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	03/07/2022

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 39059 This Citation Pertains to Intake Number MI00126059. Based on observation, interview and record review, the facility failed to provide a phone for resident use for one resident (Resident #7) of one resident reviewed for phone accessibility, resulting in the inability to communicate via phone, feelings of isolation and depression. Findings include. On 1/26/22, at 3:00 PM, a telephone call was placed to the facility's main number. Receptionist J answered the phone. Receptionist J was alerted the need to speak to Resident #7 and Receptionist J stated, the residents don't have phones in their room. Receptionist J was asked if they could place the call on hold and get the resident to the phone and Receptionist J placed the call on hold. Nurse K answered and was asked to transfer the call to Resident #7 that it was important to speak to the resident and Nurse K placed call on hold for five minutes. Nurse K returned to the line and claimed that Resident #7 was sleeping and to call back after 6:00 PM. Nurse K was asked if Resident #7 had a phone in their room and Nurse K offered that the residents haven't had a phone for personal use for quite some time. On 1/27/22, at 9:20 AM, the Administrator was asked if Resident #7 had a phone for use and Maintenance Lead D who was in the Administrator's office quickly offered they would ensure there was a phone for use on the COVID unit. On 1/27/22, at 9:30 AM, Maintenance lead D was observed passing a phone through the isolation closure to Housekeeper U. Housekeeper U was instructed by Maintenance Lead D that the instructions for use was in the box and to plug in the base. On 1/27/22, at 1:12 PM, a telephone call was placed to the facility's main number and asked to speak to Resident #7. The Receptionist placed the call on hold. A staff member answered the line after five minutes and was alerted the need to speak with Resident #7. The call was placed on hold and shortly after Resident #7 answered the line. Resident #7 was asked if they were able to speak in a private setting and Resident #7 claimed they were standing at the nurses station and was concerned to speak in front of the staff. Resident #7 was asked to give the phone back to the staff member who quickly offered to assist the resident with the handheld phone from their room. (continued on next page)

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

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/22, at 1:20 PM, a phone interview with Resident #7 from their room on a private handheld phone was conducted regarding their ability to have a phone for personal use. Resident #7 claimed they have been in isolation on the COVID unit and haven't had a phone provided to talk on. Resident #7 stated they could go to the nurses station and use their phone but they don't always let them. Resident #7 began to cry and claimed they felt depressed and felt the facility was choosing to isolate them on purpose. Resident #7 denies the facility had offered a tablet or any other device for use to aide in communication. On 1/27/22, at 2:00 PM, a record review of Resident #7's electronic medical record revealed an admission on 10/12/21 with diagnoses that included Diabetes, Severe Depression and subdural hematoma. Resident #7 required assistance with Activities of Daily Living and had intact cognition.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Number MI00125545 Based on observation, interview and record review the facility failed to provide a clean, comfortable and home-like environment by ensuring that hallways, resident room floors and walls were free from dried sticky spills and debris, resulting in an unclean physical environment, resident dissatisfaction and complaints regarding the lack of cleanliness. Findings include On 1/31/22 at 12:03 PM during a tour of the East Hall of the facility, the hall floor was noticed to have soiled, dirty brown stains on both the long and short hall. Upon entering room [ROOM NUMBER], there were large brown, blotchy stains on the floor and a large, approximately 8 inch by 7-inch red, sticky stain on the floor near the head of the bed for 20 B. On 1/31/22 at 12:10 PM, Resident #32, in 20 Bed B, was interviewed about the stains on the floor in his room. He said no one had been in to mop the floor and he couldn't recall that the floor had been cleaned since he arrived. Resident #32 was admitted to the facility on [DATE] and per the Minimum Data Set (MDS) assessment dated [DATE] the resident had full cognitive abilities. A tour of the facilities East Hall on 2/1/22 at 1:30 PM, revealed the floors were still soiled with large brown stains and the large red stain was still on the floor in room [ROOM NUMBER]. Housekeeper JJ was observed preparing to enter a resident's room to clean, she was interviewed about the lack of cleaning in the hallways and some rooms and said, There was no one on the hall today. Every housekeeper has been busy. Housekeeper JJ said her shift was from 1:00 PM to 9:30 PM that day. On 2/2/22 at 8:40 AM, Housekeeping Supervisor M was interviewed about the cleanliness of the facility and stated, We have had to pull people. The Floor tech was being pulled to laundry. They have a routine that they are supposed to do. If the floor tech is pulled to another area, I'll tell the housekeepers that they need to clean the floors. Discussed the hallway and room floors were very soiled on the East Hall, the Housekeeping Supervisor was asked if anyone was assigned to clean the area and said there was not, but he would assign someone. A review of the facility policy titled, Next Level Hospitality Services and Your Environment: Introduction to Environmental Services, undated . In these guidelines you will find the tolls necessary to ensure that your department is organized and has everything it needs to complete day-to day operations. It is important to follow the procedures set forth and to continuously monitor and follow up with your team . Quality is one of the most important elements that we strive to provide . also comply with the requirements of any governmental agencies that oversee our operations . 31997 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The following observation was made on 2/2/22 at 9:00 AM, in the dinning area located between halls 26 and 50. In the dinning room, on the floor next to the wall (Left side) was noted to have multiple spills, splatters and a large stain of brown substance on the floor. While touring the East hall unit, the following observations were made: rooms [ROOM NUMBER], did not have any resident names located on the name plates indicating who the residents were in the rooms. Several staff were asked and were not able to verify who the residents were. One of the staff said They are supposed to have sticky noted on the wall plate so we know who they are. There was water noted on the floor in the hallway, out side of room [ROOM NUMBER] A. In room [ROOM NUMBER] bed B, there was a high back wheel chair in the room. In the chair was noted to have multiple items stacked in the chair to include a bag of three bed pans, wheel chair foot pedals, a wash basin, boots. The male resident verbalized They just keep piling stuff on top of stuff. Male resident verbalized he had not been showered in a month. Female resident residing in room [ROOM NUMBER] bed A, there was no name on the plate. Female resident was noted to have long grey whiskers on her chin. Female resident in 28 bed B, (no name on the plate out side room) was noted to have long grey whiskers to her chin. Resident in bed B was asked if the whiskers bother her and said, Yes, I cant get to them. They ain't doing it. Surveyor returned to the conference room and asked Corporate Staff present why there were no names on the residents rooms indicating who was in the room. One of the Corporate Staff verbalized that it was supposed to be done by Admissions Coordinator, and would look into it. 45246 On 2/14/22 at 10:20 AM Resident #14's family member interview was conducted. During the interview it was shared by complainant that she received a phone call from Resident #14 on 1/4/22 regarding flooded toilet. Resident #14 was complaining to family that sewage was everywhere, covering his room's floor. He called for help by call light and was waiting for anyone to answer. When housekeeping and maintenance staff came in, they started argument in resident's room about who is going to clean it up. Only hours later after the flood the floor in Resident #14's room was cleaned up, however family member said it still smelled like sewage for days. Complainant stated they informed the facility about the problem with toilet not properly flushing days before the incident and nothing was done about it. Resident #14 had to stay in his room while all the above was happening. During facility tour on 3/3/21 at 12:22 PM observation was made in room [ROOM NUMBER]. The base of the pole with tube feeding pump and the floor around it was covered with sticky dark cream-colored substance (Jevity tube-feeding formula). Floor stains were dried up.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31997 This Citation pertains to Intake Number MI00124773 Based on interview, and record review, the facility was placed in Immediate Jeopardy (IJ), when the facility 1) Failed to ensure that Resident #29's dietary nutritional orders were entered correctly in the proper format upon admission by nursing and 2) Failed to ensure that Resident #29 received Enteral Nutrition and hydration (tube feeding) as ordered, from the admitted [DATE], through [DATE], while receiving 2 diabetic medications, without Enteral feeding or hydration being administered, (which was the only source of nutrition), resulting in Resident #29 going 7 days without receiving Enteral Nutrition or hydration. On [DATE], Resident #29 had a change in condition (8th day). Resident #29 was noted by staff to be in Respiratory Distress and Cardiac Arrest, resulting in his death on [DATE] at the facility. Immediate Jeopardy: The Immediate Jeopardy began on [DATE]. The Immediate Jeopardy (IJ) F-600 was identified on [DATE], at 4:57 PM, upon review of the clinical record and other pertinent documents. The Administrator was notified of the Immediate Jeopardy on [DATE] at 9:55 AM, and was instructed to provide an Abatement Plan to remove the immediacy. The facility also needs to take immediate action to enter nutritional orders upon admission correctly and in a timely manner, and to provide residents with essential nutrition and hydration. The facility also needs to ensure that nursing staff are properly trained on executing dietary admission orders and making sure that residents are properly hydrated. The IJ Abatement/Removal plan was accepted on [DATE], with a removal date of [DATE], as verified by onsite date of [DATE]. Findings include: According to admission face sheet, Resident #29 was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included: Stroke with right sided weakness, Diabetes, Anemia, Dysphagia (difficulty in swallowing), High Blood Pressure, Dementia, and other complications. Resident #29 had a peg tube and received Enteral Nutrition via peg tube and was documented as Nothing By Mouth (NPO) status on admission. According to Minimum Data Set (MDS) dated [DATE], Resident #29 was not scored on the Cognition Assessment, indicating severe cognition impairment. The MDS also reflected that Resident #29 required 2 person staff assist for Bed Mobility, and Toileting, and required Limited Assist with transfers. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Hospital Discharge orders for Resident #29, reflected under 'Nourishment', order #89705368 to administer 150 cc of free water every four hours, dated [DATE]. Also noted, was order #89705344 to provide Glucerna 1.5 (diabetic) at 60 ml per hour with a start time of 11:35. The stop time was documented as 'until specified'. Review of Facility orders, December, 2021, for Resident #29, reflected an order: Glucerna 1.5 at 60 ml/hr with 37.5 ml/hr H20 flush. Under 'Directions' documented as no directions specified. Under 'Category' was documented as 'Other'. (format nutritional orders entered in into Point Click Care). Under 'Status' was documented as 'discontinued'. Under 'Start Date' was left blank (there was no documented start date, start/stop time, for administering the tube feed). The end date was documented as [DATE], for that order). Review of December, 2021, Medication Acceptance Record (MAR), reflected an entry on the MAR for: Glucerna 1.5 at 60 ml/hr with 37.5 ml flush of H20/hr, to start on [DATE]. Review of the MAR reflected no start or stop time documented, and no entry for nursing to initial in the MAR that the feeding was started or stopped. Review of dates [DATE], [DATE], and [DATE], reflected Resident #29 did not receive any Enteral Nutrition (tube feeding) or hydration as ordered. (Resident #29 received no nutrition) Further review of Resident #29's admission orders reflected 2 diabetic medications to be administered as: Glipzide 5 mg one tab via peg tube twice a day, for diabetic management, with a start date of [DATE]; and Metformin HCl tablet 1000 mg via peg tube two times a day for diabetic management, with start date of [DATE]. (Review of MAR reflected Resident #29 received the medications as documented by nursing.) Review of Resident #29's orders January, 2022, reflected an order dated [DATE], for Enteral Feeding to flush tube with 50 cc of water every hr (hour) of tube feed infusion (20 hrs) for total of 1000 ml, and formula Glucerna CC/HR as 70 X 20, on at 1600 (4 PM), and off at 1200 (noon), for total volume 1400/ml/24 hours, dated [DATE] at 11:56 (AM/PM not specified). Review of January, 2022's MAR, reflected an order started on [DATE], for Glucerna 1.5 to be administered at 70 cc/hr times 20 hrs, with a start time of 1600 hrs, and stop time of 1200 hrs. Review of the MAR reflected the first Enteral Feeding for Resident #29 was administered on [DATE] at 2:15 PM, (8th day post admission), by Licensed Practical Nurse N, who is an Agency Nurse. An interview was conducted with Registered Dietician on [DATE] at 10:53 AM, with another Surveyor present. RD E was asked about Resident #29, and indicated he was admitted on [DATE], and deceased on [DATE]. RD E said she really did not remember this resident as she has 300 residents to review in other buildings. RD E was asked if any nurses in the facility contacted her and questioned the nutritional orders for Resident #29. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RD E verbalized that she thought a nurse did contact her about Resident #29, but could not recall the conversation. I was in a different building at the time. RD E was asked to clarify the process for tube feed order entry, and indicated I don't do orders. Nursing does. They put them in. I give my orders and they enter them. RD E verbalized she went in and seen Resident #29 on [DATE], and reviewed his orders for clarification. RD E then indicated that the nurse who did the admission for Resident #29 enter the nutritional orders under 'Other' which was not the proper format for entering nutritional orders for tube feeding, because it will not always populate (pull over) on the MAR. RD E said It should have been entered under 'Enteral Orders' and not Other. RD E also verbalized she is not an expert on nursing orders, and would often ask the Director of Nursing to check on certain orders. RD E verbalized again that nursing entered Resident #29's nutritional orders under the wrong format as 'Other' and not in the proper category. RD E was asked when Resident #29's Enteral Feeding orders should have been started and verbalized, The Enteral Feeding orders ideally should have been started on [DATE] at 3:30 PM. RD E was asked if nursing informed her that the tube feeding for Resident #29 had not been running in days, and verbalized No one told me. RD Ewent on to say that she seen the order had been written vaguely and not to the Standard that I like it to be. A second interview was conducted on [DATE] at 11:07 AM, with RD E for clarification on entering orders into the system on admission. RD E indicated she sometimes had to ask the previous DON to clarify the Enteral Feeding orders due to nursing not entering in the proper format, and it had been an ongoing problem. RD E indicated that for Resident #29 she had asked the previous DON to clarify Resident #29's Enteral Feeding orders, but not until [DATE]. RD E verbalized that was when the Enteral Feeding had begun for Resident #29 at 70 cc per hour. (Admission on [DATE], 8 days after admission.) An interview was conducted with LPN A on [DATE] at 3:01 PM. LPN A was asked how it was working Agency in the facility, and then verbalized several issues that were happening in the building. LPN A verbalized that at times 5 to 7 admissions would come through the doors on one shift, without any additional help, and that it took up to 2 hours to complete the admissions by the nurse working that shift. LPN A also verbalized that if you couldn't finish everything for that admission, the next on coming nurse was supposed to finish it. LPN A indicated a lot of things were not getting done and that most of the admissions were coming on second shift, or later in the evening. LPN A had to end the interview on this day due to personal obligations. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A second interview was conducted on [DATE] at 3:49 PM, related to Resident #29. LPN A was asked if she was the nurse in care of Resident #29 on [DATE], and said she was. LPN A was asked if she remembered Resident #29 and said Yes, he was the tube feed guy that was not fed for 3 days. LPN A was asked how she knew that he had not been fed tube feeding. LPN A indicated another nurse had told her that information. (gave the name of the nurse). LPN A went on to say that she was in care of Resident #29 on [DATE], after 6 PM, when she took over the care after the previous nurse had left. LPN A verbalized she was at the nurse station and had been working on several admits on the North hall. LPN A indicated that was during the time Resident #29 experienced a change in condition, on [DATE] and died . LPN A indicated she was up passing medication, and Resident #29 resided in room [ROOM NUMBER], near the nurse station. She verbalized on [DATE], she could hear Resident #29 having what she called 'Stridor'. LPN A was asked to clarify 'Stridor' and said Bubbling or gurgling sounds. (According to medical definition of Stridor defined as: abnormal, high-pitched, musical breathing sound, caused by blockage in the throat/voice box (larynx) most often heard when taking a breath). LPN A said it was loud enough to hear without the stethoscope at the nursing station. LPN A verbalized she went in room [ROOM NUMBER] and looked at Resident #29. LPN Asaid he was not elevated to ,d+[DATE] degrees in bed, and that his tube feed was actively running. LPN A verbalized she was upset about the bed being down flat. LPN A verbalized that she raised the head of the bed up. LPN A said she auscultated Resident #29's lungs and documented in Progress notes her findings. LPN A verbalized she went and called upper management. LPN A said she took air pod into the room to let upper management hear that Resident #29 was making gurgling noise and in distress. LPN A then indicated she got called to another room to deal with other resident issues. LPN A verbalized she was planning to send Resident #29 out of the facility. An interview was conducted on [DATE] at 2:48 PM, with LPN N related to Resident #29. LPN N verbalized she was an Agency Nurse, but worked in the facility doing double shifts on 2nd and 3rd shifts weekly. LPN N was asked if she was working on [DATE], and verbalized she was the other nurse working the Long Hall with LPN A. LPN N was asked if she remembers Resident #29 and said she did, and went on to say that LPN A came out of Resident #29's room and said he was laying flat, and was mad about it. LPN N was asked if she was aware that Resident #29 had not been fed for days, and verbalized I had heard from other nurses that his tube feeding had not been hooked up and running. LPN N verbalized it (tube feed formula) was hanging on the pump, and the water was there too. no one hooked him up or turned on the pump. LPN N then verbalized she was involved with the Code that occurred with Resident #29 on [DATE], in the evening. LPN N was asked if she received any training on completion of admissions/orders and entering nutritional orders into their system, and verbalized No, I just figured it out along the way. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN N verbalized various issues that had been happening in the facility, and indicated she did not receive any training when initially working in the facility. LPN N indicated she had to ask other staff often about how things were done. I had to ask what is this, and what is that. No one ever gave me any training on orientation. LPN N verbalized initially she was uncomfortable with the conditions in the facility, and indicated she had to ask the previous Director of Nursing how to do certain things. I did a lot of complaining. LPN N indicated, If a new admit came in, and the nurse was not able to complete it, the next nurse was supposed to. There were times when residents did not get there medications for 2 days. There were up to 7 admits that came on 2nd shift, at one time, with no help. Things got missed a lot. It was not do-able. We did not always have access to everything, especially on weekends. Residents were not getting meals and proper care. There were many resident and family complaints. Things have gotten a little better recently since you guys are here. An interview was conducted on [DATE] at 4:15 PM, with Licensed Practical Nurse P related to Resident #29. LPN P verbalized she was an Agency Nurse that had been working in the facility. LPN P was asked how it was at the facility and indicated It is not been the best experience. LPN P was asked why, and verbalized there are a lot of things going on there, and not good things, such as missing medications and poor resident care. LPN P was asked if she remembered Resident #29 and said she did. LPN P verbalized she had cared for Resident #29 a few times before he died , and recalled he was supposed to receive tube feeding and did not. LPN P indicated the orders for Resident #29's tube feeding administration were not clear. LPN P verbalized what she could recall was that when she went into care for Resident #29, the tube feeding was never running and verbalized from 6 AM through 2 PM, the tube feed was off. The MAR did not have and Up or Down (Start/Stop) time documented. I would say Ok, every day there is a full bottle of feeding and water, and nothing is running LPN P said the MAR did not specify what time to hang it, turn it on, or take it down. So, I talked to the Registered Dietician. We went in and seen Resident #29. The Registered Dietician showed me how to check the volume to be infused on the pump. I did not know how to do that. No one had ever shown me that. The Registered Dietician went and told the Director of Nursing that Resident #29's tube feeding had not been started for days. I started his tube feeding and got him running. It was in the beginning of January. When the RD and I checked the tube feeding pump, it was discovered that nothing had been infused to Resident #29, there was no volume infused. The tube feed was hanging. The water flush was hanging. The pump had not been programmed to infuse the rate of feeding or anything. He did not get his feeding for days. The Registered Dietician was angry about Resident #29 not getting his feeding. She went to the DON who blew her off. I am not really sure how long it was going on, but I know it was for several days. LPN P then verbalized what the other nurses told her about the day Resident #29 had coded on [DATE]. LPN P also verbalized she was told that Resident #29 had been found lying flat with tube feed running on [DATE], by one of the nurses who was mad at the nursing assistants. LPN P was asked if she received any training on orientation and verbalize no, not on anything. LPN P reiterated again that things were pretty bad at the facility, and said that residents are not being fed, not getting medications, not getting cleaned up, and that there are a lot of admissions that are coming through the doors. LPN P said that she was responsible to care for 40 residents with only 2 aids by herself. We could not get it all done. The other nurse has to care for 30 residents with 2 aids and 4 or 5 admissions come through the door. No one comes to help us because we are Agency and they tell us You make more money than we do, do it your self, or do your job. The other nurse on the other hall has 39 residents and 2 aids. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 12:14 PM, with LPN S. LPN S was asked if she remembered Resident #29 and said she did. He was non-verbal, tube feed, feisty and combative at times. LPN S verbalized that 2 Aids told her on [DATE], that a resident had been throwing up and that they cleaned him up. They never said the name of, or who the resident was. I said ok. I was told on the 6th or the 7th of January that Resident #29 passed away. I was shocked, and the 2 Aids said, that was the guy we cleaned up after he threw up. LPN S went on to talk about the code that occurred on [DATE]. LPN S was asked about the tube feeding orders for Resident #29. LPN S said she had been told by the former DON, that Resident #29 had not been fed for three days and was crying. She was asking How did this happen. LPN S indicated that one of the Agency Nurses had been hiding admission packets, behind printers, placing in drawers, because there were so many admissions coming through the doors. LPN S said that a lot of things were not being entered in the computer on the day of admissions for residents. They were not getting their medications, or diets, and other things. LPN S was asked about the tube feeding order for Resident #29 and indicated the nurse that did the admission did not enter the order correctly into the system, which resulted in no start or stop time. The tube feed order was not the right order. I am not sure how long he was not fed, but I was told 3 days. One of the nurses finally contacted the Registered Dietician for clarification on the feeding order. LPN S indicated when there are 7 admissions coming through the doors, a lot of things are left incomplete. LPN S indicated the tube feeding was started on [DATE], and he (Resident #29) died on [DATE]. LPN S talked more details about her involvement with the Code for Resident #29. An interview was conducted on [DATE] at 2:25 PM with the current Director of Nursing. The DON was asked how long she had been in the role and said only 2 weeks. The former DON left. DON was asked if she knew any information about Resident #29 and said she knew some. DON said what she knew was: Resident #29 passed away after a Code in the building on [DATE]. DON said she spoke with the Registered Dietician and was informed that Resident #29 had not been fed in roughly 6 days, due to lack of diet order because an Agency Nurse entered the order into the system incorrectly. The DON verbalized that if nursing enter the orders under the category as 'Other' it will not show up on the MAR. We have to make sure the nurses are educated. An interview was conducted on [DATE] at 4:00 PM, with Administrator. Administrator was shown that Resident #29 was admitted into the facility on [DATE] and did not receive any enteral nutrition or hydration until [DATE]. Administrator was asked if anyone had shared that information with her, and indicated she did not know. Administrator asked How does this happen. 18 or so nurses over a six day period did not feed this resident. An interview was conducted on [DATE] at 11:00 AM, with LPN T. LPN T who indicated she was an Agency Nurse and often worked a lot of hours in the facility. LPN T was asked how many residents she provides care to, and said 40 residents for herself and 2 aids. LPN T verbalized she stopped working on 2nd shift because that was when all the admissions were coming through the doors, and no one help with the admissions. There would be anywhere from 4 to 7 admissions depending on the day. (continued on next page)

