, hypertension, atrial fibrillation, and pain. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities and needed assistance with all care including 2-person assistance with bed mobility, transfer, dressing and toileting. On 6/2/21 at 11:00 AM, Resident #22 was observed lying in bed, watching TV. He was asked about timeliness of care and call light answering and stated, I ask for something and I get the opposite. I needed a shower and my teeth brushed. It took until 2:30 PM for them to get me up and provide my care. There aren't enough staff here. A review of the resident's Care Plan titled, ADL self-care deficit related to generalized weakness, impaired mobility, physical limitations . date initiated 2/19/2021 with Interventions: Hoyer (Maxi lift) for transfers, dated initiated 2/26/2021 and revised 3/12/2021. Resident #31: On 6/2/21 at 1:50 PM, Resident #31 was observed in her room, sitting in a wheelchair watching TV. She was asked if her call light was answered timely when she needed care and she responded, There is not enough staff. If I need something, they say they will get it, but they never get it. I asked for juice this morning and I never got it. A record review of the Face Sheet and MDS assessment indicated Resident #31 was admitted to the facility on [DATE] with diagnoses: Diabetes, history of a stroke, left-sided weakness, heart failure, Atrial fibrillation, COPD, asthma, arthritis, and depression. The MDS dated [DATE] revealed the resident had full cognitive abilities and needed 2-person assistance with bed mobility, transfers, dressing, bathing, and toileting. On 6/2/21 at 1:50 PM, CNA II was interviewed and stated, They know we are short-staffed. We can't get in the room on time. Not a lot of people like to work over here. Staffing is a big deal. Resident #32: A record review of the Face Sheet and Minimum Data Set (MDS) assessment, indicated Resident #32 was admitted to the facility on [DATE] with diagnoses: history of a brain bleed, right and left-sided weakness, diabetes, depression, anxiety and hypertension. The MDS assessment dated [DATE] revealed the resident had moderate cognitive loss and needed 2-person assistance with bed mobility, transfers, hygiene, bathing, and toileting. On 6/2/21 at 2:30 PM, Resident #32 was observed lying in bed watching TV. He was alert and oriented x 3 and readily conversed with this surveyor. Resident #32 described an incident that had occurred about 1-week prior involving Certified Nursing Assistant (CNA) Z. The resident said the aide had worked with him previously and he had not had any issues with her. On this day, she complained to him about changing his brief, because she felt that the previous shift should have changed it prior to the next shift arriving; Resident #32 said the aide was rough with him when she turned him with care. Resident #32 said there are supposed to be 2 staff members assisting him with care and CNA Z had not taken care of him since he reported the incident. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Care Plans for Resident #32 identified the following: ADL (activities of daily living) Self-care deficit . dated initiated 1/22/2016 and revised 5/20/2021, with Interventions: 2-person extensive assist for showers, bed mobility and incontinence care, dated 7/20/2017 and revised 11/15/2017. An interview with CNA Z on 6/3/21 at 11:39 AM, I went in his room and he said he needed to be changed. He said 'I had my light on and nobody came in.' I said, I guess I have to do that. I asked him why the shift before didn't clean him up. Sometimes the residents are drenched. We get a little aggravated. The CNA was asked how many staff were supposed to assist the resident with care and said, I guess there is supposed to be 2, but we are always short-staffed. An interview with the DON, on 6/3/21 at 10:45 AM related to staffing provided, I know staffing is an issue. We are trying. We have to have enough staff to care for the residents. RN Journal 2000-2020, Literature Review: Safe Nurse Staffing, . Safe nurse staffing poses substantial issues a the clinical level including its tremendous impact on patient mortality, patient satisfaction, increased incidence of medical errors, and nurse dissatisfaction and burnout . A review of the facility provided document titled, Resident Rights, dated 11/28/16 revealed The resident has a right to be treated with respect and dignity . The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to, receiving treatment and supports for daily living safely . 37668 On 6/2/21 at 4:30 PM, an interview was completed with Registered Nurse (RN) EE. When queried regarding staffing in the facility, RN EE stated, The problem is acuity. I have labs, tube feedings, wound care, feeding assists, and people who require two-assist. We have two aides (CNA's) for 34 residents. RN EE indicated they barely have time to keep up with everything. An interview was conducted with Certified Nursing Assistant (CNA) Y on 6/3/21 at 8:30 AM. When queried regarding staff in the facility, CNA Y stated, We are always short and indicated they cannot give resident's the extra attention they deserve.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to ensure comprehensive medical social services were provided following an abuse allegation for one (Resident #4) of one resident reviewed for psychosocial assessment and care following allegations of sexual assault within the facility resulting in resident verbalization of fear and lack of resident-centered, purposeful psychosocial assessment related to a rape allegation. Findings include: Resident #4: Review of intake documentation for Resident #4 revealed, On 4/3/20, (Resident #4) stated were raped about 3 or 4 weeks ago by a white doctor wearing a white lab coat who was in a wheelchair . Record review revealed Resident #4 was most recently admitted to the facility on [DATE] with diagnoses which included Cerebral Vascular Accident (CVA- Stroke), bipolar disorder, and dementia without behaviors. Review of the Minimum Data Set (MDS) assessment, dated 3/17/21, revealed the Resident was cognitively intact and required extensive assistance to perform all Activities of Daily Living (ADLs) with the exception of eating. The MDS further indicated the only behaviors displayed by the Resident included rejection of care one to three days. A review of Resident #4's medical record revealed a behavioral assessment was not completed following the allegation of being raped. Review further revealed Resident #4 was seen for a regularly scheduled visit by a psychiatric service provider on 5/4/21. The provider note detailed the Resident was being seen, Per standard of care in managing efficacy of psychotropic medications and ongoing treatment plan . Review of progress note documentation in Resident #4's medical record revealed the following: - 4/3/20: Medical Practitioner Note (Physician/NP) . Chief Complaint / Nature of Presenting Problem: C/O (complain of) vaginal discharge . denies vaginal pain, states does have vaginal discharge but is unable to describe discharge responds yes . when asked if had burning with urination and/or increased frequency. Suprapubic tenderness elicited with gentle palpation of abdomen. During course of above conversation, patient made the following statement . 