STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 34275 Based on interview and record review, the facility failed to provide adequate and timely resolutions to grievances expressed by the resident council for 14 residents who attended the confidential resident council interview, resulting in unresolved complaints from residents. Findings include: Review of the facility's Resident Council minutes provided by the facility from 8/3/22 to 11/20/22 identified multiple environmental concerns, food concerns including not filling up coffee cups, food not being cooked or provided as requested and staff taking breaks at the same time and therefore not addressing concerns resulting in residents remaining wet and an odor in the building. On 12/20/22 at 11:30 AM, a confidential interview was conducted with 14 members who reported they either sometimes or frequently attended the resident council meeting in the facility. During the interview, the residents reported multiple complaints that were expressed in previous resident council meetings that have not yet been resolved. When asked about the facility's response to their concerns, it was reported that staff indicated they were going to follow up, but the concerns remained unresolved. During the confidential group meeting it was reported by multiple residents that food was an ongoing concern. Examples provided included, residents not always receiving what they requested, not receiving full cups of coffee and the food often was cold. Several residents reported that snacks sometimes are not passed out. The residents also noted that prior to the facility being taken over by another company they were able to contact the kitchen via either their phone or the facility phone to express concerns and/or make requests. When asked about concerns pertaining to the facility's environment. Residents reported that there was a general smell in the facility and specifically linens smelled like poop. Further bathrooms and showers rooms were not being cleaned. One resident reported a leaky ceiling. Multiple residents expressed concerns about being treated with dignity and respect as the Certified Nursing Assistants (CNAs) often would go on break at the same time leaving them without staff. Several residents expressed a specific concern about CNA C and reported that they were rude to them and at times would not addresses any of their needs. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When asked about whether these concerns had been brought up during resident council meetings, the residents reported it had. When asked about the facility's response to these concerns, they reported it was not being addressed and had remained a concern. On 12/20/22 at approximately 3:16 PM an interview was conducted with Activity Director (AD) N. When asked whether certain issues including food, environment and staffing issues had been addressed, AD N reported that she was aware of the concerns and noted that they had been forwarded to the Dietician, Administrator and other staff members. On 12/21/22 at approximately 4:04 PM, an interview was conducted with Dietary Manager (DM) CC. When asked if they were aware of the grievances/concerns expressed by the Resident Council, DM CC noted that they were. She expressed that they had been working on concerns but thought in terms of food temperatures it is our of her hands once the food leaves the kitchen and it is up to the staff to ensure it is served timely. With respect to other issues pertaining to food she did not that if food received is not in good standing then it is returned and alterations in the menu are made. On 12/21/22 at approximately 5:07 PM the Administrator was asked if he was aware of concerns expressed by the Resident Council. The Administrator reported that he was and noted that the facility has been operating with a limited staff, specifically with housekeeping and noted that most likely was what caused issues regarding the environment. With respect to CNA C the Administrator noted that they were aware of the concerns.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 30675 This citation pertains to intake #: MI00131289 and MI00132464. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, safe and homelike environment throughout the building. Findings include: On 12/19/22 at 8:40 AM, upon entry to the nursing unit from the lobby, it was noted the unit had a smell of urine about the air. On 12/19/22 at 10:13 AM, the bedside table in room [ROOM NUMBER]-1 was observed to have the vinyl overlay peeled off leaving a porous particle board type surface that did not appear to be smooth and easily cleanable. On 12/19/22 10:28 AM, the bathroom for room [ROOM NUMBER] was observed to have a yellow/brown soiled ceiling tile above the toilet that appeared soggy and drooping. On 12/19/22 at approximately 10:45 AM, a resident who wished to remain anonymous verbalized complaints about the unit's shower room conditions. They indicated the toilet seat was broken and they were afraid they would fly right off of the seat. On 12/19/22 at 10:54 AM, an observation of the