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Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN T was asked about Resident #29 and said she never took care of him, but was told by other nurses that he was not fed for days and then coded. LPN T was asked if she knew how to enter nutritional orders into Point Click Care (PCC) on admission, and said I just enter the orders under the category 'Other', sometimes it will populate over to the MAR with a start time or stop time, and sometimes it does not. I just put in what I have for an order in under 'Other' and when the Dietician comes back to the building on her next day, she will usually clarify what and how she wants the order. LPN T was asked what happens if the resident is admitted on a Friday or weekend. LPN T said the next Monday, the Dietician will clarify the order. It is hard to do. I did not receive any training on how to put the orders into the system. My training with PCC was from another building that I worked in before, but not from this facility. Review of Progress notes in the clinical record, reflected there was not an entry in the notes made by nursing from [DATE] through [DATE]. The first entry in Progress notes was made by the admission nurse on [DATE], and did not have any orders entered for tube feeding. There was no documentation entered during that time for Registered Dietician follow up, Unit Manager follow up, Physician/Provider follow up, or nursing to clarify start or stop time during that time frame. According to interviews by nursing staff, the tube feeding was hanging on the pump along with water flush, it just was never started. There was no entry in the medical record made by nursing until Resident #29 had a change in condition as documented on [DATE]. Review of General Progress Notes [DATE] at 21:00 (9 PM), and a creation date of [DATE] at 21:51(9:51) PM, reflected a documented entry Resident was found lying flat in bed while tube fed was actively running. Resident was repositioned to the high fowlers position immediately. Resident stridor continued. On call was notified the resident's condition. Report will be given to the third shift nurse to watch for orders from On- call. Management notified of this situation. LPN A made the entry. Further Review of Progress Notes reflected an Interact SBAR form, dated [DATE] at 21:54 PM (9:54 PM), documented : Situation: The Change In Condition/S reported on this CIC Evaluation are/were: Respiratory arrest Shortness of breath Unresponsiveness Change in skin color or condition. At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP ,d+[DATE] - [DATE] 07:16 Position: Lying l/arm - Pulse: P 88 - [DATE] 07:16 Pulse Type: Regular - RR: R 17.0 - [DATE] 10:47 - Temp: T 97.9 - [DATE] 10:47 Route: Tympanic - Weight: W 203.0 lb - [DATE] 16:39 Scale: - Pulse Oximetry: O2 95.0 % - [DATE] 10:47 Method: Room Air - Blood Glucose: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident/Patient is in the facility for: Long Term Care Primary Diagnosis is: Relevant medical history is: Dementia Diabetes Code Status: FULL CODE Advance directives are: N/A Resident/Patient had the following medications changes in the past week: N/A Resident/Patient is on Coumadin/warfarin:No The result of last INR: Date: Resident/Patient is on anticoagulant other than warfarin: No Resident/Patient is on: Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: - Mental Status Evaluation: Unresponsiveness - Functional Status Evaluation: Other - Behavioral Status Evaluation: - Respiratory Status Evaluation: Shortness of breath Other respiratory changes - Cardiovascular Status Evaluation: - Abdominal/GI Status Evaluation: - GU/Urine Status Evaluation: - Skin Status Evaluation: No changes observed - Pain Status Evaluation: Does the resident/patient have pain? - Neurological Status Evaluation: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing observations, evaluation, and recommendations are: Resident was found at 8:30 pm with stridor on extortion.[SIC] On call was notified at 8:30 and finally provided orders and confirmed them at 9:50 pm. Staff found resident unresponsive at 9:50 pm. One nurse began CPR after the check the code status.[SIC] 911 was called at 9:50. The unresponsive code was called at 9:50 as well. Staff joined other nurse to perform CPR until EMS arrived. EMS called time of death at 10:41 pm. Medical examiner will arrive within an hour to perform an investigation. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: On call ordered a nebulizer treatment for this resident at 9:50. Nebulizer treatment. This entry was documented by Licensed Practical Nurse A, who is an agency nurse. (The vital signs documented in the SBAR, did not reflect LPN A obtaining any vital signs, or performing an assessment to reflect current status change in condition. Some of the vital signs documented above were taken greater than 12 hours prior to Resident #29's change in condition, and were from 2 different nurses that had assessed Resident #29 earlier in the day. LPN A never obtain any vital signs as documented in the clinical record. LPN A notified the On-Call Provider the vital signs that had been taken early in the day, not during her shift, while in care of Resident #29 to reflect current health status and change in condition.) Further Review of the clinical record reflected General Progress Notes, dated [DATE] at 22:17 (10:22 PM), documented by Licensed Piratical Nurse A that Resident was found at 9:50 pm unresponsive by both second shift nurses. Resident was warm to touch. One nurse started CPR and the nurse called 911 after checking his code status. The code was called overhead. Both nurses continued CPR until EMS arrived at 10:18 PM. Review of Progress Notes dated [DATE], documented a Teleheath Visit by FNP (Family Nurse Practitioner) at 11:11 PM, as Notified by nursing that Resident had stridor with effort, TF (tube feed) patient, CXR (chest X-ray) and Albuteral Neb (breathing treatment) ordered. Also documented was 'Addendum Details' as: pt vitals were requested, not updated in the chart. Then notified that resident became unresponsive at 9:50 PM. CPR was started at 9:50 PM. Time of Death was called at 10:41 PM, by EMS. (The creation date for the addendum was documented as [DATE] at 23:23 (11:23 PM), post death of Resident #29). Review of Policy Enteral Nutrition (undated) documented Adequate nutritional support through enteral nutrition is provided to residents as ordered .If the resident has a feeding tube placed prior to admission or returning to the facility, the provider and the interdisciplinary team will review the rationale for the placement of the feeding tube, the resident's current clinical and nutritional status, treatment goals, and wishes of the resident .the dietician monitors residents who are receiving enteral nutrition and makes appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings. The nursing staff and provider monitor the resident for signs and symptoms of adequate nutrition, altered hydration, hypo-or hyperglycemia, and altered electrolytes. The nursing staff and provider also monitor the resident for worsening of conditions that place the resident at risk for above .The Nurse confirms the orders for enteral nutrition are complete. Complete orders include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-enteral nutrition product, -Delivery site, -Specific enteral access device, -Administration method, -Volume and rate of infusion, -Volume goals and recommendations, -Instruction for flushing (solution, volume, frequency, timing and 24 hour volume) The provider will consider the need for: -Conformation of tube placement, -Laboratory monitoring, -Nutritional Consultation, -Head of bed elevation, -oral care, and check for gastric residual volume. Staff caring for residents with feeding tubes are trained on potential adverse effects of tube feeding . Review of 'Abuse Prevention Policy' dated as revised 2018, documented Our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, and involuntary seclusion, and any physical or chemical restraint . Neglect is the failure of the facility, its employees or service providers, to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or mental illness . On [DATE] at 9:55 AM, the Immediate Jeopardy was presented to the facility Administrator, as it was identified on [DATE]. The facility provided an Abatement Plan that was reviewed and accepted on [DATE], by State Agency Survey Manager. The IJ was removed on [DATE], based on the facility's implementation of the Removal Plan as verified onsite. The Abatement Plan was as follows: Abatement of the IJ F-600 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Event date: [DATE] [DATE]- All residents tube feed orders were evaluated, and orders have been checked by the RD and the Regional Director of Clinical Services. This ensured that every resident on tube feeding obtained the proper nutrition and the hydration orders. [DATE] All residents' nutritional orders were evaluated in PCC by the Regional Director of Clinical Services. [DATE]-current orders for residents on tube feeding are now correct in PCC [DATE]-new admissions that are tube fed will be forwarded via email to the RD at the time of admission so she can approve and make recommendations to the nutritional orders. The orders will be reviewed for approval by the Physician. Then the DON will ensure that the order is placed into the correct format and that it is visible on the MAR and the TAR. Admission Director will notify the RD, DON and Administrator at the time of the admission to ensure orders are placed as needed via email. We have hired an Admission Director and they will be responsible for clarification of hospital discharge orders. [DATE] Nurses will fill out the admissions dietary sheet per admission orders and give to kitchen as well place in the RD's mailbox. RD will review all dietary orders the following business day. [DATE] If there are any questions or concerns regarding the admissions orders the admitting nurse will reach out to the on call clinical leader [DATE]- education has been started on training licensed nurses on how to execute dietary admission orders and residents are properly assessing for hydration needs. RD will be notified for those residents at risk of dehydration. Nurses that haven't had the education will not take the floor until they are educated. Education will be ongoing. [DATE]- education has been started on medication administration via the peg tube. Nurses that haven't had the education will not take the floor until they are educated. Education will be ongoing. [DATE] After hours all admission orders will be verified by 2 nurses to ensure that they are entered correctly. [DATE]- All new admits will have the clinical assessments completed and audited for completion & accuracy by the Unit Mgr, DNS and/or designee within 24 hrs. Clinical assessments to be completed by the admitting nurse and will include Comprehensive nursing admission assessment, Braden assessment, Morse Pain, Elopement, Hydration and Fall assessment. [DATE] Licensed Nursing staff will be re-educated on admission process including expectation of completion of assessments and validation of orders. Nurses that haven't had the education will not take the floor until they are educated. Education will be ongoing. [DATE] Licensed Nurses will be re-educated on medication administration, medication assessment and nutritional values and change in condition. Nurses that haven't had the education will not take the floor until they are educated. Education will be ongoing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] Facility will print out a step-by-step guide in how to place admissions orders into PCC, and how to place tube feeding orders in PCC and how to run tube feeding pump and check for residual. Clinical responsibilities will be upheld by the Director of Nursing Services during the morning clinical meetings, where admits and readmits will be evaluated to ensure proper nutritional needs have been ordered and hydration assessments have been completed. Clinical services will monitor the orders within 24 hours after admissions or re-admission to ensure the correct diet orders are in PCC. Administrator and Director of Nursing Services is responsible for compliance Substantial compliance was obtained on [DATE] 45246 During interview with the Registered Dietitian E on [DATE] at 10:55 AM s [TRUNCATED]

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation pertains to Intake Numbers MI00124773, MI00125680, and MI00125742. Based on observation, interview and record review the facility failed to account for narcotics and controlled substances on a daily basis and resolve discrepancies per Standards of Practice, for 3 residents (Resident #2, Resident #25 and Resident #33) of 13 residents reviewed for medications and narcotics, leading to Resident #2, Resident #25 and Resident #33 not receiving their prescribed narcotics as ordered and the likelihood for a serious adverse outcome including harm and untreated pain if residents were not receiving necessary pain medications due to drug diversion. Findings Include: Review of a Facility Reported Incident (FRI) date [DATE] indicated the narcotic medication counts were not accurate: liquid hydrocodone; on the long hall North. Per the investigation, Former Nurse Manager PP provided a written statement for [DATE] that said Nurse XX had contacted her via phone and said another nurse would not take the medication cart keys after completing the narcotic count with Nurse XX because the narcotic count for liquid Morphine for Resident #2 was inaccurate: She said the count is 155 on paper it's only measuring 150. Nurse XX told Nurse Manager PP I'll work it out, but she can go home. The call was ended. A witness statement by Nurse XX dated [DATE] provided the following, . (Nurse YY) stated there was a bottle of liquid narcs short on the other cart. The Agency Nurse stated this was going to be a problem. As (Nurse YY) started count with the Agency nurse, she abruptly stopped and stated she don't feel comfortable taking the keys Called Unit Manager (PP). The narcotic shortage was discussed. (Nurse Manager PP) told us through the phone to correct the count. The other agency nurse she needed to contact her agency. Once the nurse left the hall she never came back. The facility was unable to reconcile the missing medication- liquid hydrocodone/acetaminophen (Norco) and substantiated that it was missing and unaccounted for. Within the FRI investigation report, the facility cited Past non-compliance identified on [DATE], reviewed in QAPI on [DATE] and The facility alleges substantial compliance on [DATE]. The facility provided education for 11 nurses. They listed approximately 75 nurses on their list provided during the survey. Per the surveyor investigation and findings, the facility had continued discrepancies with narcotics on multiple occasions after [DATE]. Resident #2: An interview with Confidential Person SS on [DATE] at 10:15 AM provided, Meds were late, nothing was ever on time. She had terrible muscle spasms and I kept telling them to contact the doctor. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Face Sheet and Minimum Data Set (MDS) assessment for Resident #2 indicated an admission and date of [DATE] with diagnoses: History of a recent stroke, dysphagia, a gastric tube (feeding tube), history of throat and lung cancer, COPD, Hospice services and hypertension. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] and the resident needed 1 to 2-person assistance with all care. Resident #2 died on [DATE]. A review of the Medication Administration Records and Treatment Administration Records (MAR/TAR) from [DATE] revealed, Resident #2 had an order for Hydrocodone-Acetaminophen solution 7XXX,d+[DATE] mg (Norco) Give 5 ml via G-tube every 4 hours as needed for Pain, start date [DATE] to [DATE]. Resident #2 received 8 doses from [DATE]-[DATE]; Four of the doses administered by Nurse YY. The last dose was administered on [DATE] at 11:35 PM by Nurse Q. On [DATE] at 2:15 PM during a tour of the Central hall, former Director of Nursing Q was observed counting narcotics at the short hall/Central medication cart with Nurse BB. Upon counting the narcotics with both nurses, a cassette of medications was observed taped over on the back. Nurse BB said it was because the cassette had been opened on the back (Alprazolam ,d+[DATE] tab of 0.25 mg daily) for Resident #33. A photocopy of the front and back of the cassette was obtained. Five doses were opened, circled, and taped. The doses were numbered 4, 5, 6, 7, 8. The cassette indicated there were 14 doses received from the pharmacy. There were 6 doses remaining. A review of the corresponding Controlled Substance Record, for Resident #33's Alprazolam 0.25 mg tablet: Take 0.5 tablet by mouth once a day, ordered [DATE] for Resident #33 had 3 entries on it: ,d+[DATE] at 12:00 AM crossed off- said One given 13 remained; ,d+[DATE] 10:30 PM wasted 4 count 10 remaining- 2 nurses signed illegible; entry back punched three With no further information; Last entry undated, Wasted / fell on floor, 9 remain 2 nurses signed illegible. Nurse Q was asked if there was an investigation and she stated, No. Further review of the Narcotic and Controlled Substance, Shift to Shift Count Sheet, dated [DATE] on the Central Hall short, Identified multiple empty spaces where a nurse was supposed to sign that they counted narcotics with another nurse. No one signed for a narcotics count on the following dates: Day shift- [DATE] off going nurse or oncoming nurse; [DATE] and ,d+[DATE] 22 Oncoming nurse; [DATE] offgoing nurse; [DATE] offgoing nurse; [DATE] and [DATE] offgoing nurse; [DATE] offgoing nurse; Night shift- [DATE] on coming nurse; [DATE] on coming nurse; [DATE] offgoing nurse; [DATE] off going nurse; [DATE] off going nurse. A review of the Central hall long Narcotic and Controlled Substance Shift to Shift Count Sheet, for [DATE] identified 36 missing signatures that the nurses counted narcotics to ensure the medication were reconciled. A review of the East long hall, Narcotic and Controlled Substance Shift to Shift Count Sheet, for [DATE] identified 22 missed nursing signatures. The [DATE], East hall short Narcotics and Controlled Substance Shift to Shift Count Sheet had multiple entries crossed off and only had 21 entries for the month. The signatures were undated. The East short hall [DATE], Narcotic and Controlled Substance Shift to Shift Count Sheet, had 25 missing nurse signatures. A review of the Medbridge/North, [DATE] (misdated) had 28 missed signatures. The nurses were not consistently counting narcotics with each other to ensure the narcotics doses were accurate. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No one was monitoring the Narcotic and Controlled substance Shift to Shift Count Sheets to ensure the narcotics were accounted for. The missed nursing signatures were from [DATE], to [DATE]. Resident #33: A record review of the Face Sheet and MDS assessment for Resident #33 identified an admitted [DATE] and readmission of [DATE] with diagnoses: Morbid obesity, diabetes, end stage renal disease, dialysis, depression, anxiety, and heart disease. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities with a Brief interview for mental status score of ,d+[DATE] and needed assistance with all care. A review of the resident's Care Plans for Pain generalized related to ESRD (end stage renal disease), date initiated [DATE] and revised [DATE] with Interventions: Administer pain medication per physician orders, date initiated [DATE]. On review of the physician orders for Resident #33, the Alprazolam had been discontinued on [DATE] and a new cassette with 14 Alprazolam pills had been sent to the facility on [DATE]. The resident did not have a current order for the medications, but the narcotic was still present on the medication cart. Nurses were punching out the medications, multiple tablets at a time and then documenting they were wasted. The medication was not destroyed or returned to the pharmacy. The former Director of Nursing was asked why it was still on the cart? There was no response. A review of Resident #33 MAR/TAR's for [DATE] identified the resident had an order for Hydrocodone/Acetaminophen tablet ,d+[DATE] mg: Give 1 tablet by mouth every 6 hours as needed for pain, start date [DATE]. The medication was documented as given twice during the month: [DATE] at 8:02 AM and [DATE] at 7:49 PM. A review of the Controlled Substance Record for Resident #33's Hydrocodone/Acetaminophen: Take 1 tablet by mouth every 6 hours as needed, revealed Nurse HHH removed 1 tablet on [DATE] at 11:00 AM, but never documented that she gave it to Resident #33. Then 5 hours later, the resident was transferred to the hospital for uncontrolled pain. A note dated [DATE] at 4:34 PM by Nurse Q, Resident placed on LOA (leave of absence) . Resident taken via ambulance to (hospital) ER for complaints of uncontrolled pain . A review of the progress notes identified a note from Nurse HHH on [DATE] at 5:30 PM, Resident returned from Hospital. No new orders. No (complaints of) pain at this time. Will reassess. A review of the Controlled Substance Record for Resident #33's Hydrocodone/Acetaminophen (Norco): Take 1 tablet by mouth every 6 hours as needed, revealed Nurse MMM removed 1 tablet of the Norco at 10:00 PM on [DATE] and did not administer it to the resident. There was no documentation on the MAR/TAR that it was given. A review of the [DATE] MAR/TAR indicated the Hydrocodone/Acetaminophen Tablet ,d+[DATE] mg Give 1 tablet by mouth every 6 hours as needed for Pain, was documented as given to Resident #33 three times: [DATE], [DATE] and [DATE]. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Controlled Substance Record, for Resident #33's Hydrocodone/Acetaminophen ,d+[DATE] mg Take 1 tablet by mouth every 6 hours as needed had 4 doses documented as removed- [DATE] at 8:00 PM by Nurse NNN, [DATE] at 10:30 AM by Nurse HHH, [DATE] at 8:00 PM and [DATE] at 8:00 PM both by Nurse NNN, but no documentation on the MAR/TAR for [DATE] that they were given to Resident #33. Both Nurses HHH and NNN repeatedly removed narcotics intended for Resident #33 and did not give the medication to the resident, this was discussed with the Administrator and Corporate Nurse DD on [DATE] at 10:00 AM. Also reviewed that Resident #33 was transferred to the hospital due to uncontrolled pain after the nurse HHH removed the Norco from the narcotics box, but did not administer it to the resident. The Administrator said Nurse HHH no longer worked at the facility. The nurse was still on the staff list during the survey. The MAR/TAR for [DATE] identified a Pain evaluation for Resident #33. It was not consistently completed. The assessment was not documented on [DATE], [DATE] and [DATE]. Resident #25: A record review of the Face sheet and MDS assessment for Resident #25 indicated he was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Psychotic disorder, depression, history of a brain tumor, heart disease and pain. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a BIMS of ,d+[DATE] and needed assistance with all care. A review of the Care Plans for Resident #33 provided, At risk for pain related to generalized weakness, impaired mobility, physical limitations . date initiated and revised [DATE] with Interventions: Administer pain medication per physician orders, date initiated [DATE]. A review of the physician orders for Resident #25 revealed the following: Tramadol HCl tablet 50 mg: Give 1 tablet by mouth three times daily, start date [DATE]. A review of the MAR/TARs for [DATE] for Resident #25 revealed the following: Pain evaluation every shift, every day and night shift for Monitoring of patient's pain level, start date [DATE] and discontinue [DATE]. The resident's pain was not monitored as ordered. It was not assessed on the day shift 4 times during the month: [DATE], [DATE], [DATE] and [DATE]. Tramadol HCl Tablet 50 mg: Give 1 tablet by mouth three times a day for pain, start date [DATE]. There was 7 doses missed for the month of [DATE]: 3 at 6:00 AM- [DATE], [DATE], [DATE]; 3 at 2:00 PM- [DATE], [DATE], [DATE] and 1 at 8:00 PM on [DATE]. A review of the Controlled Substances Record for [DATE] for Resident #25's Tramadol 50 mg: Take 1 tablet by oral route 3 times daily, identified multiple crossed off entries and missed doses. There were days too many doses were pulled and other days not enough. There were 2 Controlled Substances records- 1 for a cassette with 45 meds and one with 30, both for the same order. The nurses were not consistently taking medications from the same cassette. It was very disorganized. On [DATE] four doses were removed for Resident #25's Tramadol from the narcotics box: [DATE] 5:00 AM, [DATE] 10:00 AM, [DATE] 1:00 PM and [DATE] at 8:00 PM. There were 3:00 doses documented as given: 6:00 AM, 2:00 PM and 8:00 PM. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled, Controlled Substances, dated revised [DATE] provided, The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances . The Director of Nursing Services will identify staff members who are authorized to handle controlled substances. Controlled substances must be counted upon deliver. All keys to controlled substance containers shall be on a single key ring that is different from any other keys . Nursing staff must count controlled medications a the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. The Director of Nursing services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties, and shall give the Administrator a written report of such findings . The Director of Nursing Services shall maintain and disseminate to appropriate individuals a list of personnel who have access to medication storage areas and controlled substance containers. Documentation of Medication Administration, dated revised [DATE] provided, The facility shall maintain a medication administration record to document all medications administered. A nurse . shall document all medications administered to each resident on the resident's medication administration record (MAR). Administration of medication must be documented immediately after (never before) it is given. Administering Medications, dated revised [DATE] provided, Medications are administered in a safe and timely manner, and as prescribed. The Director of Nursing Services supervises and directs all personnel who administer medications . Medications are administered in accordance with prescriber orders, including any required timeframe . Medications are administered within one hour of their prescribed time . the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones . the Charge Nurse must accompany new nursing personnel on their mediation rounds for a minimum of three days to ensure established procedures are followed .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Number: MI00124773. Based on interview and record review, the facility failed to ensure accuracy of Minimum Data Set (MDS) assessments for one resident (Resident #35) of 34 residents reviewed, resulting in an inaccurate MDS assessment and the potential for unmet resident care needs. Findings Include: On 1/24/22 at 1:30 PM during entrance conference with the Administrator for the abbreviated survey, she said the facility census was 93. This surveyor requested the 672 (Census and Condition) and the 802 Resident Matrix. The Administrator said the facility did not have an MDS (Minimum Data Set) Coordinator or Nurse and she would have to contact the Corporate office to obtain the documents. The Administrator was asked how long she had been without an MDS nurse and said, It's been a while. On 1/25/22 at 9:23 AM, the Administrator was asked if the facility had completed the 672 and 802 documents, as they had not been received. At approximately 10:30 AM the facility provided the documents with a resident census of 100. The Administrator was asked about the accuracy of the documents and said she would have it corrected. The 672 (Census and Condition) and 802 (Resident Matrix) documents were not received until 1/25/22 at approximately 4:55 PM; the day after the survey began (greater than 24 hours later). They indicated a census of 93 (for 1/24/22) and were signed/dated for 1/25/22. A record review of the face sheet for Resident #35 indicated an admitted [DATE] and readmission of 6/23/21 with diagnoses: Dementia, a gastric tube, difficulty swallowing, kidney disease and a Stage 4 pressure ulcer. The MDS assessment dated [DATE] did not have a completed Section C: Cognitive Patterns. It was blank. A review of a guidance document from the Centers for Medicare & Medicaid Services, CMS.gov; Minimum Data Set (MDS) 3.0 for Nursing Homes and Swing Bed Providers, dated 2/16/22 The Minimum Data Set (MDS) is a powerful tool for implementing standardized assessment and for facilitating care management in nursing homes . The MDS 3.0 was designed to improve the reliability, accuracy and usefulness of the MDS, to include the resident in the assessment process . The CMS's RAI Version 3.0 Manuel; Section C: Cognitive Patterns, provided Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care planning decisions . Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis . Structured cognitive interviews Assist in identifying needed supports . attempt to conduct the interview with all residents . Assessment of a resident's mental state provides a direct understanding of resident function . Awareness of possible impairment may be important for maintain a safe environment .