'I was raped' . NP asked how long ago did rape occur. Patient: 'about three weeks ago' . - 4/3/20: Social Services . Supportive contact with resident. She presented alert and oriented to person only with impairments to all other spheres and memory recall. Resident presented with calm moods, answered all questions posed in a normal tone of voice and presented in no distress at this time . (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/4/20: Mood/Behavior . (Psychiatric Service Provider) . history of schizophrenia and anxiety, last seen by this service on 3/2/20 . per standard of care in managing efficacy of psychotropic medications and ongoing treatment plan. Resident has history of anxiousness, yelling out, agitation, irritability, suspiciousness, paranoia, delusions, hallucinations. Staff report resident made accusatory statement . Review of facility provided investigation documentation for Resident #4 did not include any additional psychosocial assessment. On 5/27/21 at 4:11 PM, an interview was completed with Social Worker C. When queried regarding Resident #4's allegation of being raped in the facility, Social Worker C revealed they were not employed at the facility when the allegation occurred. Resident #4's medical record documentation was reviewed with Social Worker C at this time. When queried regarding Social Services follow up and assessment following the allegation, Social Worker C confirmed the lack of assessment and stated, There was a supportive visit on 4/3/21. When queried why the supportive visit documentation did not address the allegation of rape and/or subsequent emotional ramifications for the Resident, Social Worker C replied, I see what you are saying. It does not show that it was addressed. Review of Resident #4's care plans revealed a care plan related to psychoactive medication use. The care plan and interventions did not address the allegation and/or subsequent potential psychosocial effects on the Resident. On 5/28/21 at 11:45 AM, an interview was completed with Resident #4. When asked if they had any concerns with facility staff, Resident #4 replied, Not really. When asked if they had any incidents in the facility, Resident #4 replied, Yes, I was raped. With further inquiry, Resident #4 revealed they had been raped by a visitor very early in the morning in their room. The Resident was unable to provide a date and/or any additional information. On 6/2/21 at 12:45 PM, an interview was completed with Resident #4 in their room. When queried if they had ever been harmed while at the facility, Resident #4 replied, I was raped. Resident #4 was asked who raped them and stated, I don't know, but everyone's been real nice since that night. I was so scared. With further inquiry, Resident #4 revealed they were sleeping and work up when they felt skin. An interview was completed with the facility Director of Nursing (DON) on 6/2/21 at 1:50 PM. When queried regarding the lack of assessment documentation following the allegation in Resident #4's medical record, the DON stated, Should have been an assessment. With further inquiry, the DON revealed an assessment should be completed following any allegation, per facility policy/procedure. The DON further revealed there was room for improvement in facility procedure. Review of facility provided policy/procedure entitled, Patient Protection Abuse, Neglect, Exploitation, Mistreatment & Misappropriation Prevention (Dated 2016) did not address assessment and care of Residents following an allegation of abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235132	A. Building B. Wing	06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to ensure hand hygiene was performed per Standards of Practice during wound care, for one resident (Resident # 22) of three residents reviewed for wound care, from a total sample of ninety-two residents, resulting in the potential for contamination, spread of microorganisms, infection and illness, when the nurse did not wash her hands or change gloves after assisting Resident #22 with bowel care and then immediately touching clean linen and trying to begin wound care and again after removing a soiled wound dressing and trying to proceed with a clean wound dressing. Findings Include: Resident #22: A review of the Face Sheet and Minimum Data Set (MDS) assessment indicated Resident #22 was admitted to the facility on [DATE] with diagnoses: Psychotic disorder, depression, history of brain tumor, acute kidney failure, hypertension, atrial fibrillation, and pain. On 5/27/21 at 1:05 PM, Nurses F and FF were observed performing a dressing change to the resident's coccyx. Nurse F assisted the resident with positioning to the side and Nurse FF was to change the dressing. The resident had a bowel movement and Nurse FF assisted with cleaning the resident. When she was done wiping the resident after the bowel movement, she did not remove her soiled gloves or wash her hands. Nurse FF proceeded to move the resident's linens with her soiled gloves, touch the container of wipes and close it and reached for a clean brief. During the observation, Nurse FF had to be stopped to ask her about hand hygiene. She stopped and removed her soiled gloves and washed her hands with soap and water. The resident began to have another bowel movement, in addition, the brief he had on was still lying under him and was soaked in dark urine, Nurse F assisted the resident again and cleansed his buttocks. She proceeded to reach for supplies and a clean brief, again without removing the soiled gloves and washing her hands; this occurred several times during the course of the dressing change. The other nurse cued Nurse FF to remove the gloves and wash her hands after removing the soiled dressing and reaching for a new dressing. On 5/27/21 at 2:45 PM, the Director of Nursing was interviewed about the wound care observation with Resident #22 and the lack of appropriate hand hygiene and said, I heard what happened. (Nurse FF) came and told me about it. She should have washed her hands and changed her gloves. We practice that. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Centers for Disease Control and Prevention (CDC), January 8, 2021, Clean Hands Count for Healthcare Providers . Protect yourself and your patients from potentially deadly germs by cleaning your hands. Be sure you clean your hands the right way at the right times . Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces . Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Preventions (CDC) recommendations. Ensure that healthcare personnel perform hand hygiene with soap ad water when hands are visibly soiled. Unless hands are soiled, an alcohol-based hand rub is preferred .