bathroom for adjoining rooms [ROOM NUMBERS] revealed a soiled bed pan in the corner near the toilet, the ceiling tiles were stained, used toilet paper was discarded on the floor and the safety grab bars on the toilet were extremely loose. On 12/19/22 at 10:58 AM, a review of the shower room on the 1 East unit was conducted and revealed the following: The general odor in the room was musty, The bathroom in the shower room revealed a toilet seat that was broken and no longer attached to the bowl as mentioned by the anonymous resident. The broken toilet seat and grab bars were soiled with yellow and brown stains. The toilet bowl and base were smeared with brown stains. The ventilation fan in the bathroom had a thick build-up of gray dust debris. The tiles around the shower drain were broken and removed. Green algae appearing water was observed pooled in the area of the missing tiles. The grout/caulk in the shower where the tile walls met the floor had a build-up of brown/black debris. On 12/19/22 at approximately 11:05 AM, a review of the central unit shower room was conducted and revealed an area of the tile wall near the shower head covered with plastic and blue painter's tape. One of the ceiling tiles above the shower was observed (with/growing) a green unidentified substance. The door knob to the bathroom inside the shower room was extremely loose, two of the three vanity light bulbs in the bathroom were burned out, no paper towel was available in the bathroom, and the ceiling tile that contained the air vent was stained brown. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/22 at 1:19 PM and 12/20/22 at approximately 8:30 AM an observation of the 1 [NAME] shower room revealed a hole punched in the bathroom door inside the shower room, and a constantly flushing toilet with soiled toilet paper swirling in the bowl. An attempt to flush the toilet was made and it was discovered the hardware could not be engaged to flush the toilet. The linen cart in the shower room revealed clean linen falling from the cart in contact with the shower room floor. The white protective cover for the clean linen cart was observed to be dingy and soiled with unidentified brown and black stains. On 12/20/22 at 8:06 AM, room [ROOM NUMBER] was observed with strong odor of bowel movement and stains on the walls and privacy curtains. On 12/20/22 at 8:07 AM, room [ROOM NUMBER] was observed to have used gloves discarded on the floor near the end of the unoccupied bed. The bed linens were observed torn and frayed in room [ROOM NUMBER]. On 12/20/22 at 8:08 AM, room [ROOM NUMBER] had soiled privacy curtains with dark stains throughout the curtain surface. On 12/20/22 at 8:10 AM, observation of the 2nd floor shower room revealed: There was a shower chair that had piles of shredded brown paper towel and tissue paper scattered on the seat of the shower chair and surrounding floor tiles; There was dark colored mold like build up around the floor tiles in the shower area; The separate toilet area in the shower room was observed to have very low lighting; There was a brown fecal-like substance smeared on the wall tile near the entrance to the shower area; There were several unlabeled, used disposable razors and bottles of lotion and shampoo on the half wall of the shower area. On 12/20/22 from 9:20 AM to 10:15 AM, an environmental tour was completed with the Maintenance Director (Staff 'AA') who reported they had been in that role since December 2021. Staff 'AA' reported the Housekeeping Manager (Staff 'BB') was not currently at the facility, but they were responsible for overseeing their duties as well. Staff 'AA' reported they had recently hired an additional maintenance staff a few weeks ago. When asked about the facility's reporting process for when there were environmental concerns such as broken toilets, rails, lights, etc., Staff 'AA' reported there was an electronic system that staff would notify any issues or concerns and if it's an emergency, they can call them immediately. Staff 'AA' further reported the facility had managers assigned to the resident rooms that were supposed to also identify if there were concerns, but indicated that may not have been occurring as it should've been. The following were observed during the environmental tour with Staff 'AA' (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1 east hallway had two of the eight fluorescent ceiling lights not working which created dark, shadowy sections throughout the hallway; At 9:25 AM, the 1 east shower room: The handrail in the shower area was observed to be exposed rusted, sharp pieces of metal; Staff 'AA' reported that didn't just happen and should've been reported. The shower handle to turn the shower on was broken; The toilet seat was broken and poorly positioned on the toilet bowl; There was no toilet paper or paper towels available for use; There were several ceiling tiles stained brown (from previous leaks according to Staff 'AA'); The vent above sink and bathtub was heavily covered with dust; When asked to use the toilet paper to test if the vent was functioning, there