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Numbers: MI00124712, MI00124773, MI00124806, MI00125431, MI00125356. MI00125545, and MI00125680 Based on observation, interview and record review, the facility failed to ensure that residents received basic care needs including nailcare, showers, clean bedding, timely medications, wound care and skin assessments for Residents #'s 14, 15, 17, 19, 24, 30, 32, 34, and 35 of 32 residents reviewed for basic care needs and quality of life, resulting in resident and family feelings of frustration and shame and the potential for declining health related to lack of care and services. Findings Include: Resident #17 A record review of the Face Sheet and Minimum Data Set (MDS) assessment for Resident #17 indicated an admitted [DATE] with diagnoses: Alzheimer's, history of a stroke, bipolar disorder, chronic kidney disease, gout, arthritis, COPD and dermatitis. The MDS assessment dated [DATE] revealed the resident had cognitive loss with a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] and needed 2-person assistance with transfers, dressing, bed mobility, toileting, hygiene, and bathing and 1-person assistance with eating. On [DATE] at 12:30 PM, Resident #17 was observed lying in bed in his room. He appeared disheveled, unshaven, and not groomed. His fingernails were approximately ,d+[DATE].5 inches long- extending about a , d+[DATE] inch over the top of his finger. The nails were pointed with a black substance underneath. The resident was asked if anyone helped him with his nails and he stated, No, and shook his head no. He turned his hands over and looked at the back of his nails. A record review of his Care Plan titled, ADL Self Care deficit related to generalized weakness, impaired mobility, physical limitations, recurrent falls, . dementia, date initiated [DATE] and revised [DATE] with Interventions: Assist to bathe/shower as needed, [DATE]; Assist with daily hygiene, grooming dressing, oral care and eating as needed, [DATE] . The MDS assessment dated [DATE] identified that the resident needed 2-person assistance with care; not as needed. Per the Care Plan he was to have daily hygiene, grooming care. Another Care Plan titled, Resistive/noncompliant with treatment/care (history of refusing clothing change, ADL care, ADL set up, brief change . refuses to have his fingernails clipped despite encouragement . Resident often refuses check and changes as well as showers, date initiated [DATE] and revised [DATE] with all Interventions dated [DATE]. There was no indication the interventions were evaluated for effectiveness or updated with newer interventions that might be more successful. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Tasks documentation for Personal Hygiene in the electronic medical record (EMR) from [DATE] - [DATE] indicated the staff were most frequently documenting the resident was dependent with care, meaning they needed to perform the task for him. Sixteen of twenty-nine (,d+[DATE]) days there was documentation related to hygiene care 3 or more times a day. Nine of twenty-nine (,d+[DATE]) days there was documentation of hygiene care 2 times a day. Three of twenty-nine (,d+[DATE]) days were documented once a day and one day ([DATE]) there was no documentation about hygiene care. On [DATE] there was one documentation and it stated, Activity did not occur . In total the facility documented 23 times that the activity, Personal Hygiene did not occur. There was no explanation for why Personal hygiene care did not occur. A review of the Tasks documentation for Showers in the EMR from [DATE] to [DATE] indicated there were 8 days with documentation entries: 4 days documented No - [DATE], [DATE], [DATE], [DATE]; ; 1 Resident not available - [DATE]; and 3 Resident refused - [DATE], [DATE], [DATE]. There was no explanation for why the resident did not receive a shower for a month or if there were more attempts to provide the resident with a shower. A review of the Tasks documentation for Bladder Elimination for 30 days ([DATE] to [DATE]) identified multiple days (,d+[DATE]) that the resident did not have documentation of care for Bladder Elimination each shift: [DATE] documented 7:48 AM and 10:29 PM- there was no documentation for the rest of the day; [DATE] documented 4:52 PM and 11:25 PM- no documentation for the day shift or night shift before; [DATE] documented 10:15 PM and 11:23 PM- nothing during the day or afternoon or for the rest of the night; [DATE] documented once 8:03 PM; [DATE] documented once 11:01 AM; [DATE] documented 1:16 AM and 7:01 PM; [DATE] documented 10:43 AM and 9:00 PM; [DATE] documented 1:39 PM and 4:55 PM; [DATE] documented 11:42 AM and 7:26 PM; [DATE] documented 3:45 AM and 10:30 AM- there was no further documentation of Bladder Elimination care that day; [DATE] documented 2:13 AM and 9:41 PM. There was no documentation of bladder elimination care on [DATE]. A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for [DATE] indicated there were multiple days that Resident #17 did not receive medications, treatments and assessments per the following: [DATE]: There was no documentation that day shift medication or assessments were provided, including Pain, Covid and Psychotropic medication side effects assessments; 10 medications- Allopurinol for gout, Aspirin low dose for thrombus prophylaxis, Atenolol for high blood pressure, Calcium supplement, Lasix a diuretic, Potassium supplement, Vitamin D supplement, Vitamin E supplement, Apaxiban a blood thinner, Depakote for bipolar disorder, Memantine for dementia, Pantoprazole for stomach upset, Gabapentin 2 doses for pain; [DATE]: 2:00 PM - Missed medications- Gabapentin for pain [DATE]: 2:15 PM multiple missed assessments for Side effects related to Psychotropic medications, and GI symptoms. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE]: 8:00 PM one missed dose of Flonase Allergy spray; 8 missed medications - Mirtazapine (antidepressant), Senna for constipation, trazadone for depression, Apaxiban a blood thinner, Depakote for bipolar disorder, Memantine for dementia, Pantoprazole for stomach upset, Gabapentin for pain. The resident was not consistently provided medications for his mood/behavior, dementia and pain; which could affect his ability to participate in care and effect his quality of life. Resident #30 On [DATE] at 12:30 PM, while touring the East Hall a resident was heard yelling Help over and over. Upon entering her room, Resident #30 was observed lying in bed, when asked what was wrong, she said she had not received her pain medication, I need my medicine. Someone get my medicine. Nurse W was observed in the hallway at the medication cart. He said he had been called in, just received report, and was just starting to pass the medications on the hall. He said he was preparing Resident #30's medications as we spoke. He was observed entering the resident's room approximately 12:35 PM- 12:40 PM. A review of the residents MAR/TAR for [DATE] indicated Resident #30 had 12 medications due at 8:00 AM. Nurse W signed he gave those medications, but they were given ~ 12:,d+[DATE]:45 PM that day. All were late. Resident #30 had 2 pain medications Gabapentin and Norco. The Gabapentin was to be given at 8:00 AM, 12:00 PM and 4:00 PM. The Norco was to be once daily at 8:00 AM. Upon further review of the MAR/TAR for [DATE] revealed a Pain Evaluation every shift, start date [DATE] with pain assessments at 6:15 AM, 2:15 PM and 10:15 PM. There were multiple missed pain assessments: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] at 6:15 AM; [DATE], [DATE], [DATE] at 2:15 PM; [DATE] at 10:15 PM. On [DATE] at 2:15 PM, Nurse W documented the resident had a pain level of 10 out of 10 (the highest level of pain). The resident usually had pain rated between 0 and 5 with one score of 8 for the month. Resident #32 A record review of the Face Sheet and MDS assessment for Resident #32 indicated admission to the facility on [DATE] with diagnoses: History of a bleeding disorder, history of pulmonary embolism (blood clot in the lung), Respiratory failure, COPD, diabetes, history of a mini-stroke, heart failure, high blood pressure, chronic kidney disease, weakness, Morbid obesity, chronic pain, schizoaffective disorder, anxiety. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities ,d+[DATE] and needed 2-person assistance with bed mobility, dressing, toileting, and hygiene and 1-person assistance with meal tray set up, showers and transfers. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #32 at 12:35 PM revealed, It takes 40 minutes sometimes longer to answer the light. There are not enough staff, especially 2nd and 3rd shift. I haven't brushed my teeth since I've been here. It is not nice here. They haven't put lotion on my feet since I got here. They are cracked and they hurt. My nails they need to be trimmed. They have dirt and everything. They don't stay in here long enough to do anything. I haven't had a shower since I got here- It's been almost 3 weeks. Sometimes you press the button, and they don't show up so you have to scream. Resident #32 was observed to have extremely dry, cracked, flaking skin on his feet and lower legs. A record review of the Tasks documentation in the EMR for Showers Bed bath Hair washed for [DATE]-[DATE], indicated there was no documentation the resident received a shower, bed bath or had his hair washed. The weekly nursing summaries were not completed [DATE],[DATE], [DATE] and [DATE] at 8:00 AM. A review of the MAR/TAR for February 2022 indicated the following: Missing treatments: House barrier cream to buttocks, coccyx and peri-area ever shift with incontinent episodes On [DATE] at 6:15 AM or 2:15 PM or on [DATE] at 2:15 PM. There was no documentation of a pressure reduction cushion on [DATE] at 6:15 AM or 2:15 PM or on [DATE] at 2:15 PM. Missing treatments: Skin prep to left lateral heel every shift for skin disruption, [DATE] at 6:15 AM and 2:15 PM and [DATE] at 2:15 PM. There was no treatment on the MAR/TAR for his very dry skin on the lower legs and feet. A review of the Care Plans for Resident #32 provided the following: Resident needs assistance with activities of daily living, dated initiated [DATE] and revised [DATE] with 3 interventions: Continence - assist with incontinent care, dated initiated and revised [DATE]; Bed Mobility-Staff assistance x 2 staff, date initiated and revised [DATE]; Personal hygiene: staff assistance x 2 staff date initiated and revised [DATE]. Resident #32 died in the facility on [DATE]. He had no Care Plans for Activities of daily living including bathing prior to his death. Has episodes of incontinence of bladder, bowels, date initiated and revised [DATE] with Interventions: Assist with routine toileting and as needed, date initiated and revised [DATE], Check routinely for incontinence and provide incontinence care as needed, date initiated and revised [DATE]; Skin check weekly and as needed, date initiated and revised [DATE]. Resident has impaired skin integrity left heel, date initiated and revised [DATE] with Interventions: Assess and document skin condition . date initiated and revised [DATE]; Assist with toileting, date initiated and revised [DATE]; Check for incontinence and provide incontinence care as needed . date initiated and revised [DATE]. All of Resident #32's Care Plans were dated initiated on [DATE]; 6 days after his death on [DATE]. He did not have current and up to date Care Plans prior to his death to guide his daily care needs. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #34 A record review of the Face Sheet and MDS assessment for Resident #34 identified an admitted [DATE] with diagnoses: Dementia, history of a stroke with left sided weakness, left and right side above the knee amputation, peripheral vascular disease, COPD and anxiety. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a BIMS score of ,d+[DATE] and needed assistance with all care. A review of the residents MAR/TAR's for [DATE] identified multiple missed doses of pain medication (Hydrocodone/Acetaminophen tablet ,d+[DATE] mg: Give 1 tablet by mouth every 6 hours for pain) Start date [DATE]: No documentation that dose was given: [DATE] 2:00 PM, [DATE] 8:00 PM, [DATE] and [DATE] 2:00 PM, [DATE] at 2:00 AM and 2:00 PM. Multiple doses documented 9: Other, See progress notes: [DATE] and [DATE] at 2:00 AM and 8:00 AM. Dose documented 5- Hold/See Progress Notes on [DATE] at 8:00 AM, Progress note provided, I couldn't give pill due to the time being to close to next dose, on [DATE] at 12:19 PM. The dose was due at 8:00 AM. It was late. A note dated [DATE] at 10:12 PM provided, No narcs. Gabapentin Capsule 100 mg: Give one capsule at bedtime for neuropathy, was not given for multiple days as it was not available- [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. The doses were documented 5 or 9. On [DATE] there was no documentation the medication was given. Lorazepam: Give 0.25 mg by mouth one time a day for anxiety- Missed doses at 8:00 AM on [DATE], [DATE] and [DATE]. A review of the resident's Care Plan titled, Pain to bilateral AKA (above the knee amputation) evidenced by resident complains of pain related to bilateral AKA, date initiated and revised [DATE] with Interventions: Administer pain medication per physician orders, date initiated [DATE]. A review of the Care Plan titled, At risk for behavior symptoms related to effects of CVA (stroke) . closed head injury . date initiated [DATE] and revised [DATE] with Interventions: Administer medications per physician order, date initiated [DATE]. Resident #35 A record review of the Face Sheet and MDS assessment for Resident #35 indicated an admitted [DATE] with readmission non [DATE] and diagnoses: Dementia, a feeding tube, dysphagia, chronic kidney disease, Stage 4 pressure ulcer and on [DATE] Covid positive. A review of the physician orders provide: Tramadol 50 mg; Give 1 tablet via Peg- tube (feeding tube) every 12 hours for Pain. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the MAR/TAR for [DATE] identified multiple missed doses of Tramadol (pain medication): [DATE], [DATE], [DATE] [DATE], [DATE], [DATE], [DATE], [DATE]. A review of the progress notes provided the following: [DATE] at 8:55 PM- Tramadol . Seems to be out of it. [DATE] at 2:28 PM- Not available. [DATE] at 8:17 PM- On order. [DATE] at 12:11 PM- Pharm. Clarification. [DATE] at 11:29 AM- Awaiting pharm. Auth. [DATE] at 11:26 AM- Awaiting pharm. Auth. [DATE] at 7:09 PM- On order. A review of the Care Plans for Resident #35 provided, At risk for pain related to generalized weakness, impaired mobility, physical limitations . date initiated [DATE] and revised [DATE] with Interventions: Administer pain medications per physician orders. On [DATE] at 10:20 the Administrator was interviewed about the residents not receiving medications and treatments as ordered. She said she was aware that there were some Issues. An interview with Confidential Person Z on [DATE] at 4:24 PM revealed, They have had an issue with narcotics. One or two people have access to the Omnicell. We have to write that the medication is not available because we can't get it. No one on nightshift has access. A few on dayshift do. If a narcotic is needed, two people are needed and that is highly unlikely to happen. Centers for Medicare and Medicaid Services- CMS, CMS.gov/Medicare, Rights and Protections in a Nursing: Residents in a Medicare and /or Medicaid-certified nursing home have certain rights and protections under federal and state law. These rights and protections help make sure you get the care and services you need . In addition, your rights as a nursing home resident include the right to: . Get proper medical care . Be treated with respect . 45246 Resident # 14 According to admission face sheet resident #14 was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included: hypertension (high blood pressure), leaky heart valve, diabetes type 2, obstructive sleep apnea, coronary artery disease, thoracic aneurysm, acute respiratory failure with hypoxia, dysphagia (difficulty swallowing) following cerebral infarction (stroke). (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to Minimum Data Set (MDS) dated [DATE], Resident #14 was scored on the Cognition Assessment at 15, indicating no cognition impairment. The MDS also reflected that Resident #14 required 2 person staff assist for bed mobility, toileting, and with transfers. During facility tour on [DATE] at 11:24 AM in resident room [ROOM NUMBER] urinal was noticed sitting on an overbed table. It was one third full of urine. Small open milk carton was standing right next to it. On [DATE] at 10:40 AM during the interview with the family member of Resident #14 she stated that resident could not use urinal and requested Styrofoam cups to urinate in. Facility provided the cups for resident's use; however, staff was too busy to clean them on a regular basis. Family member shared that every visit she saw several cups were sitting on Resident #14 overbed table, often next to his food and drinks during mealtimes, uncovered and full of urine. On [DATE] at 12:10 PM review of the nursing progress note revealed Resident states the urinal hurts (him). He utilizes a cup instead of urinal due to the pain caused by the urinal. On [DATE] at 10:40 AM during family interview complainant shared that during Resident #14's stay in a facility he was not given his medications on several occasions. Review of Resident #14 MAR (medication administration record) revealed on [DATE] medications that were due at 8 AM were not given. Amlodipine 5 MG (prescribed to control of elevated blood pressure), Aspirin 81 MG, Fish Oil 1000 MG, Frozen nutritional treat, and Baclofen 5 MG (prescribed for muscle stiffness and pain) were note given. Also 6:15 AM vital signs were not taken/documented including Resident #14's blood pressure. Resident was prescribed oxygen as needed to maintain oxygen saturation 92% or higher due to the history of hypoxia (post Covid respiratory failure). Oxygen saturations were not assessed, and oxygen were not given. Resident had an order of Tylenol 650 mg as needed for pain. At 8 AM resident's pain was not assessed. 31997 An observation on the East Hall was done on [DATE] at 1:40 PM, the following observations were made: The male resident residing in room [ROOM NUMBER] bed B, (Resident #19) was noted to be resting in bed. Upon further observation, male resident was noted to have long, jagged, dirty finger nails, with dark/brown substance noted under the nails to the sides. Male resident also had long whiskers. Male resident was asked if he gets showered and shaved and verbalized he does not. Charge Nurse on the unit asked the Nursing Assistant in care of male resident if she performed Activities of Daily Living care of male resident and verbalized, He got ADL care. A second observation was made on [DATE] at 1:40 PM of male resident residing in room [ROOM NUMBER]-B. Observation reflected greasy, uncombed hair. Also noted dirty finger nails. A third observation of male resident in room [ROOM NUMBER]-B was done on [DATE] at 8:45 AM. Male resident was sleeping on his side and still noted to have dirty fingernails. (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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 19 According to admission face sheet, Resident #19 was an [AGE] year old male admitted to the facility on [DATE], with diagnoses that included: Covid positive, High Blood Pressure, ETOH history, Depression, Vascular Dementia, and other complications. According to Minimum Data Set (MDS) dated [DATE], Resident #19 scored 5 on the Cognition Assessment indicating cognition impairment. The MDS had coded Resident #19 for limited one person assist with ADL's to include bed mobility, transfer, and personal hygiene. Female resident residing in room [ROOM NUMBER] bed A, (there was no name on the plate out side of room). Female resident was noted to have long grey whiskers on her chin. Female resident in 28 bed B, (no name on the plate out side room) was noted to have long grey whiskers to her chin. Resident in bed B was asked if the whiskers bother her and said, Yes, I cant get to them. They ain't doing it.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31997 Based on observation, interview, and record review, the facility failed to ensure that the facility maintained current Cardiopulmonary Resuscitation (CPR) cards and proper training for nurses, failed to monitor 3 out of 3 Emergency Crash Carts daily, failed to restock crash carts' supplies after Emergency use, failed to ensure oxygen tanks were not empty, resulting in the potential for nursing to run out of emergency supplies (oxygen), and other needed items during a Code, and to not be properly trained/prepared to manage an Emergency /Code, with the likelihood to affect all residents deemed for full code status. Findings include: An observation was conducted in the facility on [DATE] at 3:00 PM, with another Surveyor present, and the Director of Nursing, on all crash carts in the facility. The DON indicated the facility had 3 Crash Carts for use. One on North, Central and East halls. Observation of the crash cart on North hall, reflected a Crash Cart by the nurse station. There was a cover over the crash cart. The DON verbalized it was ready for use. Noted on top of the Crash Cart, a suction machine sitting on top of the cart, with no canister present in the suction machine holder or tubing in place. It was not set up and ready for use during emergency life saving measures. Observation of the Oxygen tank located to the right side of cart, reflected the needle down in the red zone, indicating the tank was empty. This was verified by another Surveyor and the DON. There was an AED device with pads and extra battery noted in the bottom drawer present at that time. Review of the clip board for the North hall Crash Cart, reflected a check list of items to be verified as present on the cart. Review of the check list revealed the North hall crash cart had not been checked in months and/or restocked ready for use. The DON was asked who was supposed to checking the crash carts and indicated she thought it was the Unit Managers responsibility, but would have to get back with me. Observation of the Emergency Crash Cart located on the Central Unit reflected an Oxygen tank in the read zone, and no documentation as the crash cart being checked daily. The DON said Someone Left this one on (Oxygen tank). It is empty. There was an AED device with pads noted in the bottom drawer. Observation of East Unit Crash Cart reflected an Oxygen tank half full. Review of the monitoring check sheet reflected the crash cart was not documented as monitored for supplies. There was an AED device with pads in place in the bottom drawer. The DON was asked to provide documentation over a 3 month period that the emergency Crash Carts were being documented as checked/monitored daily. The DON was not able to provide the information. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator provided documentation for crash cart monitoring on [DATE]. The documentation provided reflected the last monitoring completed on 3rd shift, [DATE], for the East Hall Crash Cart only. The Administrator verbalized she did not have any additional monitoring to provide for any other times frames or other crash carts. It had not been done since [DATE]. The Administrator was not able to find any additional documentation for Crash Cart monitoring by end of survey. Review of East Crash Cart monitoring dated September, 2021, reflected no monitoring completed on [DATE]th and 17th as well. The areas were left blank. Review of a blank check list provided by the Administrator titled 'Basic Crash Cart Checklist' documented directions Licensed Nurse completes checklist items against contents of crash cart monthly and submits to DON upon completion. The form had a place as Center, Unit/Station, Items, Amount, Items correct, Nurses Initials. Some of the Items listed to check: AED, leads and battery back up, Stethoscope, Blood Pressure Cuff, Suction Machine and tubing, Suction Catheters, Oxygen tank with wrench, Oxygen tubing .At the bottom of the checklist was a place for nurse signature and date. Also provided by the Administrator was a paper to 'Document the following in a progress note after a patient emergency event as: Pt. status, time medical emergency identified and type of emergency care initiated, evaluation of level of consciousness, verification of pt's code status, occurrence and time code called, time and person contacting EMS, step by step description of care provided: initiation of CPR, AED use, oxygen Administration, vital sign check, suctioning, Physician notification, response received, EMS arrival and transfer of care, time and pt's status upon transfer from center, and any additional applicable information. Review of American Heart Association; Basic Life Support Healthcare Provider Adult cardiac Arrest Algorithm documented : victim is unresponsive, shout for nearby help, activate emergency response system via mobile device, Get AED and emergency equipment .2015 updated guidelines for healthcare workers. 45246 Medical records review on [DATE] at 2:54 PM revealed Resident #29 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included: stroke with right sided weakness, metabolic encephalopathy (brain disorder), diabetes, anemia, dysphagia (difficulty swallowing), high blood pressure, dementia, and other health complications. Resident #29 had a change in condition and went into cardiac arrest on [DATE]. According to Prehospital Care Report issued by Mobile Medical Response and reviewed on [DATE] at 11:00 AM, 911 call from facility was received on [DATE] at 21:56. EMS unit arrived at Resident #29 at 22:07. Per report, cardiac (presumed) arrest was not witnessed, primary symptom listed as respiratory arrest. CPR care was provided prior to the EMS arrival by healthcare professionals (non-EMS), with continuous compressions and use of bag valve mask. AED (automated external defibrillator) was not used prior to EMS arrival. Resident #29 expired on [DATE] at 22:41. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview conducted on [DATE] at 2:45 PM with LPN BBB Resident #29 went in cardiac arrest on [DATE]. Nurse BBB worked evening shift (,d+[DATE]:30 PM) that day on the East Hall. She heard overhead page and came to North Hall to help. She stated that when she came in there were three nurses in a room. LPN N was performing CPR. Nurse BBB took turns with her. She (nurse BBB) recalled that Resident #29 did not have AED pads applied to his chest. When she questioned about it nurses said they couldn't find them on a crash cart. Nurse BBB confirmed that this wasn't the first time she encountered crash cart not being stocked properly during the code situation. She shared that this happened before. In her understanding, night shift nurses were supposed to re-stock crash cart, and it was a Unit Manager's responsibility to make sure this was done. Unfortunately, nurse BBB said, no one was checking and things were missing due to being short-staffed and busy with resident care. After EMS arrived nurse BBB went to check the crash cart herself and did not find AED pads in it. When queried if there are other crash carts in the facility nurse BBB said yes, one on each hall, total of three. When she was asked if anyone thought to bring the other crash cart from the different hall, she said No. When asked if anyone was recording the code nurse BBB said No, she did not remember anyone writing anything. During interview on [DATE] at 3:50 PM with LPN A she stated that after Resident #29 coded on [DATE] during her evening shift she remembers many nurses came in the room to help with the code. She said someone brought in the crash cart. LPN A stated that no one could find AED pads on the crash cart and staff was just doing compressions and bagging with ambu (bag valve mask) bag. She does not remember anyone taking notes. She remembers some staff members just standing and looking. No one thought to bring another crash cart from different hall. When queried what CPR certification she has, LPN A looked at her card and said it doesn't say healthcare provider on it. It is from the Red Cross and she did training online. On [DATE] at 10:49 AM during interview with LPN T she stated that she worked third shift (10 PM-6:30 AM) on [DATE]. She came in during the code. Staff was already doing CPR. After paramedics came, she left the room. When asked what CPR certification she has, LPN T said it is though AHA (American Heart Association), she did online course. (without practical component) On [DATE] at 2:32 PM interview with former DON RN Q was conducted. She remembered the evening Resident# 29 went into cardiac arrest. She was receiving communications from the staff via texting. RN Q did not remember seeing any documentation from that code event. No one reported any issues with supplies to her the morning after (on [DATE]). She did not discuss the details of the event with LPN A who provided care to Resident #29. RN Q confirmed that there are 3 crash carts in the facility, and they had to be checked by the night shift nurses. When queried if staff nurses were proficient in performing CPR RN Q said that most of them are not proficient. She remembered the code she had to go in and help in December of 2021, and all staff was just standing in the room. RN Q had to take over and direct the staff (2 agency nurses and 2 agency aids) in what to do. That was a night shift incident, and she was working the floor that shift. She does not recall having any conversations or providing any education to the nurses after this event. RN Q (former DON) does not know if all agency nurses that work in a facility have CPR certification. Per Facility Policy Emergency Procedure-Cardiopulmonary Resuscitation (revised February 2018) Early delivery of a shock with a defibrillator [AED] plus CPR within ,d+[DATE] minutes of collapse can further increase chances of survival . Further, policy indicates Maintain equipment and supplies necessary for CPR/BLS in the facility at all times .