was none available; The tiles in the shower drain were broken with pooling water and the surrounding grout was observed to have pinkish, blackish colored buildup of a mold-like substance; At 9:36 AM, the 1 [NAME] shower room: There was broken, chipped and sharp tile near the bottom of the shower wall; The clean linen cart was stored inside the shower room and was observed to have a fabric covering that was heavily soiled with dark black and brownish colored stains/dirt; Additionally, there was an opened bag of briefs stored inside on top of the linens; Staff 'AA' reported they would have to remove the linen cart covering off to clean and replace. There were multiple unlabeled bags of resident's personal items (clothing/bags/briefs) stored in the corner of the shower room; The toilet in the bathroom located in the shower room was observed to be continuously running (water swirling with toilet paper in the toilet bowl); The left side arm on the elevated toilet seat was observed broken and hung down towards the floor; The wall light which contained four light-bulbs above the hand sink was missing a light bulb; The back of the toilet contained a light bulb and broken piece of the toilet paper roll holder; The toilet paper roll holder was broken and in pieces; The soap dispenser was empty and a container of liquid soap was resting on top of the paper towel holder; Staff 'AA' reported that should have been placed inside, not on top. At 9:44 AM, the 1 Center/South shower room: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The tile around the shower handle was observed missing with blue tape and clear wrap covering over the missing tile pieces; Staff 'AA' reported that was from missing tile that needed to be replaced. When asked who did that and how long, Staff 'AA' reported that was from the former maintenance staff and had been like that for a while now. The bathroom portion of the shower room had multiple ceiling tiles that were water damaged (stained brown and buckling down); There were two light bulbs out and lighting was very dim/dark; There was no paper towel available for use in the dispenser; There were multiple light bulbs out throughout the shower room. At 9:50 AM, the 2 East shower room was observed with: The ceiling tile above entry just inside the shower room was buckled/bowed down; Staff 'AA' pushed the soiled tiles back up into position but reported that should've been replaced. The shower seat observed earlier was now placed near the storage locker area and observed to still have wadded up toilet paper pieces and several clumps of dark hair on and around the attached toilet seat; Staff 'AA' reported that had not been cleaned properly. The dark brown fecal like substance remained on the wall tile near the shower area; When asked about it, Staff 'AA' left the shower room to get a washcloth and wiped off what they described as fecal matter and reported staff had done an improper job of cleaning. The light above the bathtub area had only one light bulb working making it very dim/dark; There were three unlabeled/used disposable razors on the shower ledge; a 4 oz (ounce) bottle of baby oil and 1.3 oz bottle of shaving cream (no label for which resident/who they belonged to); Staff 'AA' reported reported those should not be stored there and was unsure who they were for. At 10:05 AM, room [ROOM NUMBER]'s linens were observed in the same manner as yesterday. Staff 'AA' confirmed the large, frayed holes in the blankets and reported those should be thrown out if the staff see that when they make up the bed. When asked if there was any concern with linen supply shortage, Staff 'AA' reported No. The bed linens in room [ROOM NUMBER]-A were observed ripped (in place since day one of the survey); Staff 'AA' reported the bed linen should've been replaced. The lights above the resident's bed in room [ROOM NUMBER]-2 was observed to have a pull cord that was too short and unable to be accessed by the resident; Staff 'AA' reported that could be replaced with a longer cord. Staff 'AA' was asked about the soiled floors observed throughout the survey and during this environmental tour and they reported that should be part of daily housekeeping. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]-1 was observed with Staff 'AA' and informed that the food debris remained on the floor from the day before. When asked about the hand sink in the kitchen, Staff 'AA' reported the lack of hot water at that hand sink had been identified last week and there was an issue with the water heater and the part had arrived yesterday, but still needed to be installed. Staff 'AA' was asked to provide any documentation of estimates/invoices and audits for environmental monitoring, however there was no further documentation provided by the end of the survey. 34275 Review of the facility's Resident Council minutes provided by the facility from 8/3/22 to 11/20/22 identified multiple environmental concerns, including, but not limited to odors in the facility and linen that smelled like poop. On 12/20/22 at 11:30 AM, a confidential interview was conducted with 14 members who reported they either sometimes or frequently attended the resident council meeting in the facility. When asked about concerns pertaining to the facility's environment. Residents reported that there was a general smell in the facility and specifically linens smelled like poop. Further bathrooms and showers rooms were not being cleaned. On 12/21/22 at approximately 5:07 PM the Administrator was asked if he was aware of concerns expressed by the Resident Council. The Administrator reported that he was and noted that the facility has been operating with a limited staff, specifically with housekeeping and noted that most likely was what caused issues regarding the environment. According to the facility's policy titled, Safe and Homelike Environment dated 1/11/2021: .In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment .this includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk .Adequate lighting means levels of illumination suitable to tasks the resident chooses to perform or the facility staff must perform .Comfortable lighting means lighting that minimizes glare and provides maximum resident control, where feasible, over the intensity, location, and direction of lighting to meet their needs or enhance independent functioning .Environment refers to any environment in the facility that is frequented by residents including (but not limited to) the resident's rooms, bathrooms .Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment .the facility will provide and maintain bed and bath linens that are clean and in good condition .The facility will provide and maintain adequate and comfortable lighting levels in all areas .The Maintenance Director will perform periodic rounds to ensure functioning lights .Even light levels should be utilized in common areas and hallways to avoid patches of low light .Report any unresolved environmental concerns to the Administrator . 47128 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/22 AT 01:45 PM there was a strong, foul odor throughout the 2 East unit, as well as a red, sticky substance on the floors throughout the hallway. On 12/20/22 at 4:45 PM the red, sticky substance was still on the floor. Throughout the day on 12/21/22, the red, sticky substance was still on the floor. On 12/19/22 at 11:33 AM, room [ROOM NUMBER] was found to smell strongly of urine. There were also dirty linens in front of the heating unit under the window. On 12/19/22, beds 200-1, 206-1, 207-1, and 207-2, had soiled privacy curtains. On 12/19/22, beds 204-1, 208-1, and 208-2 had fall mats that had cracks in the vinyl covering and were soiled. On 12/19/22, rooms 201, 202, 204 had broken blind slats. On 12/19/22 at 10:26 AM room [ROOM NUMBER]-2 bed was not made, with sheets and clothes, some in bags, piled on the bed. There was a bag of clothes on the chair across from the bed, and other bags of items wedged between the bed and the wall. Bags of items were sitting on the window still. There was a gown woven/tangled in the window blinds. On 12/19/22 at 10:30 AM a CNA was interviewed regarding the condition the condition of room [ROOM NUMBER]-2, who indicated that the resident rearranges her room and packs up things every day. When asked how this is monitored in the facility, the CNA indicated that staff check on it periodically. When asked about the gown woven in the blind, the CNA state that normally her aid will take it down and (the resident) will put it back. The CNA indicated that she saw the gown in the blind this morning. CNA indicated that she was not assigned to work with the resident, but would let the assigned CNA know. On 12/19/22 1:17 PM The resident in room [ROOM NUMBER]-2 was resetting in bed with multiple tangled blankets. Items were still in bags throughout the room. The gown was still woven into the window blinds. At 2:40 PM, the room was in the same condition. On 12/19/33 at 10:39 AM the resident in room [ROOM NUMBER]-2, who has a feeding tube, was observed. Tube feeding formula was found dried on the tube feeding pump, pole, and stand. [NAME] and brown spots (likely tube feeding formula) were found on the front and surface of the two tables located along the wall to the right of the bed. On 12/19/22 at 2:40 PM dried tube feeding formula was still on tube feeding pump, pole, and staff, and the stains remained on the two tables. On 12/19/22 at 3:04 PM Unit Manager, K was taken to room [ROOM NUMBER]-2 and showed the dried formula. She indicated that it should be cleaned and stated she would clean it. On 12/20/22 at 9:33 AM and 10:34 AM the white and brown spots were still on the bedside tables.