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 45246 This Citation pertains to Intake Numbers MI00124771, MI00124773, and MI00125680 Based on interview and record review, the facility is placed in Immediate Jeopardy for 1) Failure to properly assess and monitor Resident #4's blood glucose levels while administering antidiabetic medication (Insulin), 2) Failure to comprehensively and timely assess and monitor Resident #29's change in condition, and 3) Failure to consistently and timely assess and monitor Resident #32. Both Resident #29 and Resident #32 died at the facility. This deficient practice placed all residents at significant risk of not being comprehensively, competently, and timely assessed, monitored, and treated by facility staff for their life-threatening health conditions and change in condition, with a high likelihood that residents will continue to suffer harm, injury and/or death. Immediate Jeopardy: Resident #4 was admitted to the facility on [DATE] with a diagnosis of diabetes and a physician's order to administer insulin. The facility did not monitor the resident's blood glucose until [DATE] and on that date only (one time). On [DATE] Resident #4 had a change in condition with an alteration in mental status and unresponsiveness. LPN A recorded blood glucose levels in SBAR (summary change in condition) note on [DATE] and used the value from [DATE], which was 6 days prior. He was transferred to the hospital on [DATE] and assessed to have a Blood glucose level of 40 (very low). Resident # 29 was admitted to the facility on [DATE] and had a change in condition on [DATE]. When alerted by staff at 5 PM on [DATE] that Resident #29 was in respiratory distress (described as a death rattle by resident's nursing assistant), LPN A did not obtain current vital signs, check respiratory status, perform nursing assessments, or transfer resident out to an acute care setting timely. LPN A used previous vital signs and assessments from 7:16 AM and 10:47 AM to complete the SBAR form and notify the on-call provider about Resident #29's change in condition. The vital signs used in the report were obtained approximately 11 hours before Resident #29 's change in condition and did not reflect the resident's new condition. Resident #29 died on [DATE] at 10:41 PM after going into cardiac arrest without assessments performed or timely nursing interventions attempted. Resident #32 was admitted to the facility on [DATE] and had a change in condition on [DATE] with a low oxygen saturation of 72%-90% on 4 L of oxygen with a pulse of 42 to 83 BPM. Resident #32 was transferred to the hospital. The transfer form was blank. There was no nursing documentation or assessment performed when the resident returned to the facility on [DATE]. The last vital signs (blood pressure and pulse) were recorded on [DATE]. On [DATE] Resident #32 was found unresponsive in his room at 2:50 PM and died . During his stay in the facility. Resident #32 had no vital signs taken or assessments performed from [DATE] until his death on [DATE]. Resident #32 had multiple missed medication doses, lacked diabetes monitoring, and lacked nursing assessments. The Immediate Jeopardy began on [DATE]. The Immediate Jeopardy was identified on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was notified of the Immediate Jeopardy on [DATE] at 1:00 PM and instructed to provide a plan of correction to remove the immediacy. The Immediate Jeopardy was abated or removed on [DATE]. Findings include: According to admission face sheet, Resident #29 was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included: stroke with right sided weakness, metabolic encephalopathy (brain disorder), diabetes, anemia, dysphagia (difficulty swallowing), high blood pressure, dementia, and other complications. Resident #29 had a peg tube in place and was documented as Nothing By Mouth (NPO) status on admission. According to Minimum Data Set (MDS) dated [DATE], Resident #29 was not scored on the Cognition Assessment, indicating severe cognition impairment. The MDS also reflected that Resident #29 required 2 person staff assist for bed mobility, toileting, and required limited assist with transfers. Record review on [DATE] at 1:23 PM revealed nursing admission progress note documented on [DATE]: Resident has right sided weakness. [ ] Resident is incontinent and total assist. No signs of pain or respiratory distress. Progress note by mid-level provider, nurse practitioner, on [DATE] (no time recorded) indicated Patient is being seen today at request of nursing for cough/congestion. Upon exam patient is sleeping in bed. Patient was easily awakened. No congestion, SOB (shortness of breath), dyspnea (difficulty breathing), or distress noted. He appears comfortable. Patient denies any chest pain, palpitations, SOB, dyspnea nocturnal dyspnea, fatigue, n/v (nausea or vomiting), headache, dizziness, change in vision, changes with bowel/bladder habits, or any acute pain/discomfort. Bilateral lungs are CTA (clear to auscultation), respirations are regular and non-labored. He is using regular respiratory effort. Patient reported that he coughed but it was not an ongoing cough. Patient is in pleasant mood, he is calm and cooperative with exam. Nursing has no other acute concerns. Note was signed on [DATE] at 10:22 AM (after resident #29 died on [DATE]). On [DATE] at 5:00 PM during interview with CNAs R and AAA both stated that Resident #29 did not look good at the beginning of their shift (2 PM) on [DATE]. Both nursing aids were covering North Hall where resident #29's room was located. CNA R said that around 5 PM she could hear in a hall Resident #29's gurgling breathing. His room was next to the nursing station, and she could hear him loudly breathe even at the nursing station. CNA R notified LPN A about her findings and received directions from LPN A to clean the resident because she (LPN A) was planning to send him out. CNAs R and AAA did not recall LPN A taking Resident #29's vital signs or delegating this task to CNAs. Both CNA R and AAA went and cleaned Resident #29. He wasn't acting in the usual way, he was lethargic, his eyes were glassy. CNA AAA stated they were afraid to lay him completely flat because of his breathing. Nurses aids shared that from 5 PM till CNA R discovered Resident #29 unresponsive around 9:40 PM LPN A did not assess her resident or provided nursing interventions. She was waiting for the response from on-call provider for further instructions. Both CNAs R and AAA shared their understanding that LPN A did not act timely and failed Resident# 29 in her nursing judgment and actions. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview was conducted with LPN N on [DATE] at 3:20 PM. She stated that she worked double shift on [DATE]. LPN Y was working with her till 6 PM and was passing afternoon medications. LPN A was at the nursing station doing new admissions. LPN N recalled nurse A started passing medication around 7:30 PM. LPN N remembered nurse A being upset with how Resident #29 was positioned flat in his bed while his tube feeding was running. She (LPN N) recalled nurse A stating that Resident #29 is not breathing normal and questioning if she should send him out. Later in a shift LPN N remembers one of the aids (CNA R) calling for help and saying that Resident #29 is dead. LPN N went in resident's room along with CNA R and checked his pulse. She did not feel any pulse. She went to the nursing station and asked LPN A if Resident #29 was a full code. After confirming the code she went back and began CPR. During interview with LPN A on [DATE] at 3:49 PM she indicated that during her medication pass on [DATE] on evening shift she heard Resident #29 in his room breathing abnormally. She called it 'Stridor'. LPN A was asked to clarify 'Stridor' and said Bubbling or gurgling sounds. (According to medical definition of Stridor defined as: abnormal, high-pitched, musical breathing sound, caused by blockage in the throat/voice box (larynx) most often heard when taking a breath). LPN A said it was loud enough to hear without the stethoscope at the nursing station. LPN A verbalized she went in the room and looked at Resident #29. LPN A said he was not elevated to ,d+[DATE] degrees in bed, and that his tube feed was actively running. LPN A remembers being upset about the head of the bed being down flat. LPN A verbalized that she raised the head of the bed up. LPN A said she went and called upper management and sent a Tiger page to provider on call. LPN A also said she took air pod into the room to let upper management hear that Resident #29 was making gurgling noise and in distress. LPN A then indicated she got called to another room to deal with other resident issues. LPN A stated she was planning to send Resident #29 out of the facility. Review of Resident #29's medication record administration showed LPN A administered following medications: Sucrafate suspension 1GM via PEG tube, Nystatin suspension 4 ML (100000 Unit/ML) via PEG tube, and Artificial tears solution 1.4% (instill 2 drops in both eyes) at 8:00 PM on [DATE]. Medications that were due at 4 PM were given by LPN Y. Further Review of Progress Notes reflected an Interact SBAR form entered by LPN A and dated [DATE] at 21:54 PM (9:54 PM), documented: Situation: The Change In Condition/S reported on this CIC Evaluation are/were: Respiratory arrest Shortness of breath Unresponsiveness Change in skin color or condition. At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP ,d+[DATE] - [DATE] 07:16 Position: Lying l/arm - Pulse: P 88 - [DATE] 07:16 Pulse Type: Regular - RR: R 17.0 - [DATE] 10:47 - Temp: T 97.9 - [DATE] 10:47 Route: Tympanic - Weight: W 203.0 lb - [DATE] 16:39 Scale: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Pulse Oximetry: O2 95.0 % - [DATE] 10:47 Method: Room Air - Blood Glucose: Resident/Patient is in the facility for: Long Term Care Primary Diagnosis is: Relevant medical history is: Dementia Diabetes Code Status: FULL CODE Advance directives are: N/A Resident/Patient had the following medications changes in the past week: N/A Resident/Patient is on Coumadin/warfarin:No The result of last INR: Date: Resident/Patient is on anticoagulant other than warfarin: No Resident/Patient is on: Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: - Mental Status Evaluation: Unresponsiveness - Functional Status Evaluation: Other - Behavioral Status Evaluation: - Respiratory Status Evaluation: Shortness of breath Other respiratory changes - Cardiovascular Status Evaluation: - Abdominal/GI Status Evaluation: - GU/Urine Status Evaluation: - Skin Status Evaluation: No changes observed - Pain Status Evaluation: Does the resident/patient have pain? - Neurological Status Evaluation: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing observations, evaluation, and recommendations are: Resident was found at 8:30 pm with Stridor on extortion.[SIC] On call was notified at 8:30 and finally provided orders and confirmed them at 9:50 pm. Staff found resident unresponsive at 9:50 pm. One nurse began CPR after the check the code status.[SIC] 911 was called at 9:50 . The unresponsive code was called at 9:50 as well. Staff joined other nurse to perform CPR until EMS arrived. EMS called time of death at 10:41 pm. Medical examiner will arrive within an hour to perform an investigation. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: On call ordered a nebulizer treatment for this resident at 9:50. Nebulizer treatment. As evident in the SBAR documentation, LPN A did not obtain vital signs or perform nursing assessments to reflect resident #29's change in condition. Vital signs documented by LPN A were taken greater than 12 hours prior to the incident and were from 2 different nurses that had assessed Resident #29 earlier in the morning on [DATE]. LPN A notified the On-Call Provider about Resident #29 change in condition and used the vital signs that did not reflect current changes in resident's condition. Further Review of the clinical record reflected General Progress Notes, dated [DATE] at 22:17 (10:22 PM), documented by Licensed Piratical Nurse A that Resident was found at 9:50 pm unresponsive by both second shift nurses. Resident was warm to touch. One nurse started CPR and the nurse called 911 after checking his code status. The code was called overhead. Both nurses continued CPR until EMS arrived at 10:18 PM. According to Prehospital Care Report issued by Mobile Medical Response and reviewed on [DATE] at 11:00 AM, 911 call from facility was received on [DATE] at 21:56 (9:56 PM). EMS unit arrived at Resident #29 at 22:07 (10:07 PM). Per report, cardiac (presumed) arrest was not witnessed, primary symptom listed as respiratory arrest. CPR care was provided prior to the EMS arrival by healthcare professionals (non-EMS), with continuous compressions and use of bag valve mask. AED (automated external defibrillator) was not used prior to EMS arrival. Resident #29 expired on [DATE] at 22:41 (10:41 PM). Review of Progress Notes dated [DATE], documented a Teleheath Visit by FNP (Family Nurse Practitioner) at 11:11 PM, as Notified by nursing that Resident had Stridor with effort, TF (tube feed) patient, CXR (chest X-ray) and Albuteral Neb (breathing treatment) ordered. Also documented was 'Addendum Details' as: pt vitals were requested, not updated in the chart. Then notified that resident became unresponsive at 9:50 PM. CPR was started at 9:50 PM. Time of Death was called at 10:41 PM, by EMS. (The creation date for the addendum was documented as [DATE] at 23:23 (11:23 PM), post death of Resident #29). As evident by documented notes breathing treatment and chest X-ray was ordered by provider on call due to communication of inaccurate vital signs and nursing assessment that did not reflect Resident #29's critical condition, respiratory distress and ultimately cardiac arrest. Facility Policy for Acute Condition Changes- Clinical Protocol (revised [DATE]) under Assessment and Recognition indicated: In addition, the nurse shall assess and document/report the following baseline information: a. Vital signs; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Neurological status; c. Current level of pain, and any recent changes in pain level; d. Level of consciousness; e. Cognitive and emotional status; f. Resident's age and sex; g. Onset, duration, severity; h. Recent labs; i. History of psychiatric disturbances, mental illness, depression, etc.; j. All active diagnoses; and k. All current medications. On [DATE] at 1:00 PM, the Immediate Jeopardy was presented to the facility Administrator, as it was identified on [DATE]. The facility provided an Abatement Plan that was reviewed and accepted on [DATE], by State Agency Survey Manager. The IJ was removed on [DATE], based on the facility's implementation of the Removal Plan as verified onsite. The Abatement Plan was as follows: Abatement of the IJ F-864 Event date: [DATE] [DATE] The Director of Nursing/designee will ensure that current assessments have been started for all residents in the facility, which include vital signs, BP, temp, lung sounds, respiratory and mental status. [DATE] The Director of Nursing/designee will ensure that education was started with licensed nurses on how to perform an assessment, change in condition, S-BAR, assessments needed on admission and re-admission, and the need for current vitals at all assessments as ordered. The on-call/nurse practitioner will be notified of the current condition and assessment. Educate on signs of hypoglycemia and hyperglycemia regarding DM. [DATE] The Director of Nursing/designee will ensure that all DM residents have routine and PRN glucose monitoring orders. [DATE] The Director of Nursing will monitor during the morning clinical meeting to ensure compliance. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing/designee will maintain compliance. Substantial compliance was obtained on [DATE] 31997 Resident #29 According to admission face sheet Resident #29 was an [AGE] year old male admitted to the facility on [DATE], with diagnoses that included Stroke with right sided weakness, Diabetes, Anemia, Dysphagia (difficulty in swallowing), High Blood pressure, Dementia, and other complications. Resident #29 had a peg tube and received Enteral Nutrition via peg tube and was documented as Nothing By Mouth (NPO) status on admission. According to Minimum Data Set (MDS) dated [DATE], Resident #29 did not receive a score on the Cognition Assessment indicating severe cognition impairment. The MDS also reflected that Resident #29 required 2 person staff assist for Bed Mobility, and toileting, and limited assist with transfers. An interview was conducted with Licensed Practical Nurse A on [DATE] at 3:49 PM, related to Resident #29. LPN A was asked if she was the nurse in care of Resident #29 on [DATE], and said she was. LPN A was asked if she remembered Resident #29 and said Yes, he was the tube feed guy that was not fed for 3 days. LPN A went on to say that she was in care of Resident #29 on [DATE], after 6 PM, when she took over after the previous nurse had left. LPN A verbalized she was at the nurse station and had been working on several admits on the North hall. LPN A indicated that was during the time Resident #29 experienced a change in condition, on [DATE], Coded and died . LPN A indicated she had been working on several admission on the North hall, then was up passing medications, after 6:00 PM. LPN A said Resident #29 resided in room [ROOM NUMBER], near the nurse station. She verbalized on [DATE], a she could hear Resident #29 having what she called 'Stridor'. LPN A was asked to clarify 'Stridor' and said Bubbling or gurgling sounds. (According to medical definition of Stridor defined as: abnormal, high-pitched, musical breathing sound, caused by blockage in the throat/voice box (larynx) most often heard when taking a breath). LPN A said it was loud enough to hear without the stethoscope at the nursing station. LPN A verbalized she went in room [ROOM NUMBER] and looked at Resident #29. LPN Asaid he was not elevated to ,d+[DATE] degrees in bed, and that his tube feed was actively running. LPN A verbalized she was upset about the bed being down flat. LPN A verbalized that she raised the head of the bed up. LPN A said she auscultated Resident #29's lungs and documented in Progress notes her findings. LPN A was asked if she checked Oxygen sats or applied oxygen and said she raised the bed up. LPN A verbalized she went and called upper management. LPN A said she took air pod into the room to let upper management hear that Resident #29 was making gurgling noise and in respiratory distress. LPN A then indicated she got called to another room to deal with another resident issue. LPN A verbalized she was planning to send Resident #29 out of the facility around 8 PM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	I started a tiger text to on-call. I did not know his code status at that time. My first intervention was to raise the head of the bed up ,d+[DATE] degrees. I got called away to another room after that, by one of my new admission's family members. One of the Aids went to check on him during that time, and came out of the room and said he is silent and not making that noise. Something is wrong. I went back to the desk checking for a tiger text. I had called the unit manger, who called the former DON, then called me back and said, Do all the interventions before you send him out. I went back in the room. He was pale. Not blue. I did not auscultate him. I could not get a pulse. Another nurse from the other hall was in there now. She stayed with the Resident. I left the room to check Code Status and the other nurse had started CPR, as I was running back to the room. There were other nurses present taking turns doing compressions. I don't remember who brought the crash cart. I don't remember who documented the code. Someone should have been taking notes. The crash cart did not have any AED pads on it, and the Oxygen tank was almost empty. We ran out of oxygen during the code. There was only one crash cart on the unit. No one went and got another crash cart. I was continuing compressions. There was no oxygen for the ambu bag, it was being done manually. LPN A said I don't typically wait to send someone out. I did this time. LPN A was asked about an assessment and vital signs done by her and said, I documented them in the progress notes. I am sure I did. LPN A was asked if she checked oxygen saturations at any time, and said, I am sure I did. LPN A was asked when the last time she seen Resident #29 responsive and said she could not remember. LPN A was asked why she texted on-call instead of calling and said 'I don't know. LPN A was asked if she was current with her CPR and said yes, I did it online, not with a healthcare provider though, just online. LPN A was if she applied oxygen to Resident #29 when she noted respiratory distress and said, I just raised the head of the bed. LPN A was asked if there was something more she could have done and said, Yes, I could have sent him out when he started having breathing problems. I was told not to send him out right away. The other nurse that was helping did not assess him either. He was my patient though. She was in there helping. 911 was called and we provided a report to EMS when they got here. An interview was conducted on [DATE] at 2:48 PM, with LPN N related to Resident #29. LPN N verbalized she was an Agency Nurse, but worked in the facility doing double shifts on 2nd and 3rd shifts weekly. LPN N said that on [DATE], she was the other nurse working the long hall on North unit and LPN A was working the other hall. LPN A was Resident #29's nurse that day. LPN N said she had been called to look at a wound from a family member on another resident, when one of the nursing assistants said Something is wrong. I think he is dead. There was also another nursing assistant close by. I hit the room. He was gone. I left out (the room) and asked LPN A is he a full code. She said yes. I said call the Code. No one moved quick enough for my liking. I remember LPN A coming out of Resident #29's room earlier in the shift and was talking out loud. She said He is laying flat and shouldn't be. I said Why you telling me. Send him out. She was mad at the aids. LPN A had been at the desk for quite some time because there were 3 admits. This happened around 8:00 PM. LPN N said that LPN A did not do good job during the code, and that the AED did not work, because there were no pads in the crash cart. We should have went in together to assess him earlier and got him out. We did not go in together. One of the nursing assistants was in the room helping me. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 2:33 PM with RN Q (former DON). RN Q was asked if she could recall Resident #29 and said He was the tube feed guy. I don't remember a lot about him. I remember one of the nurses being mad about his head being down flat in bed with tube feed running, and called me or texted me, and the unit manager, and said she put his head of bed up. Then someone told me he had a change in condition and died . I said, Oh my, was he a full code and did they do CPR. I reminded the nurse to document details of the code, notify physician and family. I was not informed of any problems with the code. I know the nurse called the Unit Manager before starting CPR and said, 'He is dead'. The Unit Manager told her to hang up the phone and go start CPR. RN Q was asked about AED machines and verbalized There is one for every crash cart, and it is the night nurse's responsibility to check the crash cart. There is a list kept in a book or clip board. The cart is to have backboard, suction machine, AED, portable oxygen tank and other items in drawers., They are stocked and ready to go. RN Q was asked about previous codes in the facility and verbalized that Agency Nurses are not proficient in codes. RN Q talked about a code that had happened in [DATE], and when she entered to room to help manage the code, that no one was doing compressions or anything. They were on their phones making calls. I took over and was able to get him back (could not recall who the resident was). No one documented anything. There was no one next to the resident. No one was checking for a pulse. I was upset with the way they managed the code. An interview was conducted on [DATE] at 3:45 PM with Agency Nursing Assistant CCC related to Resident #29. NA CCC verbalized she had been working at the facility for a couple of years before the current corporation took over and that she had been working as an Agency Aid for 3 or 4 months. NA CCC indicated she remember working with Resident #29 and that on [DATE], I came on shift and seen blood in his brief and in his stool. He was fighting us during care. He pulled the tube feed pole over him while he was in bed. He was hard to care for. The next day he passed away at night. It was hectic. LPN N was on one end and LPN A was on the other end. Around 8 PM, LPN A was at the nurse station. The other Aid was rounding on her residents and told LPN A that Resident #29 had a gurgling sound. This was around 8 PM. The nurse said I am going to send him out. Clean him up and change his brief. She went to the desk. We continued doing are rounds after cleaning him up. The other aid went to check on Resident #29 somewhere before 10 PM. She came back out of the room and said He is not making that noise anymore. Something is wrong and alerted us that something was wrong. Me, the other Aid and LPN N ran in the room. LPN N started CPR and I helped her. LPN N was doing compressions. Then I took over doing CPR. I did one cycle. LPN A was at the desk and paged a code. She came back without the crash cart and only carrying an Ambu bag. No crash cart. They did not use an AED. LPN A did not do any compressions. The other staff came to help, but not immediately. EMS showed up and I left to take care of my other residents. An interview was conducted on [DATE] at 4:15 PM, with LPN P. LPN P was asked if she knew about the code for Resident #29 that occurred on [DATE]. LPN P verbalized only what the other nurses told her about the day Resident #29 had coded on [DATE]. LPN P also verbalized she was told that Resident #29 had been found lying flat with tube feed running on [DATE], by one of the nurses who was mad at the nursing assistants. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 12:14 PM, with LPN S. LPN S was asked if she remembered Resident #29 and said she did. He was non-verbal, tube feed, feisty and combative at times. LPN S verbalized that 2 Aids told her on [DATE], that a resident had been throwing up and that they cleaned him up. They never said the name of, or who the resident was. I said ok. I was told on the 6th or the 7th of January that Resident #29 passed away. I was shocked, and the 2 Aids said, that was the guy we cleaned up after he threw up. LPN S went on to talk about the code that occurred on [DATE]. LPN S verbalized that she was called in the evening somewhere between 9 and 11 PM, by LPN A who indicated I just walked in this man's room and he laying flat, gurgling, and his tube feed is running. I can hear a 'death rattle' going on. It is very deep. She wanted to send him to the hospital. I directed her to use nursing interventions first (lung sounds, vital signs, oxygen saturation, and set him up). She tiger texted the doctor and was waiting for a response and wanted to send him out. I told her I was calling the DON. I said get his lung sounds and make sure you can wake him up. Get off the phone. She called me 30 minutes later and said He is dead. I said what is his code status and she said Full code. I said, Oh My God. Get the F off the phone and go start CPR, call 911. I called the DON back and told her what was happening. She said is there a bunch of F ing idiots in the building. I called the nurse back who informed me that the other nurse had started CPR. I relaxed at that point and went back to bed. The next day, we went over it with the Administrator, DON, and the Unit Manager. I told them how things went. My issue with the nurse was, she was told about the emesis and never said she took vital signs or what she did about it. When I spoke with the nurse then next day, she said the crash cart did not have everything. I told the DON, who was suppose to be refilling/stocking the crash cart This was a few days after resident #29 passed. An interview was conducted on [DATE] at 1:55 PM, related to Resident #29 with Nursing Assistant R. NA R was asked what she remembered about [DATE]. NA R said she cleaned Resident #29 up around 8 PM because the nurse was going to send him out and with help from another Aid. The next time I seen him, he was struggling to breathe, the nurse was informed. The next time i checked on him was around 9:40 PM, he was unresponsive. The other nurse (LPN N) and Aid started CPR before the other nurse (LPN A) told them the code status. The crash cart was next to the nurse station and another nurse brought the crash cart. LPN A did not do CPR. She brought an AMBU bag with out the crash cart. After the other staff came, I left the room. Review of Progress notes in the clinical record, reflected there was not an entry in the notes made by nursing from [DATE] through [DATE]. Review of General Progress Notes [DATE] at 21:00 (9 PM), and a creation date of [DATE] at 21:51(9:51) PM, reflected a documented entry Resident was found lying flat in bed while tube fed was actively running. Resident was repositioned to the high fowlers position immediately. Resident Stridor continued. On call was notified the resident's condition. Report will be given to the third shift nurse to watch for orders from On- call. Management notified of this situation. LPN A made the entry. Review of an Interact SBAR dated [DATE] at 21:54 PM (9:54 PM) documented : Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Respiratory arrest Shortness of breath Unresponsiveness Change in skin color or condition (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP ,d+[DATE] - [DATE] 07:16 Position: Lying l/arm - Pulse: P 88 - [DATE] 07:16 Pulse Type: Regular - RR: R 17.0 - [DATE] 10:47 - Temp: T 97.9 - [DATE] 10:47 Route: Tympanic - Weight: W 203.0 lb - [DATE] 16:39 Scale: - Pulse Oximetry: O2 95.0 % - [DATE] 10:47 Method: Room Air - Blood Glucose: Resident/Patient is in the facility for: Long Term Care Primary Diagnosis is: Relevant medical history is: Dementia Diabetes Code Status: FULL CODE Advance directives are: N/A Resident/Patient had the following medications changes in the past week: N/A Resident/Patient is on Coumadin/warfarin:No The result of last INR: Date: Resident/Patient is on anticoagulant other than warfarin: No Resident/Patient is on: Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: - Mental Status Evaluation: Unresponsiveness - Functional Status Evaluation: Other - Behavioral Status Evaluation: - Respiratory Status Evaluation: Shortness of breath Other respiratory changes - Cardiovascular Status Evaluation: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Abdominal/GI Status Evaluation: - GU/Urine Status Evaluation: - Skin Status Evaluation: No changes observed - Pain Status Evaluation: Does the resident/patient have pain? - Neurological Status Evaluation: Nursing observations, evaluation, and recommendations are: Resident was found at 8:30 pm with Stridor on extortion.[SIC] On call was notified at 8:30 and finally provided orders and confirmed them at 9:50 pm. Staff found resident unresponsive at 9:50 pm. O[TRUNCATED]

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F 0686 Level of Harm - Minimal harm or potential for 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** 31997 This Citation pertains to Intake Numbers MI00124773 and MI00125680. Based on interview, and record review, the facility failed to prevent the development and worsening of a pressure ulcer/injury for one resident (Resident #15) out of 4 residents reviewed for pressure ulcers, resulting in Resident #15 admitted to the facility with no pressure ulcer/injury and acquiring a Stage II pressure ulcer/injury that required treatments. Resident #15 acquired a Stage II pressure ulcer to the sacral area while residing in the facility. Findings include: Resident #15: According to admission face sheet Resident #15 was an [AGE] year old male admitted to the facility on [DATE], with diagnoses that included Diabetes, Depression, High Blood Pressure, Urinary Tract Infection and other complications. According to Minimum Data Set (MDS) dated [DATE], Resident #15 received a score of 10 on the Cognition Assessment indicating moderate cognition impairment. The MDS also reflected that Resident #15 required extensive 2 person staff assist for Bed Mobility, and Toileting, and Transfers. According to MDS, Resident #15 was coded as 'No' for pressure ulcers. Review of Resident #15's Admission Evaluation, dated 11/24/21, 2 sections were left as incomplete on the admission assessment. One section was for Skin (it was blank) and the other section was for an Admission progress note, which was also left blank. Review of Braden scored dated 11/25/21, documented a score of 18 indicating Resident #15 was at High Risk for the development of pressure ulcer/injury. Review of Resident #15's orders reflected an order for weekly skin assessments, one time a day, every 7 days, with a start date of 11/25/21, and end date of 12/27/21. Review of the clinical record reflected under Evaluations, no documented skin assessment completed weekly for Resident #15. Review of Progress notes reflected an entry on 12/1/21 by Nurse Practitioner as, Resident skin warm and dry. Review of Progress notes reflected an LPN who was in care of Resident #15, made an entry on 12/8/21, Observed resident with opening on buttocks. Notified Unit Manager, Cleansed area and placed dressing on the buttocks. There was no other description or measurements provided, or what the treatment was. There was no documentation related to notification of family or physician. Review of orders for Resident #15 reflected an order dated 12/8/21, Apply calmospetine twice a day for wound to buttocks. Started on 12/8/21 and end date 12/27/21. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress notes in the clinical record documented by an Registered Nurse related to Resident #15 on 12/9/21, documented: Skin inspected by Nurse Practitioner and RN, resident skin. 4.5 x 4.5 x 0.1 (Centimeters not specified) split in the middle of coccyx. Resident educated on turning frequently to relieve pressure. To be added to wound rounds. Resident coded on MDS as requiring 2 person assist with Bed Mobility. Review of Resident #15's orders reflected an order to Clean and dry sacrum, apply a small piece of Calcium AG to slit in coccyx. Apply mixture of A & D ointment and Z- guard paste to peri -wound, cover with optifoam, change daily, every day shift for Stage 2 . start date of 12/10/21 and end date of 12/14/21. Another order was enter in the clinical record Clean and dry sacrum. apply Chamosyn with Manuka honey twice daily, start date of 12/14/21 and end date of 12/27/21. Review of Progress Notes dated 12/14/21, by Nurse Practitioner, for Wound Care, documented Stage II wound to scrum on admission as 0.9 x 0.7 x 0.2. (Resident's MDS documented no pressure ulcer on admission) Interview was conducted with Administrator on 1/31/21 at 12:59 PM, related to lack of skin assessment in the clinical record. Administrator was asked to provide any/all skin assessments completed by nursing and all wound notes for Resident #15. Reviewed with the Administrator the incomplete Admission skin assessment that an Agency Nurse never completed, and the MDS documenting no pressure ulcers. Administrators verified there were errors made on admission, and with lack of skin assessments. The Administrator clarified the skin assessment should have been completed weekly by nursing. Administrator verified that skin assessments had not been done weekly by nursing, until the Nurse Practitioner identified and staged the open area. Review of Resident #15's care plans reflected a Skin Care Plan resident is at risk for Skin Breakdown. Resident will be free from skin breakdown. The intervention documented was for Preventative care as ordered/indicated. There were no other interventions or documentation for weekly skin assessments. Review of Resident #15's discharge MDS dated [DATE], has Coded Resident #15 as yes for pressure ulcers as 1 Stage II as present on admission. Review of facility Policy 'Skin Management' dated October 2019, documented for Purpose To assess each resident to determine the risk of potential skin integrity .It is the policy of Facility to assess each resident to determine the risk of potential skin integrity impairment. Residents will have skin assessment completed on admission and no less then weekly by the licensed nurse in an effort to assess overall skin condition, skin integrity, and skin impairment . A head to toe assessment will be completed by a licensed nurse upon admission/readmission and no less than weekly .A care plan will be developed specific to the resident's needs including prevention interventions .

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31997 This Citation pertains to Intake Numbers MI00124773, MI00125369, and MI00125447 Based on interview, and record review, the facility 1) Failed to provide a safe environment to prevent falls resulting in serious injuries; 2) Failed to perform Neurological Assessments post-fall and 3) Failed to complete Incident/Accident reports post fall, for 3 residents (Resident #9, Resident #13, Resident #31) of 5 residents reviewed for falls, resulting in a fracture to the Left leg for Resident #13 requiring surgical repair, pain and suffering, laceration to the scalp and requiring staples for Resident #9 with transfer to the hospital, and facial and forehead contusions with bruising for Resident #31, leading to the likelihood to not recognize serious changes in Level of Consciousness (LOC) or other Neurological changes post falls and prevent further falls with serious injuries. Findings include: Resident #13: According to admission face sheet, Resident #13 was a [AGE] year-old female, admitted to the facility on [DATE], with diagnoses that included: Diabetes, Heart Disease, Depression, Dementia, and other complications. According to Minimum Data Set (MDS) dated [DATE], Resident #13 was not scored on the Cognition Assessment, indicating severe Cognition Impairment. According to the MDS, Resident #13 required staff assistance with transfer, toileting, and bed mobility, and coded as balance not steady only stable with staff assistance. Resident #13 was also coded as a wanderer under 'Behaviors'. According to MDS, Resident #13 was coded as 'Yes for Falls, one with major injury.' Review of Resident #13's Nursing Admission reflected it was not completed until 12/2/21, Resident was admitted on [DATE]. Review of Progress notes reflected an entry dated 12/2/21 at 19:41 (7:41 PM), Resident found on floor, says going to smoke, fell going up stairs, broke her leg, going to closet to weigh herself. The Facility was asked to provide an Incident/Accident report and was not able to provide one by the end of Survey. The Administrator indicated one had not been completed for this fall on 12/1/21 and was not able to provide any Neurological Assessment for the unwitnessed fall (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 2/15/22, with the Complainant, who indicated that her family member was admitted to the facility on [DATE], and had a fall on 12/2/21, which resulted in a broken leg. Complainant indicated she and was told by nursing that Resident #13 was found in her room, underneath the other bed that was in the room. Complainant said that she seen her, before she was sent to the hospital, and her wheelchair was next to the bed on the other side of the room. I think she was attempting to climb up in the bed on the other side of room. I had asked the facility to get the bed out of there when she came in the facility. They told me the bed was broken and would not go down. It was left way up high in the air. I was told by staff that they couldn't move the bed because it was broken. They also kept shutting the door. I asked several times for staff to keep the door open so they could see her. They just continued to keep the door shut. The complainant verbalized that another family member had been in the facility to visit Resident #13 on 12/1/21, (day of admission) and that Resident #13 got out of her wheelchair and was scooting across the floor on her butt. My relative was trying to get help for my mom. Staff were just walking by, and not one person stopped to help her. My family member had to ask several staff for help to get her (mom) back in the wheelchair. Complainant said I got the phone call from the nurse in charge of her, on 12/2/21, who verbalized this is Nurse (gave name) from (gave name of different LTC facility) and said We are going to be sending Resident #13 to the hospital, looks like she broke her leg. Complainant went on to say that Resident #13 required surgery for repair the next day for a broken leg. Complainant verbalized that Resident #13 was transferred to a different facility upon discharge from the hospital. Complainant also indicated she was able to get to the facility with another family member before EMS took Resident #13 to the hospital, and that it had been about 30 minutes from the time she was called before EMS took her. I was able to go to the facility and see mom for myself. Her leg was messed up. I was angry. Review of Hospital notes (Emergency Department dated 12/2/21, documented Closed displaced spiral fracture of shaft of Left femur, as Initial Encounter, dated 12/3/21. Under Chief Complaint: Pt had a fall at nursing home today. Unwitnessed. Deformity noted to L. thigh. 50 mcg [NAME] PTA. Under History: Resident (gave name) is a [AGE] year-old female with history of dementia, diabetes, prior right femur fracture . prior subarachnoid hemorrhage, who presents for fall. Pt. had a fall at nursing home today that was unwitnessed. Pt. was found on the ground with left femur deformity. Unknown loss of consciousness or head trauma. Pt states she was attempting to open the door when she fell on her left side. Otherwise had been feeling well . X-ray Leg Left 2 view, Final result IMPRESSION: Acute, displaced fracture of left femur as above. This was electronically signed by the MD on 12/2/21 at 10:43 PM. Acute spiral fracture of the mid to left femoral shaft with significant angulation, displacement, override, and rotation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Under ED Course documented: [AGE] year-old female with history as above presenting with fall. Unwitnessed. Upon arrival, vitals reassuring. Exam is notable for obvious deformity to left mid-thigh. Neurovascularity intact distally. No other evidence of trauma. No focal Neurological deficits. Concern for left femur/hip fracture as well as possible dislocation. Will evaluate with x-ray pelvis, left hip, left femur, left knee, left tib-fib. Given patient is on aspirin and Effient, will evaluate with CT of head and C-spine. Basic labs obtained. XR with acute spiral fracture of the mid to left femoral shaft with significant angulation, displacement, override, and rotation. No other lower extremity fractures. Orthopedics consulted and recommended CT LLE. Required multiple doses of fentanyl then dilaudid for pain. Surgery: 1. Intramedullary fixation left oblique femoral shaft fracture with previous sliding hip screw requiring removal of screws for placement of the nail. 2. Removal of superficial orthopedic hardware left leg, tibial traction pin. An interview was conducted with Licensed Practical Nurse N on 2/1/22 at 2:48 PM. LPN N was asked if she remembered Resident #13. LPN N said she was Resident #13's nurse when she was admitted to the facility. LPN N verbalized she remembered that Resident #13 had previous fracture that had healed on the right hip. LPN N verbalized that her daughter was going to Nursing Assistant school to help care for Resident #13, and also was a cop. LPN N indicated the daughter had been in visiting, and with another family member and, set up a tablet so they could talk to Resident and see her. LPN N went on to say she had worked a double shift. She (Resident #13) would wander up and down the hall in her wheelchair. I documented on her admission assessment she was a wanderer. I remember her being in bed when I left her. The door was closed. I heard her yelling short time later. There was a 2nd bed in the room. The bed was up high. Bed was not broken. The facility keeps the unoccupied beds up high when not being used. She (Resident #13) started screaming, I went in the room, and she was sitting on the floor, in front of the door. She must have got up and tried to walk to the door. She said, My leg is broke. The other nurse working came down, and we seen that her leg (left) was in the wrong position. It was extending outward. The lower part of her leg was bent the wrong way. I called 911. I called her daughter and left a message. I called the sister too, they both popped up on screen of the tablet. They seen Resident #13 on the floor. They came to the facility before EMS showed up and seen Resident #13. LPN N was asked if she completed an Incident/Accident report and said No, I should have but I did not. LPN N was asked if she performed any Neurological Assessment post fall for Resident #13 and said, No. I sent her to the hospital. LPN N was asked how long it took to get Resident #13 out to the hospital, and said almost 30 minutes., long enough for her two family members to get here and see her. LPN N was asked if 2 Neurological Assessments should have been completed if the Standard of Practice is to assess every 15 minutes for the first hour, and said, Yes, I should have performed a Neurological Assessment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	LPN N was asked what safety precautions were in place, at the time of the fall, and said Resident #13 should have been 2 persons assist with transfers not one. She was confused and could not use the call light. She was self-transferring a lot. LPN N went on to say she was new to the facility and there was no Director of Nursing in place at that time of the fall. I did not know how to properly do a Fall Report. They never showed me any of that. I had been here only 3 or 4 days at that time. I had to do a Change in Condition to get resident out, at that time. That is why there is no fall packet. The paperwork on the units still have the old facility's name on it, not the new corporation. LPN N verbalized again that no one taught her to properly manage a fall in the facility. Review of Resident #13's Care Plans, reflected a Care plan initiated on admission for: At Risk for Falls and Fall related injuries. Resident will have reduced risk for falls and fall related injuries. Under Interventions documented: -Encourage and assist to wear appropriate nonskid footwear. -Keep call light and frequently used personal items in reach. - Assist with toileting. -Specify Resident specific interventions. Review of Resident #13's 'Nursing Admission/Readmission Evaluation' dated 12/2/21 at 05:07 (resident admitted on [DATE].) Under the heading of Falls: Question Number 1 asked if the resident had falls prior to admission. The box was left blank for 'Yes or No'. Under the heading of Memory Ability: The box was checked for 'memory problem'. Under the heading of Behavioral symptoms: the box was checked for Wandering. Under Level of Assistance needed for Ambulation , with device if utilized: The box was checked for Independent or Supervision. (MDS coded for staff assist.) Level of assistance for Transfers: the box was checked as Independent or supervision. Level of Assistance for Toileting was checked as: Independent or Supervision. Level of Assistance for Bathing: checked as Independent or Supervision. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Under the section for Care Planning: ADLS: The box was checked for: The resident needs assistance with Activities of daily Living and the Goal: Resident will have care needs met daily with staff assistance. (Under assist with continence was left blank and not checked for staff assistance.) The box was checked for staff assistance with Toilet Use. For Transfer: checked as staff assistance. Under Fall prevention/Safety Boxes checked for: resident is at risk for falls or fall related injury: The box to assist with Transfer was left blank and was not checked for an intervention. (MDS has Resident #13 coded as staff assistance.) Review of Facility policy Fall Management dated as October, 2019, documented under Policy 'Purpose' : To prevent injuries related to falls. Under Procedure: Fall Risks will be assessed on admission, quarterly and with significant change .A care plan will be developed on admission with specific care planned interventions . Under Post Fall: Any Resident experiencing a fall will be assess immediately by the charge nurse for possible injuries . -a neurological assessment will be initiated on all unwitnessed falls every 15 minutes for 1 hour, then every 1 hour times 4 hours, then every 4 hours for 20 hours .then every 8 hours for 48 hours .A neurological assessment will be initiated on all residents with suspected head injury . 37666 Resident #31: On 1/31/22 at 9:30 AM during a tour of the North Unit, Resident #31 was observed lying in her bed. The right side of her face and forehead was dark purple and red. There were scattered abrasions on the right side of her face and cheek. Upon saying hello and asking how she was doing; Resident #31 did not answer. She was awake and alert but didn't not respond to questions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A record review of the Face Sheet and Minimum Data Set (MDS) assessment for Resident #31 indicated an admitted [DATE] and readmission of 1/26/22 with diagnoses: Dementia, heart disease, anxiety, COPD, dysphagia, and Covid-19 infection on 1/17/22. The MDS assessment dated [DATE] revealed moderate cognitive impairment and the need for 1-person assistance with all care. A review of the assessments indicated there was no admission nursing assessment after the resident was admitted to the facility on [DATE]. There was a Transfer Form status In progress dated 1/26/22. It said the resident was transferred to the hospital on 1/26/22 at 4:10 AM due to a fall, with a hematoma on the right side of her face, bruised shin, skin tear on left index finger, and resident reports pounding headache related to fall that occurred earlier in the night. Further review of the assessments revealed there was no fall risk assessment either before or after Resident #31 fell . On 2/1/22 at 11:30 AM Resident #31 was observed in a wheelchair in the hallway with Physical Therapy Assistant X. Her facial bruising had spread to include most of her face. The therapist said the Resident was, Really active and moves around a lot. She fell in her room. Therapist X said Resident #31 needed assistance with transfers- contact guard and her walking was unsteady. Nurse W was interviewed on 2/1/22 at 11:45 AM related to Resident #31's facial injuries and fall and said the resident had fallen on the weekend. A record review of the progress notes revealed the following: 1/25/22 at 11:22 PM, At approximately (10:40 PM) resident called out to writer while writer was coming down the hall approaching med cart. As writer entered the room resident asked for a bandage for her finger and reported she fell earlier awhile ago. Resident and roommate reports he had assistance back in bed while writer completed skin assessment. Hematoma on right side of face, bruises/discolorations noted along left shin and skin tear and bruising noted on index finger of left hand. Director, off going nurse and on call provider notified. Neurochecks initiated . will continue to monitor. 1/26/22 at 4:51 AM, Resident sent out to (hospital) . after reporting severe headache and stiff neck . 1/26/22 at 12:02 PM, Resident has returned from ER with new order to start Macrobid (antibiotic for urinary tract infection) . The next progress note was completed by the provider on 1/27/22. There was no additional assessments or progress notes until 2/1/22 with an additional provider note. The nurses were not documenting assessments or notes related to the resident's condition. The neurological assessments were incomplete. A review of the physician orders on for Resident #31 identified 8 orders that were Queued but not completed: Non-skid footwear: 1/26/22; 5 TB test orders: 1/26/22; Activity orders: 1/26/22; Weekly Nursing Summary: 1/26/22. The orders were not enacted because they had not been completed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the Care Plans for Resident #31 dated 1/26/22 after return from the hospital due to a fall with a head injury indicated the resident did not have a Fall or Safety care plan before or after the fall. There was a Activities of Daily Living Care Plan, dated 1/10/22 and an Impaired Mobility Care Plan dated 1/4/22 with one intervention dated 1/4/22 The resident requires by 1 staff for locomotion using wheelchair. Neither Care Plan was updated after the resident's fall. On 2/9/22 at 10:18 AM, Corporate Nurse DD was interviewed related to the lack of fall assessments, reassessments and an Incident and Accident report for Resident #31. Corporate Nurse DD stated, I know fall reports have not been written and assessments have not been completed. We are working on that. A review of the facility policy titled, Fall Management, dated October 2019 provided . Fall risk will be assessed upon admission, quarterly and with significant change. A Care Plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factors . Any resident experiencing a fall will be assessed immediately .A neurological assessment will be initiated on all unwitnessed falls; every 15 minutes for 1 hour then every 1 hour for four hours, then every 4 hours for 20 hours then every 8 hours for 48 hours. A neurological assessment will be initiated on all residents with a suspected head injury . The care plan will be reviewed and updated . 