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to protect the resident's right to be from resident to resident sexual abuse, resulting in unwanted sexual touching from R90 to R16 using the reasonable person concept. Findings include: R16 On 12/19/22 at 11:02 AM, R16 was observed lying in bed and upon approach, closed their eyes. When asked simple questions, R16 did not respond verbally, and proceeded to close their eyes. Multiple attempts to talk with R16 on 12/20/22 were unsuccessful. Review of the clinical record revealed R16 was admitted on [DATE], readmitted on [DATE] with diagnoses that included: encephalopathy, anxiety disorder, unspecified dementia with other behavioral disturbance, schizoaffective disorder bipolar type, other seizures, and insomnia. According to the Minimum Data Set (MDS) assessments dated 9/24/22, R16 had impaired short- and long-term memories with severely impaired decision making skills. R90 On 12/19/22 at 10:58 AM, R90 was observed lying in bed talking to staff that were seated in a chair at the end of the bed. According to staff, R90 had a 1:1 staff assigned to provide 1:1 supervision due to an incident with another resident approximately one week ago. Review of the clinical record revealed R90 was admitted into the facility on [DATE] with diagnoses that included: unspecified dementia without behavioral disturbance, psychotic disturbance mood disturbance, and anxiety. According to the MDS assessment dated [DATE], R90 had severe cognitive impairment (scored 6/15 on Brief Mental Status Exam/BIMS) and had no mood or behavior concerns. On 12/20/22 at approximately 8:30 AM, the Administrator was requested to provide any documentation of incident/accidents for R16 and R90. Review of the facility's investigation dated 12/16/22 included: .Date of Occurrence: 12/11/22 .Time of Occurrence: 3:15pm .Analysis: (Name of R90) is a [AGE] year old male admitted to (facility name) on 9/7/22 .Resident is alert and oriented x 1-2. His BIMS score is 7 which indicates severe cognitive impairment. Resident is ambulatory and requires supervision to limited assistance with care. per section B of the MDS, the resident makes himself understood and the ability to understand others. Resident has had no sexual related incident while a resident at (facility) . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.(Name of R16) is a [AGE] year-old female admitted to (facility name) on 4/22/16 .Resident is alert and oriented x 1-2. Her BIMS score is 1 which indicates severe cognitive impairment. Resident uses wheelchair for locomotion and requires extensive assist with care. Per section B of the MDS, the resident usually makes herself understood and the ability to understand others. Resident has had no sexual related incidents while a resident at (facility name). .According to staff interviews, witness statements, and record review (Staff 'T') housekeeper, was entering the 2 East dining room and observed (R90) with his hand in (R16) pants. (Staff 'T') immediately removed (R16) from the room, taking her to the nurse's station and reported it to (Nurse 'U'). (Nurse 'U') immediately notified (Name of Administrator). (R90) was placed with 1:1 supervision. The facility completed a head-to-toe skin assessment on both residents. No skin issues or physical injuries were identified to either resident during the skin assessment. The resident's voiced no complaints of pain. There were no psychosocial changes noted to (R16) and she reports feeling safe at the facility Police Department was notified . Conclusion: The facility was able to substantiate that (R90) put his hand in)R16) pants. (R16) day-to-day activities are unchanged. There has been no physical harm, pain, or mental anguish observed by the resident. No skin issues or physical injuries were identified during skin assessment. The resident voiced no complaints of pain, nor was there any mental anguish or psychosocial changes noted after the incident. Resident reports feelings safe at the facility. Therefore, Abuse cannot be substantiated . On 12/21/22 at 8:35 AM, an interview was conducted with Staff 'T'. When asked to recall the incident with R16 and R90, Staff 'T' reported they were completing their last rounds for housekeeping when they came into the dining room on 2 east there were several other residents in the area, without staff and when they entered the room R90 had his hand down R16's front side of their pants. Staff 'T' was unable to recall exactly how far down R90's hand was, but they reported they immediately said to R90 to get get your hands our to her pants and immediately took R16 to the nurse. On 12/21/22 at 9:15 AM, an interview and record review was conducted with the Administrator (who is also the facility's Abuse Coordinator). Upon review of the facility's investigation and when asked about how it was determined that sexual abuse did not occur, the Administrator reported since there was no psychosocial outcome or any physical injuries, they felt it wasn't substantiated. According to the facility's policy titled, Abuse, Neglect and Exploitation dated 3/28/2022: .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes .sexual abuse .Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Sexual Abuse is non-consensual contact of any type with a resident .