45246 Resident # 9: During interview with the family on 2/17/22 at 11:57 AM complainant shared that during her mother's (Resident # 9) stay in the facility she fell multiple times and was hospitalized with injury to her head. Complainant shared that she wanted to transfer her mother from the facility, but she (Resident #9) was very weak, lost so much weight, it wasn't safe to move her. According to admission face sheet Resident #9 was [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included: hypo-osmolarity and hyponatremia (low blood sodium levels), chronic obstructive pulmonary disease, asthma, legal blindness, presence of cardiac pacemaker, neuromuscular dysfunction of bladder, major depressive disorder, and dementia. According to Minimum Data Set (MDS) dated [DATE], Resident #9 was scored on the Cognition Assessment at 7, indicating substantial cognition impairment. The MDS also reflected that Resident #9 required 2 person staff assist for bed mobility, and with transfers, and 1 person staff assist with eating and toilet use. Upon review of Electronic medical records (EMR) Care plan dated 10/8/21 at 23:56 (11:56 PM) indicates: Focus: Resident is at risk for falls or fall related injury. Goal: Resident will have reduced risk for falls and fall related injuries. Intervention: Encourage and assist to wear appropriate nonskid footwear; Keep call light and frequently used personal items within reach; Assist with toileting; Assist with transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Progress note dated 10/11/21 at 6:28 AM specifies: Resident is legally blind and calls out for someone to hold hand and stay in room with her. Will cont (continue) to monitor and reassure patient per writer's shift while maintaining safe. Call light within reach. On 10/18/21 at 12:08 PM note by nurse practitioner was charted Nursing staff notified provider that patient was noted with fall this AM. Neuro checks initiated. Upon assessment patient is alert and oriented x 1-2. She is confused, able to be verbally redirected. ROM (range of motion) and neuro checks are at baseline. She denies any acute pain or discomfort. Fall prevention measures reviewed with both patient and nursing staff. Will continue to follow. A review of Care Plans provided by the facility and dated 10/8/21 did not show any revisions or adjustments in Resident #9 goals or interventions regarding fall risk after resident fell on [DATE]. No incident report or neuro checks were found on record. Note by a healthcare provider was recorded on 10/25/21 Notified by RN patient sustained a fall with a laceration to her head. She is alert and oriented x 1, which is her baseline. They (staff) were unable to get the bleeding to stop from laceration and requested to send out for repair. Patient was sent out to repair laceration, will notify primary team. Nursing note on 10/25/21 at 2:53 AM regarding Resident #9 change in condition revealed At 1:45 AM the resident was discovered on her room floor by the writer crying and bleeding from the back of her head. She stated that she had to use the bathroom and fell . The bed next to her was displaced and the footboard was broken off and hanging. Upon further inspection she also complained of left hip and shoulder pain. Resident was sent to [NAME] hospital for treatment. Hospital records from 10/25/21 reveal emergency room assessment Approximately golf ball size hematoma located just left of the occiput with overlying laceration. There is a note about scalp wound closure with 3 staples. Resident was evaluated for fractures and brain injury/bleeding due to trauma and taking anticoagulant (Plavix). She was sent to back to facility after evaluation. A review of the Care Plans for Resident #9 provided by the facility did not show any changes or indicated new fall prevention assessments/interventions after return from the hospital status post fall with a head injury. Incident report was filed by nurse. Neuro checks records were requested and were not found by the facility. On 11/16/21 at 4 PM note was filed patient fell at 15:15 (3:15 PM) full assessment done patient states chest pain and pain to left hip no other injury noted. Patient states that she wants to go to hospital. Daughter notified at 15:40. Note by Nurse Practitioner (NP) on 11/17/21 shows Patient was sent out to the hospital status post fall due to patient and daughter requesting her to be sent out and evaluated. She returned to the facility same day no follow up paperwork. Facility to get any follow up appointments/ instructions if any. She had full work up at the hospital. A review of the Care Plans for Resident #9 provided by the facility did not show any changes in intervention or indicated new fall prevention strategies after return from the hospital status post fall. Neuro checks records were requested and were not found by the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Electronic medical Record review showed no healthcare provider, nursing or follow up notes from 11/17/21 to 11/26/21 (for 9 days post fall and hospitalization). There is a note on 11/30/21 at 10:57 AM Nurse found patient laying on the floor next to wheelchair in hallway by nurse's station, assessment completed, patient placed in wheelchair. NP notified of fall, patients daughter notified of fall. Upon record review no changes in Care plan for Resident #9 were noted or implemented. No neuro checks records or incident report were found. Record review revealed no provider or nursing notes from 12/17/21 to 12/28/21 (for 11 days) addressing Resident #9 health status. On 1/7/22 at 11:30 AM nursing note indicates The CENA came to this nurse and stated, The resident daughter packed all of her mother's items and took her mother out of here The daughter did not speak to this nurse at all. Daughter did talk to S.W. (social worker) that she was taking her mother home. Called the S.W. office to inform that the daughter took her out of the building AMA (against medical advice). During interview with the family on 2/17/22 at 11:57 AM complainant shared that her mother passed away on 2/12/22. She said She didn't live through all of it. I am so sad. It has been hard. She stated that facility did not provide her mother with a good care.

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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. 37666 This Citation Pertains to Intake Numbers MI00121806, MI00124712, MI00124771, MI00124773, MI00124943, MI00125431, MI00125356, MI00125447, and MI00125670 Based on observation, interview and record review the facility failed to ensure that there was adequate staff to meets the needs of the residents, resulting in staff verbalizations of being unable to adequately provide care, residents waiting for assistance with Activities of Daily Living (ADL), residents not receiving necessary care and a lack of staff to monitor and provide for resident safety. Findings include: During a tour of the facility East Hall on 1/31/22 at 12:15 PM, Resident's were heard yelling for help over and over. Nurse W was observed standing in the hall at the Medication Cart. He was interviewed and said he had just started the shift at 12:00 PM. He said he was called in because there wasn't a nurse on the hall that morning. He said he was trying to provide the 8:00 AM medications to the residents and it was now 12:20 PM and many of the resident's had doses due at 12:00 PM for the same medications. He said there were residents that hadn't received their pain medications and he was preparing to give them. An interview with Confidential Person EE on 1/31/22 at 12:30 PM, revealed the following, Staffing is a huge problem. 80% of the lights are going off. Mostly for meds. There was no nurse scheduled. They had to call in the Unit Manager and then a Nurse at 12:00 PM. It's not right. It's not safe. They are just now getting their morning medications. On 1/31/22 at 12:32 PM Confidential Person DD stated, The residents are crying because they haven't received their medications. An interview with Resident #32 on 1/31/22 at 12:35 PM revealed, It takes 40 minutes sometimes longer to answer the light. There are not enough staff, especially 2nd and 3rd shift. I haven't brushed my teeth since I've been here. It is not nice here. They haven't put lotion on my feet since I got here. They are cracked and they hurt. My nails they need to be trimmed. They have dirt and everything. They don't stay in here long enough to do anything. I haven't had a shower since I got here- It's been almost 3 weeks. Sometimes you press the button, and they don't show up so you have to scream. Resident #32 was observed to have extremely dry, cracked, flaking skin on his feet and lower legs. On 2/2/22 at 2:00 PM, during an interview with Nurse Aide FF stated, Sometimes I have 40 resident by myself. Me and one nurse. I don't think it's right. When you guys are here they give us more help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2/7/22 at 10:15 AM, interview with Confidential Person SS, The staffing is outrageous. They have one aide to 38 residents. They have so many people to take care of. Meds were late nothing was ever on time. They didn't have time. I could never get the nursing staff to understand about tube feeding- It was supposed to go up at 4:00 PM and down at 12:00 Noon the next day. Rarely was it on time. I would always have to go and ask the nurse when were they going to do the feeding. The very first day there was 1 LPN and nobody to put the orders in the system. They didn't hang it for hours. The biggest thing is they are all agency staff; No consistency. I even went to the Administrator and told her about the staffing, she said, We meet minimum requirements. I said, I don't care about minimum requirements. They are not getting care. After that she was terrible to me. There were times there were no RN's in the building. On 2/7/22 at 11:20 AM, an interview with Nurse O revealed, At one point they (Administration) said our max (nurse to resident ratio) was 1:27; but I've been over that. When there was a time the central and east units were full it was 1:38 and 1:40 with 1 nurse and 1 aide on the 2nd shift. Staffing Scheduler TT was interviewed on 2/7/22 at 11:48 AM and stated, The census is 98 today. Today (dayshift) we have 5 nurses and 9 aides. We try to schedule 3 aides for each unit. Central hall 1 nurse; 2 nurses East and North. Afternoons are the same way. Nights, we have 4 nurses total with 2 on North (1 East, 1 Central) and 6 aides; 2 on each hall. We use a lot of agency, but still have no calls, no shows. We are down to having not much of our own nurses. We use a couple agency aides. On 3rd shift we have all of our own aides; couple agency aides for 1st and 2nd shift. Typically, throughout the day, I check for admits. If we are going to get slammed with admissions, they will say, 'Hey, can you get an extra nurse or aide. Sometimes I can't; maybe only an aide. Last week we had call ins. I know there have been instances where I have been off and someone chose a double and then stayed for the next shift (24 hours). We've never mandated that. I think it has come from management and they say, Are you sure you are staying? There was a couple instances where the Director of Nursing (DON) or Unit Manager reassured they were ok and they volunteered to stay. A review of the the staff Schedules and Assignment sheets revealed the following: 12/21 21: Nurse on the Central hall crossed off for the night shift. No replacement identified. There were 2 nurse aides on the hall for approximately 30 plus residents. 12/22/21: 1 nurse on the Central Hall for 30-40 residents on day shift. 12/23/21: 1 nurse on the Central Hall on day shift. 12/24/21: 1 nurse on the Central Hall on day shift (about 30 residents) and 1 nurse on the East Hall for about 30 residents; 1 nurse aide on the Medbridge/North hall on afternoon/evening (2 pm to 10:30 pm) shift for approximately 30 residents. 12/25/21: 1 nurse on the Central hall dayshift, 1 nurse on the Central hall evening shift, 1 nurse on the East hall evening shift; 1 aide on the East hall evening shift (2 pm to 10:30 pm- includes the evening meal/dinner). 12/26/21: 1 nurse on the Central hall dayshift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1/19/22: no nurse Central hall day shift; 1 nurse East hall day shift; 1 nurse Central hall evening shift; 1 nurse Medbridge/North (with the Covid unit) evening and night shifts. 1/20/22: 1 nurse Central hall and East halls day shift; 1 nurse Medbridge/North hall night shift 1/22/22: 1 nurse Central Hall and East hall day shift. 1/23/22: 1 nurse Central hall day shift; 1 nurse East hall evening shift; 1 nurse Medbridge/North hall (50 residents (Covid) Evening shift. 1/24/22: 1 nurse (DON) Central hall day shift; 1 nurse East hall day shift; 1 nurse East hall evening shift. 1/25/22: 1 nurse Central and East halls day shift; 1 nurse evening shift East hall. 1/26/22: 1 nurse Central and East halls day shift. 1/27/22: 1 nurse East hall day shift. Rarely were there 3 aides scheduled for each unit on day and afternoon shifts and there was often not 5 nurses on day or afternoon shifts. This coincided with multiple resident, family and staff complaints of residents not receiving the care and services they needed. The facility had a Covid-19 outbreak beginning in December 2021 with a Covid unit created on the North hall adjacent to the Medbridge Hall; Increasing to 52 Covid positive residents transferred to the Covid unit in January 2022. There were multiple instances when there was not enough staff for the Covid units and adjacent halls, and staff were working in both areas. Staff were also working in other areas of the building and the Covid unit. On 1/17/22, both the Medbridge and North halls became the Covid unit. On 3/3/22 at 11:50 AM, a Confidential Resident was interviewed about their stay at the facility and replied, It has been up and down. Sometimes it's ok and sometimes it's not. I have to wait a long time sometimes and shouldn't have to. It's not right. Sometimes there are 3 aides and sometimes 1. They can't take care of 28 or 40 people by themselves. They just can't. That's crazy. On 3/3/22 at 3:00 PM, an interview with the Administrator and Corporate Nurse DD related to the review of the staffing schedules and findings, with many complaints from residents, families, and staff that the resident's were not receiving appropriate care provided from Corporate Nurse DD, We are working to hire our own staff. This is something we are making a plan for. We are going to fix this. I am working on the schedules now. Trying to assign people to the same areas for consistency. Discussed with the Administrator that the facility has greater than 75 agency nurses on their list and they account for greater than 90% of the nurses in the building. She said she was aware and was working to bring back some of their own nurses who left previously. A review of a facility policy titled, Resident's Rights, dated October 2019 provided, All resident's will be treated with dignity and respect and resident's rights will be followed . You have the right to make a complaint to the staff of the nursing home, or any other person, without fear of punishment. The nursing home must address the issue promptly . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 31997 Based on interview, and record review, the facility failed to ensure that 15 nursing staff received annual trainings, Competencies/Performance Evaluations for 9 Nurses, (Facility and Agency) and 6 Nursing Assistants, (Facility and Agency, to include waiver Aids) out of 21 staff reviewed for education, trainings and yearly competencies, resulting in nursing staff lacking the necessary qualifications and trainings to adequately care for all the needs of all residents, and lacking the skill set to care for residents. Findings include: During an extended survey, it was identified that 15 of staff's files reviewed, lacked the mandatory and necessary training from the facility to include Dementia, Abuse, Resident Rights, Skills check off/competencies, Performance Evaluations, Assess and Monitor, Change in Condition, and Vital Signs as noted with Immediate Jeopardizes identified in the facility. During an extended survey, the Administrator was asked to provide new orientation/competency checklist, or Performance Evaluations for several staff to include RN Q, RN GGG and the current DON. The Administrator was also asked to provide the same for: LPN's N S T W and FFF and HHH. The Administrator indicated that staff should have been checked off by the DON, or department head before working on the floor and that there was no Staff Educator in place presently. The Administrator provided a general orientation checklist, one for LPN's and one for RN's. Review of the education checklist for Nurses (RN's and LPN's) 'Orientation/ Competency Checklist' reflected the following Topics to be checked off as competent: Orientation to the Organization, Orientation to the Facility, Admissions/Discharges, Job Specific Skills, Communication, Safety, Resident Rights (Abuse Policies), Documentation, Medication Administration, Clinical Care Services, IV Therapy, Infection Control, and Tube Feedings. At the bottom of the form, was a place for New Employee Signature, Reviewer Signature and date. Review of trainings provided by the Administrator, reflected that: There were to trainings provided by the end of survey for: RN Q and DON. RN GGG was evaluated on 9/26/11, and again on 10/16/20. The evaluation for 10/16/20, was not completed. The facility did not provide any other training for this RN. The Administrator was not able to provide trainings for: LPN N, LPN FFF, LPN W, LPN T, LPN HHH, and LPN S. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of CNA ' s Orientation/Annual Competency cover the Topics: Report/Assignment, Documentation, Infection Control, Bathing, Vital Signs, Nutrition/Hydration. Under 'Competency Skill' for Reviewer and Demonstration' listed to demonstrate competency with: Bed Making, Incontinence Care, Call lights, Dressing/Grooming, Admission Task, Skin Care, Transfers, Personal Functions, safety/Health, and Weigh/Measure. , At the bottom of the form is place for Employee Signature and Reviewer Signature. Review of Nursing Assistant trainings provided by the facility, reflected that NA III, did not have a competency skill check completed, and did not receive training related to Abuse, Resident Rights, or Dementia. Review of NA JJJ did have a competency checklist, but was not signed or dated by an evaluator/reviewer as completed. Review of NA KKK reflected no trainings or competency provided upon request. Review of Waiver Aid LLL a competency checklist not signed by an evaluator/reviewer as completed, and also did not receive Abuse, Resident Rights or Dementia trainings. Review of Waiver Aid DDD reflected no Abuse, Resident Rights, or Dementia trainings provided. Review of Waiver Aid NN reflected no trainings or competency provided. An interview was conducted with the Administrator on 2/23/22, who verbalized that each time a new nurse starts, We cover specific items. We only have one nurse that is ours. The rest are Agency. An interview was conducted with Human Resource staff on 2/23/22 at 4:45 PM, related to staff education and trainings. HR verbalized there is not a Facility Educator in house currently, and no one is doing the trainings. Nurses and CNA's go with other staff on the floor and are supposed to be checked off as competent. Agency staff take a small test and if they pass, they are good to go. We just started in October and nothing has rolled over. HR was asked to provide any trainings that had been completed for staff in the last 5 months. Under 'Purpose' of Facility Assessment documented, The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being . Review of the Facility Assessment Part 3 Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies documented Consider the type of staff and other professionals .that show the type of staff needed to care for Resident Population .Administrator, Staff Developer, Infection Control . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Under 'Staff training/education and competencies' documented: 3.4. Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education, training, competency instruction, and testing policies. The Administrator provided a 12 month calendar that staff are to complete trainings on a monthly basis. During an interview with Administrator, it was verbalized that the facility did not have a Facility Educator presently in the facility. According to the State Operational Manual (SOM) for competency for Nursing Services documented: The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Providing care includes, but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident needs. Under 'Proficiency of nurse aids' documented: The facility must ensure that nurse aids are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Review of 'Staff Competencies in Identifying Change in Condition' documented: A key component of competency is a nurse's (CNA, LPN, RN) ability to identify and address a resident's change in condition. Facility staff should be aware of each resident's current health status and regular activity, and be able to promptly identify changes that may indicate a change in health status. Once identified, staff should demonstrate effective actions to address a change in condition, which may vary depending on the staff who is involved. For example, a CNA who identifies a change in condition may document the change on a short form and report it to the RN manager. Whereas an RN informed of a change in condition may conduct an in-depth assessment, and then call the attending practitioner. According to the SOM, All nursing staff must also meet the specific competency requirements as part of their license and certification requirements defined under State law or regulations. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Many factors must be considered when determining whether or not facility staff have the specific competencies and skill sets necessary to care for residents ' needs, as identified through the facility assessment, resident-specific assessments, and described in their plan of care. A staff competency deficiency under this requirement may or may not be directly related to an adverse outcome to a resident ' s care or services. It may also include the potential for physical and psychosocial harm. According to the Code of Ethics for Nurses (American Nurse Association, 2001, pg 14) the nurse's primary commitment is to health, well-being, and safety of the patient. The nurse must take appropriate action regarding any instances of incompetent, unethical, or impaired practices by any member of the health care team. The Code of Ethics for Nurses (pg. 17) states the nurse is accountable to the quality of nursing care given to patients and the delegation of nursing care activities of other health care workers. The nurse is responsible for monitoring the activities of those individuals and evaluating the quality of care provided.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 31997 Based on interview, and record review, the facility failed to ensure that a Registered Nurse was on duty for 8 consecutive hours a day for seven days a week, resulting in the likelihood of inadequate coordination of emergency or routine care with negative clinical outcomes affecting all residents residing in the facility. Findings include: During an extended survey, the Administrator was asked to provide documents ensuring that RN coverage was present for 8 hours a day in a 24 hour period weekly. Review of the documents provided by the Administrator reflected a time frame of 12/21 through 2/22, 5 days where the was no RN coverage.: On 1/3/22, no RN coverage on all three shifts documented as working in the facility. On 1/12/22, there was no RN coverage on all three shifts documented as working in the facility. On 1/13/22, there was no RN coverage on all three shifts documented as working in the facility. On 1/14/22, there was no RN coverage documented as working on all three shifts in the facility. On 1/31/22, there was no RN coverage documented as working on any shift. The sheet was not completed. The Administrator was asked on 2/23/22, if the documents provided were accurate, and indicated she would have to get back with me. No additional information was provided to Surveyor by end of survey. The Administrator verbalized they used a lot of Agency staff, and that most of the staff that came to work in the building were Licensed Practical Nurses (LPN's). The Administrator verbalized that a lot of the regular nurses quit and there were times when there was not an RN working.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 31997 Based on interview and record review, the facility failed to ensure that 4 nursing assistants out of 4 nursing assistants reviewed for mandatory 12-hour yearly training (to include Abuse, Resident Rights, and Dementia), had completed the trainings annually, identified during an extended survey, resulting in staff not deemed/determined competent to perform Activities of Daily Living (ADL) care, care for Dementia residents, ensure residents' safety, and decreased Quality of Care, recognition/reporting Abuse, with the likelihood to affect all residents residing in the facility. Findings include: During an extended survey, the Administrator was asked to provide annual 12 hours inservice trainings for 4 Nursing Assistants, NA L, MMM, R, and NNN to include Abuse, Resident Rights and Dementia training in the 12 hour inservice training. An interview was conducted with Human Resource staff on 2/23/22 at 4:45 PM, related to staff education and trainings. HR verbalized there is not a Facility Educator in house currently, and no one is doing the trainings. Nurses and CNA's go with other staff on the floor and are supposed to be checked off as competent. Agency staff take a small test and if they pass, they are good to go. We just started in October and nothing has rolled over. HR was asked to provide any trainings that had been completed for staff in the last 5 months for the above staff. Review of NA L's information reflected there was not 12 hour of yearly inservice's completed or provided. Review of NA MMM there were not 12 hour of yearly inservice's completed or provided. Review of NA R reflected there was not 12 hours of inservice's completed or provided. Review of NA NNN reflected there was not 12 hours on inservice's completed or provided by end of survey. Review of 'Abuse Prevention Program' documented under Preventing Abuse: Our facility is committed to protecting our residents from abuse . Under 'Abuse identification, Training and Education' documented Our abuse prevention/intervention education program includes: -Training all staff and practitioners how to resolve conflicts, -Allow staff to express frustration with their job . -Assisting and rotating staff with difficult or aggressive residents . (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Training staff to understand and manage a residents verbal or physical aggression . Review of the training calendar provided by the Administrator on 3/3/22, documented the following training that is supposed to be completed annually by Nursing Staff as: January Protecting Resident Rights (1.0) February Respecting Diversity (1.0) Infection Control Basics (0.25) COVID-19 PPE Guidance (0.75) March Accident Prevention (0.75) Basics of Hand Hygiene (0.25) PAC Skills Make a Difference V Chapter 1: Positive Approach. Techniques (0.5) April About COVID-19 (0.25) Workplace Emergencies: Tornadoes (0.50) *Caring for Those with Cognitive Impairment (0.5) Filling the Day with Meaning (2.5) May Sexual Harassment (0.50) Cyber Security - email (0.25) (continued on next page)

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	235132	A. Building B. Wing	03/07/2022

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Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Determining Dementia (0.5) June Understanding Wandering and Elopement (0.75) Blood Borne Pathogens (0.50) July Fire Prevention (0.50) Personal Protective Equipment (0.25) PAC Skills Make a Difference - Chapter 2: Care Partnering with Changing Abilities (0.5) August Elder Justice Act (0.50) Cyber Security - Passwords (0.25) Transmission Based Precautions (0.50) September Abuse and Neglect (0.75) *Alzheimer ' s: Behavior and ADL management (1.0) October Influenza Prevention (0.50) Airborne Precautions (0) About Falls (0.50) November (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Advanced Directives (0.50) Cultural Competence (0.50) *Dementia Care: Challenging Behaviors and Direct Care Staff (0.5) December Understanding Corporate Compliance (0.50) HIPPA (0.50) Revised 12.30.2021 Training hours All Staff (12) * Dementia Specific (3.0) Dementia Director (3.0

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 31997 Based on observation, interview, and record review, the facility failed to ensure that the clinical staff posting of nursing hours was completed daily for 5 days of clinical staff on duty, resulting in residents and visitors not being informed and unable to determine if a Registered Nurse was on duty, or knowing the number of clinical staff working on those days. Findings include: According to the State Operational Manual (SOM) reflected The facility must post the total number and actual hours worked by Licensed and un-licensed nursing staff directly responsible for resident care per shift . to include, Registered Nurses .Licensed Practical Nurses .and Certified Nursing Aids. The SOM guides that the facility must , Ensure staffing information was posted in a prominent place readily accessible to resident and visitors . The Administrator was asked on 2/23/22, during an extended survey to provide the daily postings for a time frame of December, 2021, through February, 2022, to reflect posting of daily staff hours in the facility. The Administrator indicated she would have to get with Human Resources, and get the posting from the book. The Administrator provided the documents for postings. Review of the documents provided reflected 5 days of incomplete posting of daily staff hours working in the facility.: On 12/8/21, there was no documented hours of licensed or un-licensed staff working that day. It was not completed per Administrator. On 2/12/22, there was no documented hours of the number of staff providing care to residents in the facility licensed or un-licensed. On 2/13/22, there was no documentation of hours of staff providing care to residents in the facility. On 2/19/22, there was no documentation provided of the number of staff providing care to the residents provided. On 2/20/22, there was no documentation provided of the number of staff providing care to the residents in the facility. The Administrator was asked on 3/3/22, if there were any additional documents related to the missing dates above. The Administrator indicated she would check with HR and by the end of survey indicated They are missing.

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on observation, interview and record review, the facility is placed in Immediate Jeopardy for its failure to maintain a sanitary kitchen and its failure to not prepare food in that unsanitary kitchen where dietary employees were observed walking through and pushing food carts through a known unsanitary contaminant on the floor from two broken drains. This deficient practice affects all 93 facility residents. Immediate Jeopardy: The Immediate Jeopardy (IJ) began on 01/21/2022. The IJ was identified at 3:10 PM, on 01/25/22. The Administrator was notified on 01/26/22, at 8:52 AM. A plan of correction was requested to remove the IJ. The IJ was removed at 5:15 PM, on 01/25/22 when the facility closed the kitchen for use and submitted the acceptable Plan of Correction that was implemented and verified on site by the survey team. Findings include: On 1/25/22, at 3:10 PM, observation of the kitchen was conducted. The floor was discolored with a grey residue in the grout of the tile of approximately 10 foot by 10 foot section which was the main walkway located between the 2 compartment sink and prep table. There were food carts rolled on top of the dirty floor. There were kitchen workers walking on the dirty floor and all throughout the kitchen. There was visible water, a large amount of [NAME] substance greyish in color measuring approximately 2 foot by 6 foot under the 2 compartment sink with visible muddy water in the drain. The floor drain near the food prep table had water leakage along the grout of the tile approximately 2 foot by 2 foot area with a 4 inch area of dark black sludgy substance. On 1/25/22, at 3:12 PM, an interview with Assistant Dietary Manager (AM) B of kitchen services was conducted in the kitchen. AM B , was asked why the ice machine was off and AM B stated, the ice machine is off because of the sewer drain backing up on Friday. AM B was asked who they alerted and AM B stated that they notified Dietary Manager F on Friday who notified the housekeeping supervisor who then called the sewer people. AM B was asked to explain the leakage smell and appearance and AM B stated, there was a strong feces smell on Friday when the leak started with no visible stool solids. AM B further offered that the leakage on Friday went all through kitchen along the 2 compartment sink, the juice table covering the entire walkway and leaked out into the dining room under the doorway of the kitchen. AM B denies being educated as to what to do if there was a leak in the kitchen. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 1/25/22, at 3:17 PM, an interview with Kitchen Worker C was conducted in the kitchen. Kitchen Worker C stated, the drains leaked both Friday and Saturday of a light grey watery substance under the 2 compartment sink and the floor drain near the prep table had about a 2 foot by 2 foot area of leakage that was black in color and smelled like sewage. Kitchen Worker C stated that both drains ended up going down on their own but if they use the hand washing sink it backs up and the leak gets worse. Kitchen worker C denied mopping or sanitizing the floor. On 1/25/22, at 3:20 PM, an observation along with AM B was conducted in the kitchen of the mop bucket which had dark grey dirty water inside. AM B was asked if they had mopped the floor and AM B stated that housekeeping supervisor came in the kitchen and told them they needed to mop the floor themselves but No, they did not mop the floor. On 1/25/22, at 3:25 PM, an interview with Kitchen Worker G was conducted while they were standing at the prep table prepping sandwiches. The floor drain is on the opposite side of the prep table near the end close to the walkway. Dietary worker G stated that they worked on Saturday, Sunday and Monday and that the floor was leaking all those days, smelled like sewer each day and on Monday morning the floor drain by the prep table even had black leakage around the drain. Kitchen Worker G denied being told to mop and sanitize the floor and stated that they did not mop or sanitize the floor. On 1/25/22, at 3:30 PM, an interview with Maintenance Lead (ML) D was conducted regarding the kitchen. ML D stated, they were off Friday but came in Saturday early and attempted to snake the drain. ML D further offered that (the plumbers) were called on Friday by the housekeeping supervisor and came out but was unable to fix the drain. ML D further offered that (the plumbers) needed to come back on Monday with a better pipe camera. ML D stated, that they shut off the water to the hand washing sink in the kitchen, the ice machine in the dining room and that the staff are able to use the employee break room for ice. On 1/25/22, at 3:32 PM, An observation of the ice machine in the break room along with ML D was conducted. The ice machine was off and was overflowing water onto the floor. ML D was unaware the ice machine was not working and was asked to provide all communications from the facility with (the plumbers) regarding the kitchen. On 1/25/22, at 3:35 PM, an observation along with ML D of the kitchen drains was conducted and ML D was asked why the floor was still dirty with the leakage and ML D stated, they would clean it. ML D walked over to the hand washing sink and shut off the water supply. On 1/25/22, at 3:45 PM, a record review along with ML D of the Kitchen Proposal repair plan was conducted. The proposal was dated 1/24/22. ML D offered that the proposal was emailed later in the evening after they had gone home. ML D further offered that they emailed it to the company lead and was awaiting approval. On 1/25/22, at 4:00 PM, the Administrator was asked if they were aware of the kitchen drain leaks and the Administrator stated that they were told it was a water leak on Monday morning and did not know it was a drain leak. The Director of Nursing (DON) who was in the Administrator's office offered that they did not know about the leak until survey. The Administrator was asked to provide the contract for the kitchen, education provided to the kitchen staff regarding what to do in case of a drain leak and the cleaning policy. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 1/25/22, at 4:30 PM, the administrator and ML D entered the conference room and offered that they had texted the company lead regarding the approval for the kitchen and was awaiting their response. ML D received a telephone call while in the conference room approving the kitchen proposal. On 1/25/22, at 4:45 PM, Registered Dietician (RD) E was interviewed regarding the kitchen leak. RD E stated that they did not know anything about the kitchen drain leaks and that the Administrator just alerted them 5 minutes prior to the interview. RD E was unaware the kitchen staff had not cleaned or disinfected the floor, continued to prepare food while walking over the contaminated floor and pushing the food carts over the dirty floors out into the hallways of the facility. RD E stated they had been working since 8:30 AM in the morning and hadn't been in the kitchen. On 1/25/22, at 4:47 PM, an observation of the kitchen along with RD E was conducted. The floor under the 2 compartment sink had been wiped clean of the greyish [NAME] substance. The tiles in the walkway remained of grey residue. The floor drain near the prep table remained wet with the black sludge material. There was a bright green substance that appeared to have been poured into the drains. The grey residue remains on the tile and had not been cleaned off. Kitchen worker G offered that ML D had just been in and cleaned the floor under the 2 compartment sink and poured the cleaner into the drains. Kitchen Worker G was asked if the entire kitchen floor had been mopped and kitchen worker G stated, no. RD E was asked if they had offered any education to the kitchen staff on how to clean up after a drain leak and RD E denied and offered that they had worked with the kitchen staff on cleaning . RD E was asked if there was anything the facility could have done differently and RD E stated, Yes, you don't do service until it's cleaned. O 1/25/22, at 5:00 PM, ML D was in the Administrator's office and was asked if they had mopped the entire kitchen floor and ML D stated, I don't know if they cleaned the floor after I left. ML D was asked what area of the floor did they clean and ML D stated, I just cleaned the area near the sink. On 1/25/22, at 5:15 PM, RD E offered that the facility stopped service in the kitchen until it can be fixed. The facility planned to utilize the assisted living kitchen and planned for an alternative dinner meal. On 1/26/22, at 8:30 AM, the Administrator entered the conference room and stated that ML D was trying to get (the plumbers) to come out sooner seems the kitchen is closed and stated, we're getting an IJ aren't we. ON 1/26/22, at 10:00 AM, an interview with Dietary Manager (DM) F was conducted regarding the drain leaks in the kitchen. DM F offered that during the day on Friday there was water under the 2 compartment sink going all the way out the dining room door. DM F offered they notified ML D about 6:20 PM because it was still leaking. DM F stated that it leaked again on Saturday, Sunday and again on Monday ant it appeared to be wet sand coming from under the 2 compartment sink. The DM F did not mention the leak from the floor drain near the prep table. DM F stated, that (the plumbers) did come out and confirm a broken pipe under the floor so they had called their regional leader who said they may need to go to a cold simplified menu. DM F was asked who they assigned to clean and disinfect the floor and DM F stated, nobody and that they used bath blankets to mop up the water and to keep it from going into the dining room. DM F was asked again who was told to clean and disinfect the kitchen floor and DM F stated, nobody the floor was not mopped or sanitized. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 1/26/22, at 1055 AM, the Administrator was asked again if there was any education offered to the kitchen staff on what to do with a drain leak and the Administrator stated, education was just started yesterday after this all blew up. On 1/26/22, at 11:00 AM, RD E was observed in the hallway with two kitchen workers. RD E was asked if there was any education offered to the kitchen staff on what to do with a drain leak prior to the leak and RD E stated, I'm doing it right now. On 1/26/22, at 11:05 AM, a record review of the Culinary Services Agreement provided by the facility revealed . (contracted kitchen company) shall be responsible for routine cleaning and housekeeping in the food preparation areas (excluding dining rooms), including culinary service equipment, kitchen floors . There was no noted information on what the kitchen staff should do in an emergency of a drain leak. On 1/26/22, at 11:10 AM a record review of the facility provided (contracted kitchen company) revealed no mention as to what the kitchen staff should do in an occurrence of drain back flow leakage. The following plan of correction was submitted by the facility. On 1-21-22 Dietary manager noticed a water backing up in the kitchen, she notified the Environmental Director at approximately., 1:00 pm and he was unable to unclog the drain where the water was coming from. [NAME], plumbers, was contacted. They arrived at the facility and was unable to correct the problem due do needing another technician to come out, at that time Maintenance was notified. [NAME] told staff that they would be back on Monday to correct the problem. At 5:30 pm the water went down in the drain. Maintenance was off due to Covid and he placed a call to [NAME] from home after he was notified of the plugged drain. On 1-22-2022 at 4:00 am Maintenance Director came into the building and tried to snake the drain, but it didn't work. On 1-24-2022 at 9:00 am Administrator was made aware of the drain problem. [NAME] came out and can a quote on the repairs. At 7:08 am the quote was emailed to the Regional Director of Operations, who was on vacation with a 3-hour time difference. The surveyor went into the kitchen, at 3:51 pm a text message was sent to the RDO for approval on the quote for approval. At 4:30 pm a text was sent to the Corp Environmental Supervisor for Approval. At 4:34 pm the approval was obtained. At 5:12 pm, the Regional Culinary Service Director was called and made aware of the situation. At 5:13 pm, the decision was made to have the food prepared at the Assisted Living Kitchen until the SNF kitchen was fixed. At 5:15 pm the Kitchen was closed. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	At 5:30 pm Pizza was ordered for the residents as well as salad and dessert At 6:15 pm the pizza arrived. Residents were monitored for signs and symptoms GI problems, which none have been noted as of 1-27-2022. On 1-26-2022, [NAME] was to come and repair the kitchen, repairs will take longer to complete as expected, so the SNF kitchen remains closed, and the Assisted Living Kitchen continues to be used. Modernistic was called and will be doing the cleaning of the kitchen once [NAME] is completed with the work. Education was completed on 1-25-2022 by the RD to the dietary department on the following: The different zones, food cart travel, proper PPE, how to response the leaks in the kitchen, and cleaning the kitchen once leaks occur. The Dietary Director and Maintenance Director was educated to notify the Administrator at once when events like this occur, at that time the Administrator will notify the RDO. The Dietary Director will monitor the drain and will report findings immediately to the Administrator. If this occurs again, the kitchen will be immediately closed, will cleaned immediately, and sanitized prior to resuming food preparation in that area. The maintenance director will notify the administrator and will obtain a quote for any new repairs. Substantial compliance has been achieved on 1-25-2022 The Administrator is responsible for maintaining compliance.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Numbers MI00124771, MI00124773, MI00124806, MI00125356, and MI00125680. Based on observation, interview and record review, the facility was placed in Immediate Jeopardy due to the facility's systemic collapse of the Infection Prevention and Control program with failure to follow evidence-based practices for Infection Control, including collection and analysis of surveillance data to identify trends and patterns and implement appropriate interventions, including Transmission Based Precautions to prevent the spread of infections, including the Covid-19 virus. The failure to maintain infection control practices resulted in a likelihood for a serious adverse outcome including infectious illness and death if appropriate Infection Prevention and Control Standards of Practice were not enacted. The facility failed to institute and operationalize appropriate Infection Control Standards of practice in accordance with the Centers for Disease Control and Prevention's (CDC) recommended measures to prevent exposure and transmission of Covid-19 to residents and staff. Immediate Jeopardy: The Immediate Jeopardy began in [DATE]. The Immediate Jeopardy was identified on [DATE]. The Administrator was notified of the Immediate Jeopardy on [DATE]. The IJ Abatement (Removal) Plan was approved on [DATE] with a Removal Date of [DATE]. Findings include: On [DATE] at 1:50 PM, during the survey Entrance Conference with the Administrator, she said 50 residents had tested positive for Covid-19 from a facility census of 94 residents. The Administrator said the 50 residents were still residing in the building on the Medbridge/North units that were enclosed to create a Covid-19 unit. The Administrator was asked who was overseeing the Infection Prevention and Control program and she said the Director of Nursing was in charge of the IPC program. The Administrator was asked for copies of the Infection Surveillance data for [DATE] and [DATE] and various Infection Control (IC) policies, including Covid-19 policies. The Administrator said she would request the Infection Surveillance from an out-of-state Corporate Infection Control Nurse QQ; He would send the information to the facility. On [DATE] at 2:15 PM, The Director of Nursing (DON Q) was observed working as a Floor Nurse. She was asked if she often worked on the floor and she said, Yes. DON Q introduced Nurse OO, whom she said had recently been hired to assume the Infection Prevention and Control (IPC) Nurse role. He did not have training and had worked at the facility for 2 days. The facility did not have an Infection Prevention and Control Nurse. The DON said she tried to oversee the IC Program. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Centers for Disease Control and Prevention (CDC), [DATE], Infection Prevention and Control Program: Assign One or More Individuals with Training in Infection Prevention and Control to Provide On-Site Management of the IPC Program. This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs . On [DATE] at 3:10 PM, the Administrator provided a Covid-19 surveillance report from the out-of-state IC Nurse QQ. There was no additional Infection Surveillance received for other infections. For (example: fever, cough, wounds, rash, diarrhea, UTI etc.) from [DATE] to [DATE]. There was no respiratory monitoring for Influenza. Centers for Disease Control and Prevention (CDC): COVID-19: Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes- Nursing Homes and Long-Term Care Facilities, Updated Feb. 2, 2022, Older adults living in congregate settings are at high risk of being affected by respiratory and other pathogens, such as SARS-CoV-2. A strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP). Even as nursing homes resume normal practices, they must sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalization s, and death. The Association for Professionals in Infection Control and Epidemiology (APIC), [DATE] provided, Surveillance of healthcare-associated infections (HAI) is the cornerstone of an effective infection prevention program. By definition, surveillance is a comprehensive method of measuring outcomes and related processes of care, analyzing the data, and providing information to members of the healthcare team to assist improving those outcomes and processes . Facility staff were testing themselves for Covid-19 at the nurses' desk with other staff and residents in close proximity, potentially exposing others to Covid-19. The facility is not consistently tracking Covid-19 test results for residents or staff. The facility did not have a complete Line List (surveillance) for Covid testing for residents and staff. The facility did not track test dates with results, if negative. They only recorded Covid-19 positive test results. Agency Nurse K was observed on the Central Unit, on [DATE] at 2:15 PM. She was at the nurses desk talking to the DON Q about her schedule, several nurse aides and nurses were also present at the desk. At 2:40 PM, Nurse K went to the East hall to receive report from the day shift nurse and count narcotics on 2 carts. The nurse was interviewed about medication administration processes on the unit and then Nurse K was observed while touring the medication room. It was after this that a Covid test in process, awaiting results, was observed on the Nurses desk with several staff nearby. This surveyor asked who's Covid test was on the desktop and Nurse K said, That's mine. The nurse was asked if she was Covid positive or negative and she looked at the test and said, I'm negative. The nurse was asked if she always tested at the desk and she said, Yes. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 3:10 PM, the Administrator was interviewed related to where the staff were supposed to complete Covid tests and she said, In the conference room or at the front door when they are screened. Explained that the nurse was Covid testing at the nurse's desk and if she was positive, she would have exposed all of the nearby staff and residents. The facility was not following accepted Standards of Practice for Transmission Based Precautions: Staff were not wearing appropriate PPE, including a gown and gloves when entering the Covid Unit. Staff did not know what PPE was required for the Observation Unit (Yellow zone). Dietary staff were observed transporting food carts from the kitchen through the Covid Observation Unit to other non-Covid areas of the building, while residents were observed in the hallways without PPE (masks). On [DATE] at 1:50 PM, Aide NN was observed unzipping the plastic barrier to the antechamber to the Covid positive unit (Red zone) he did not don PPE (Personal Protective Equipment)- no isolation gown or gloves, He had on a kN95 mask and face shield. He walked through the antechamber to the next zipped plastic barrier. He unzipped it and stepped into the Covid unit. He did not sanitize his hands or don a gown or gloves. He asked out loud to staff on the unit about staffing needs and turned around, rezipped the plastic barrier to the unit, walked through the antechamber and began to exit through the outside zipped barrier. The transportation aide was asked if he was supposed to wear PPE to enter the Covid unit and he looked around the antechamber and stated, This is for taking off your equipment. He was asked if he was supposed to wear PPE? There were clear signs on the outside barrier to the antechamber, Stop and another sign with wording and pictures of the necessary PPE and in what order to put them on. The employee was asked about the signs on the plastic, and he said he didn't think he had to wear the PPE because he was just standing in the doorway to the unit. Pointed out that he had entered with his body when he stepped into the unit. The Aide was asked if he had received education related to Infection Control practices, PPE, Covid policies and procedures and he said, No. On [DATE] at 4:54 PM, a loud noise was heard in the hallway outside the conference room. A Dietary aide was observed pushing a dietary cart with trays through the door of the Yellow unit (Covid-19 observation unit- Staff were to wear PPE in the resident rooms and residents to wear a Facemask when leaving their rooms). He had no PPE except for a Face shield and mask. Residents were observed in their wheelchairs and some walking without masks in the hallway of the unit, as the Dietary cart was pushed by them. The aide pushed the cart down the hall out the exit door down to the side walk to an outside door to the Assisted Living Building. On [DATE] at 4:56 PM, the Administrator and Registered Dietitian (RD) E were interviewed. This surveyor explained to them the dietary staff were observed transporting meal trays from the kitchen through the Covid observation unit and then to the Assisted living residents. The Administrator said, They could have went through the [NAME] unit (Non-Covid-19 unit). She asked the RD to educate the dietary staff on not using the observation unit as a transport area. On [DATE] The facility was not tracking employees' or agency staff signs or symptoms of illness. They only track confirmed cases of Covid-19. Facility staff were testing themselves for Covid-19 at the nurses' desk with other staff and residents in close proximity, potentially exposing others to Covid-19. The facility is not consistently tracking Covid-19 test results for residents or staff. The facility did not have a complete Line List (surveillance) for Covid testing for residents and staff. The facility did not track test dates with results, if negative. They only recorded Covid-19 positive test results. (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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A serious adverse outcome occurred. 11 facility residents tested positive for the Covid-19 virus in [DATE]. 52 facility residents tested positive for the Covid-19 virus from [DATE] through [DATE] (16 days). 14 of the 52 positive residents had to be hospitalized for Covid. 3 of the 52 positive residents died from Covid. 4 facility staff tested positive for the Covid-19 virus in [DATE]. 20 facility staff tested positive for Covid-19 from [DATE] through [DATE]. The facility's failure to 1) Complete infection surveillance of residents and staff with signs and symptoms of illness including Covid-19, 2) Conduct appropriate testing and tracking of test results and 3) Act in compliance with Transmission Based Precautions, made it likely that a significant number of residents and/or staff became symptomatic or infected with the highly contagious Covid-19 virus The facility needs to take immediate action to contain the scope and severity of the current Covid-19 outbreak to prevent further cases for both facility residents and staff. The Immediate Jeopardy began in [DATE]. The Immediate Jeopardy was identified on [DATE]. The Administrator was notified on [DATE] of the Immediate Jeopardy that began on [DATE]st, 2021. The IJ Abatement (Removal) Plan was approved on [DATE] with a Removal Date of [DATE]. CDC, Long-Term Care (LTC) Respiratory Surveillance Line List, [DATE], 'The Respiratory Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak . Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness . Each row represents an individual resident or staff member who may have been affected . The information . capture data on the case demographics, location in the facility, clinical signs/symptoms, diagnostic testing results and outcomes . ' Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases and assist with implementation of infection control measures . Per the CDC, [DATE], Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions (Standard Precautions are used for all patient care. They're based on a risk assessment and make use of common sense practices and personal protective equipment use that protect . from infection and prevent the spread of infection from patient to patient.) for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission . Source: Guidelines for Isolation Precautions. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	[NAME]/APIC (Society for Healthcare Epidemiology of America/The Association for Professionals in Infection Control and Epidemiology) Guideline: Infection prevention and control in the long-term care facility, [DATE] AJIC (American Journal of Infection Control), provided . Because of the impaired immunity of elderly person, viral respiratory infections that generally mild in other populations may cause significant disease in the institutionalized patients. Examples include influenza, respiratory syncytial virus (RSV), parainfluenza, coronavirus, rhinoviruses, adenoviruses and recently discovered human metapneumovirus . Rapid identification of cases in order to promptly initiate treatment and isolate them to prevent transmission remains the key . An outbreak or transmission with in the facility may occur explosively . Outbreaks in LTCF's (Long Term Care Facilities) accounted for a substantial proportion (15%) of reported epidemics . CMS (Centers for Medicare and Medicaid Services) regulations address the need for a comprehensive infection control program that includes surveillance of infections; implementation of methods for preventing the spread of infections including use of appropriate isolation measures . An ICP (Infection Control Practitioner) is an essential component of an effective infection control program and is the person designated by the facility to be responsible for infection control . Infection surveillance in the LTCF involves the systematic collection, consolidation, and analysis of data on HAI's (Healthcare associated infection) . resources that include practice guidance for surveillance identifying seven recommended steps . 1. Assessing the population, 2. Selecting the outcome or process for surveillance, 3. Using surveillance definitions, 4. Collecting surveillance data, 5. Calculating and analyzing infection rates, 6. Applying risk stratification methodology and 7. Reporting and using surveillance information . The surveillance process consists of collecting data on individual cases and determining whether or not a HAI is present by comparing collected data to standard written definitions (criteria) . One recommended data collection method . Walking rounds . collecting concurrent and prospective infection data that are necessary to make infection control decisions . should be done on a timely basis . may use house reports from nursing . chart reviews, laboratory or radiology reports, treatment reviews, antibiotic usage data and clinical observations . On [DATE] at 10:15 AM, Corporate Nurse DD and Corporate IC Nurse CC were interviewed about the Infection Control Program at the facility. Corporate Nurse DD stated, There was an IPC at one point. (unsure of the date or whom). (Corporate IC Director QQ is Offsite (out-of-state). There has not been a nurse solely in the IC role. DON assuming duties. (Corporate IC QQ) stated he trained the (DON) and she was responsible. During the interview, reviewed the facilities Infection Control and Covid-19 Policies with Corporate IC Nurse CC. The policies were greater than 1 year since they were created or reviewed. IC Nurse CC did not know when the policies had been reviewed. Some of the policies were dated 2018. During the interview, IC Surveillance was reviewed with the Corporate Nurse DD and Corporate IC Nurse CC on how the Infection Surveillance data was gathered, sources, employee call ins, contract services. The facility was only using antibiotic reports for the Infection Line lists. They were not monitoring for signs and symptoms of infections. When asked if staff illnesses were monitored, Corporate Nurse DD said they were not allowed to track employee illnesses. The Corporate Nurses were asked if staff signs and symptoms of illness were tracked to aid in monitoring the potential spread of infection to the residents, she said, No. They only tracked Covid-19 infections. Corporate IC Nurse CC said they had discussed using a Change of condition form: we discussed earlier we think that would be our process. None of the change of condition was placed in the line listing or any surveillance. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Employee illnesses were not tracked; Neither was contracted employee illness. The majority of nurses at the facility (approximately 75, which was over 90%) were Agency staff. Corporate nurses CC and DD were asked if they received education on the facilities process for Infection Prevention and Control and said they were not educated or oriented to the facility's policies and procedures for Covid-19 or Infection Control. Corporate Nurse DD stated, We don't have any control over them. They are not our employees. When asked if the facility provided education to ensure the facilities policies were followed, she stated, The agency educates them or they learn it in school. On further review of surveillance data there was no surveillance or analysis or summary of data for trends from September to [DATE]. There was some Covid surveillance data from January to- [DATE]. Per the Corporate nurses, that was prior to the facilities current ownership taking over in [DATE]. Infection Surveillance had not been accurately completed since then. Reviewed green, yellow, red zones for management of resident admissions, Covid-19 exposures and positive Covid-19 cases. Corporate IC Nurse CC stated, [NAME] zone: No signs and symptoms of infection, mask- depends on positivity rate. That is sent to us every morning; Yellow zone: Possible exposure: PPE mask, face shield, gown gloves to enter a resident room- resident with masks in the hallway; Red zone: positive Covid-19- Full PPE to enter the unit. During the interview, reviewed Covid-19 testing. Could not locate Resident Covid-19 test results in the resident charts. Corporate IC Nurse CC stated, The results are not in the medical record. Discussed with Corporate IC Nurse CC if the facility was testing for Influenza and she stated, I do not know the answer for that. They should be in progress notes. Corporate IC Nurse CC was asked if anyone was performing IC Rounds and stated, When I'm in the building, I do the rounds. There were no documented rounds by IC in the building. Reviewed with the Corporate Nurse and Corporate IC Nurse if Infection Prevention and Control surveillance data, analysis and trends was reviewed either in an Infection Control Committee or at the QAPI (Quality assessment and process improvement) meetings. They said no IC surveillance analysis or summary data was reviewed, but it would be in the future. On [DATE] at 3:15 PM, the Administrator said prior DON QQQ left employment at the facility on [DATE]. She was overseeing the IC program and then DON Q became the Director of Nursing and assumed duties for IC on [DATE]. DON Q did not have training in Infection Prevention and Control. On [DATE] at 3:03 PM Agency Nurse A was interviewed and asked if she received orientation or training on the facilities policies and procedures for infection control and said she had None. She said the agency provided a skills test, but no education. On [DATE] at 11:20 AM, Corporate Nurse CC said, We didn't have any surveillance, but we are working on it now. On [DATE] at 4:24 PM, Agency Nurse Z was asked about orientation to the facilities Infection Control practices and stated, There is no orientation. A lot of people have a hard time. The agency doesn't provide it either. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the facility policies provided the following: Policies and Practices-Infection Control, dated ,d+[DATE], The facilities infection prevention and control program is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . The facilities infection control policies and practices apply equally to all personnel, consultants, contractors . All personnel shall be trained on our infection control policies and practices . Surveillance for Healthcare-Associated Infections, dated reviewed/revised ,d+[DATE], The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAI's) and epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative measures. 1. The purpose of the surveillance of infections is to identify both individual cases and trends in the transmission of epidemiologically significant organisms and Healthcare-Associated Infections, to permit interventions to try to slow or stop the transmission of such infections . Nursing staff will monitor residents for signs and symptoms that may suggest infection . The nurse will notify the Attending Physician and the Infection Preventionist of suspected infections . The Infection preventionist will collect data . The Infection Preventionist or designee will gather and interpret surveillance data. The surveillance should include a review of any or all of the following information to help identify possible indicators of Healthcare-Associated Infections: laboratory records, skin care sheets, infection control rounds or interviews, infection surveillance sheets, temperature logs, pharmacy records, transfer log/summaries . all positive blood cultures . wound cultures . urine cultures . positive sputum . other cultures . All Group A streptococcus cultures . organize the data on a tracking log . Identify predominant organisms or sites of infection . compare prevalence . summarize the information . review . at the facilities QAPI monthly meetings . COVID-19 Resident Policy, dated [DATE] and updated [DATE], Policy: To implement infection control procedures to minimize chance for exposure to COVID-19 and to prevent the spread . Utilize CDC LTC Respiratory Surveillance Line List in addition to the infection control daily surveillance log, when there is an increased number of respiratory illnesses regardless of suspected etiology . positive Covid . don (put on) the following personal protective equipment (PPE) prior to entering the room: Gown, Face Mask, Eye protection . Gloves . The IJ Removal Plan was reviewed on [DATE] at 12:57 PM, with the Administrator, Corporate Nurse and Corporate Infection Control Nurse and contained the following: [DATE] The corporate/regional onsite IP nurse began to maintain the Infection Surveillance (Line listing) tracking for the residents and staff. The IC tracking and surveillance form began review five days per week in the IDT meeting to ensure completion and accuracy. Trends to be reviewed and addressed immediately with education and or increase surveillance. The line listing to be reviewed monthly in the QAPI meeting. [DATE] An ICP trained leader will be in the building until the ADN/IPC nurse has completed and received certification training will consist of the online CDC Infection Preventionist training through the Train Learning Network and orientation to the ICP role in the facility. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	[DATE] The facility tracker for employee's illnesses will be completed by each department head and will be forwarded to the IP nurse daily. The facility currently monitors staff signs and symptoms through the (Covid Screening) prior to clocking in. Education of the Department heads, Nursing Department, Kitchen, Housekeeping, Therapy, has been completed [DATE] and they began to educate their staff [DATE] on the updated call-in tracking log information. The tracking form was given to department heads for tracking call ins. The Covid screening system alerts facility leadership when any person entering the building identifies that they have symptoms of an illness. [DATE]-The orientation/education, of Infection Control for agency staff started [DATE] and will continue until the building is no longer requiring agency usage or if new agency staff is obtained. [NAME] Staff and Ancillary staff began education [DATE] prior to the start of their shift and monthly thereafter for all staff in-services on infection control practices as deemed appropriate. Education will include Covid Policies and procedures, as well as the CDC and CMS training materials on proper PPE donning and doffing, proper utilization based on Covid status and community positivity rates along with the facility policy. [NAME] Care staff will complete a monthly COVID in service in Relias and this in service. All agency staff will be required to sign off stating that have completed COVID-19 education prior to working at the facility. [DATE] Education included appropriate IC practices including, use of PPE for all staff including a gown and gloves when entering the Covid unit, correct PPE per unit (Yellow) for staff, hand washing, donning and doffing. All staff began education using the COVID zone stop lights. Stop lights to be prominently displayed for staff reference. Each room door will have a sign identifying red, yellow, green with the required PPE needed to enter, based on Covid-19 requirements. [DATE] Dietary staff were educated on what hall to use when transporting food carts. Dietary staff members were educated how to transport food while limiting the potential for cross contamination between zones. In the month of February 2022, staff began training on computer modules for PPE and Infection Control Policy review in conjunction with current education. [DATE] Re-education was completed with staff regarding proper PPE usage: including the proper way to wear a mask, what PPE is required for each zone and proper donning and doffing. [DATE] facility staff began education on when the Covid testing will take place and where on Tuesday and Fridays, from 8 am to 4 pm for staff in the large conference room. Notes will be posted on where and when the Covid test will be completed. All tests will be performed by trained care team members. Education regarding social distancing during testing. [DATE] The facility began scanning the results of the Covid testing into the Resident's medical record. It was also placed on the line listing for the tracking of infection for the residents. [DATE] The line listing for Covid residents was completed and ongoing, the line listing for other infections will continue to be monitored and updated daily. The facility is now tracking negative and positive results for the residents. This information will be reviewed five days per week in the IDT meeting. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	[DATE] AD HOC QA was completed for the IJ on Infection Control. [DATE] An ICP trained leader will be in the building until the ADN/ICP nurse has completed and received the certification of completion and ongoing orientation with the regional ICP nurse. Substantial compliance has been achieved.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Numbers MI00124773 and MI00125680. Based on interview and record review, the facility failed to ensure that a process was in place to assess residents for Covid-19 vaccination status and offer Covid-19 vaccinations to the residents, resulting in the potential to expose residents to the Covid-19 virus, which could lead to very serious illness, hospitalization and death. Findings Include: Centers for Disease Control and Prevention (CDC), dated February 24, 2022 Covid-19 Vaccines for Long-Term Care Residents: Residents of long-term care (LTC) settings ages 5 years and older are recommended to get vaccinated against Covid-19 . Many LTC settings, such as residential care, assisted living, nursing homes and continuing care retirement communities provide care to older adults with underlying medical conditions, often living closely together These medical conditions and living situations can make residents more likely to be infected by the virus that causes Covid-19 and to become seriously ill from Covid-19 . Nursing homes are required the Centers for Medicare and Medicaid Services (CMS) to monitor weekly Covid-19 vaccination data for residents . Staying up to date means getting all recommended Covid-19 vaccines, including a booster shot when eligible. People who are moderately or severely immunocompromised have specific Covid-19 vaccine recommendations which include an additional third dose to complete their primary series, as well as a booster shot for those eligible . . Consent or assent for a Covid-19 vaccine will be given by LTC residents (or people appointed to make medical decisions on their behalf called a medical proxy) and documented in their charts per the provider's standard practice . The federal government is providing the vaccine free of charge to all people living in the U.S., regardless of their immigration or health insurance status . A record review of the facilities report titled, Immunization Report, dated 1/24/22 with a date range of 1/1/22-1/31/22, identified 17 residents from a census of 93 that were documented to receive a Covid vaccination. All were dated 1/5/22. On 1/24/22 at 1:35 PM during entrance conference with the Administrator, she was asked the name of the facilities Infection Prevention and Control Nurse. The Administrator said the Director of Nursing was filling the role on an interim basis, but they had just hired Nurse OO. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/24/22 at 2:20 PM, former Director of Nursing (DON) Q and Nurse OO were interviewed. Nurse OO said he had been at the facility for 3 days and had no training or experience in Infection Control. Nurse Q said she was working a Nurse on the floor that day. When asked if she often worked on the floor she said, Yes. When asked who had been overseeing Infection Prevention and Control, she said no one had been. On 1/26/22 at 10:15 AM, Corporate Nurse DD and Corporate Infection Control (IC) Nurse CC were interviewed about Covid-19 vaccinations for the residents. Nurse DD stated, They are offered on admission if they haven't had them in the past and they we should offer them monthly. The Corporate nurses were asked about Covid-19 Booster vaccines and she replied, They ask on admission and then we let pharmacy know. A record review of the facility report titled, Immunization Report, dated 1/27/22 with a date range of 9/1/21 - 1/31/22, identified 16 residents from a census of 93 (17%) that were documented to receive a Covid vaccination. All were dated 1/5/22; 11 of the 16 were documented Historical but still had the date 1/5/22. There were 68 residents of 93 listed on the report as having some type of vaccination (Influenza, Pneumococcal, Covid) or TB test. Twenty- five residents (26%) had no vaccination status documented. During the month of January 2022, there was a Covid-19 outbreak at the facility and 52 of approximately 93 facility residents tested positive for Covid-19. Further record review of 3 of the 16 residents (#'s 5, 17, 33,) who had Covid-19 vaccinations documented and 1 resident (#35) who had no documented Covid-19 vaccination, consent or refusal revealed the following: Resident #5 was admitted to the facility on [DATE] with diagnoses: History of a stroke, hemiplegia left side, asthma, atrial fibrillation, neuropathy, depression, anxiety, hypertension and GERD. The Immunizations tab in the electronic medical record (EMR) identified one immunization Covid-19 Vaccine Dose 2; Date Given 1/5/22; Consent Status Complete. There was no indication for when the resident received the 1st dose of Covid-19 vaccine. Resident #5 tested positive for Covid-19 on 1/17/22. Resident #17 was admitted to the facility on [DATE] with diagnoses: Alzheimer's, history of a stroke, bipolar disorder, COPD, chronic kidney disease, anemia, gout, arthritis, neuropathy and GERD. A review of the immunizations received by the resident indicated documentation of Covid-19 Vaccine Dose 2, Administered: 1/5/22. There was no documentation for when the resident received the 1st Covid-19 vaccination. He had lived in the facility since 2/1/21. Resident #33 was admitted to the facility on [DATE] with diagnoses: Diabetes, dialysis, end stage renal disease, anemia, morbid obesity, depression, anxiety and heart disease. A review of the immunization received by the resident indicated documentation of Covid-19 Vaccine Dose 2 (Hx) (history) Consent status: Historical; Administered Info: 1/5/22. This entry is contradictory as it says historical meaning sometime in the past and then said it was given 1/5/22. There was no clarifying information. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #35 was admitted to the facility on [DATE] with diagnoses: Dementia, dysphagia, kidney disease, a gastric tube, Stage 4 pressure ulcer. A review of the immunizations received by the resident indicated no documentation of a Covid-19 vaccination or that she was offered the vaccination. The resident contracted Covid-19 infection on 1/24/22. On 3/3/22 at 11:15 AM, Corporate IC Nurse CC was interviewed about the facilities process for Covid-19 vaccinations. She said a resident Covid-19 vaccination clinic had been scheduled and was canceled. There was no future date for a vaccination clinic. She also said the new Infection Prevention and Control Nurse had resigned 3 days prior. Upon request of a Covid-19 vaccination policy for residents on 1/24/22, the facility provided a Covid-19 Resident Policy, dated March 2020; Updated June 2020, review of the facility policy provided no information about Covid-19 vaccinations for residents as it had not been updated with this information. The policy was almost 2 years old. The policy did reveal, Policy: To implement infection control procedures to minimize chance for exposure to Covid-19 and to prevent the spread . (section) 2.e. Per current CDC guidelines, if all residents in an area are fully vaccinated, social distancing and masks are not required . There was no further information related to the facilities process for ensuring Residents were offered the choice to have a Covid-19 vaccination or Booster vaccine if they were eligible.