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake number MI00132464. Based on observation, interview, and record review, the facility failed to provide activity of daily living care for four residents (R#'s 39, 46, 64, and 94) of eight residents reviewed for activities of daily living, resulting in verbalized complaints and feelings of embarrassment. Findings include: R39 On 12/19/22 at 9:46 AM, R39 was observed in their bed. At that time, they were asked about their time in the facility and verbalized complaints they had not received a shower. On 12/20/22 at 9:38 AM, a review of R39's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: heart failure, sepsis, and anxiety disorder. R39's Minimum Data Set (MDS) assessment dated [DATE] revealed R39 was cognitively intact, non-ambulatory, and required extensive assistance from one to two staff members for bed mobility, transferring, wheelchair mobility, toilet use, hygiene, and bathing. Continued review of R39's record included a review of R39's Certified Nursing Aide (CNA) task for bathing for a 30-day look-back period and revealed only 3 entries dated 11/24/22, 12/1/22, and 12/8/22. It was noted the responses for the type performed (shower, bed bath, bath, resident not available, resident refused, and not applicable) on each of the three entries was documented and Not Applicable. R46 On 12/19/22 at 10:14 AM, R46 was observed in their room in bed. At that time, R46's right hand was contracted into a fist and the nails on the right and left hand were observed to be long in length, extending well beyond the base of the fingertip. R46 was asked if it was their preference to keep their nails long and said, No, I would love to get them chopped. R46 was asked if they received their showers and said they did, but no one assisted them regularly with nail care. On 12/20/22 at 9:14 AM, a review of R46's clinical record was conducted and revealed they admitted to the facility on [DATE] with diagnoses that included stroke, hemiplegia affecting the right side, schizoaffective disorder, and anxiety disorder. R46's most recently completed MDS assessment dated [DATE] revealed R46 had intact cognition, did not exhibit any behaviors, was non-ambulatory, and required extensive assistance from one staff member for personal hygiene and bathing. A review of R46's CNA task for nail care for a 30-day look-back period was conducted and revealed one entry on the task dated 12/17/22 that indicated R46 refused. 34275 R64 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/22 at approximately 10:27 AM, R64 was observed in their room in bed. At that time, R64's right hand was contracted into a fist and the nails on the right and left hand were observed to be long in length, extending well beyond the base of the fingertip. R64 was asked if they liked having long fingernails and the resident reported that they wanted them trimmed. When asked if they were receiving showers, the resident stated mostly, but had just been put on precautions and had not had a shower in a week or so. A review of R64's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: hemiplegia following cerebral infarction affecting right dominant side, difficulty walking and major depressive disorder. A review of R64's MDS revealed the resident had intact cognition and required extensive one person assist for most ADLs, including personal hygiene and bathing. A review of R64's CNA task for nail care for a 30-day look-back period was conducted and nothing over the past 30 days was noted. The resident's shower sheet for the past 30 days noted the last shower provided was on 12/15/22. On 12/21/22 at approximately 10:11 AM an interview was conducted with the Physical Therapist (PT) FF. When discussion the residents contracted right hand and lack of nail care, PT FF noted that it is very important for all residents to have proper nail care, but it is specifically important that residents that have contracted hands that their nails are kept short and clean, so they do not dig into their hands. A facility policy titled, ADL-Basic Care Services (June 1, 2022) documented, in part: .Residents are assisted with morning and evening care as needed, which may include but is not limited to the following: .Oral Care . Shaving .Hair care . 47128 R94 Review of the clinical record revealed that R94 was admitted to the facility on [DATE]. Diagnoses include unspecified psychosis, schizophrenia, and hypertension. The most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that R94 is severely cognitively impaired. Per this assessment, R94 required extensive assistance of one person for personal hygiene (e.g., combing care, brushing teeth, shaving. R94 was also noted to require extensive assistance for bathing, dressing, and toileting. This quarterly MDS assessment also indicated that R94 did not have any mood or behavior concerns in the 7-day period prior to the assessment date, including refusing ADL care. Multiple observations of R94 were made (12/19/22 at 11:19 AM, 12/19/22 at 1:12 PM, 12/20/22 at 10:30 AM, 12/20/22 at 12:00 PM, 12/20/22 at 1:17 PM (CNA KK was present), 12/21/22 at 8:50 AM, 12/21/22 at 4:03 PM), and with each observation, R94 was found to have whiskers on her chin. On 12/20/22 at 10:10 AM an interview was conducted with CNA KK. CNA K indicated that R94 requires two-person assistance when providing care, and she calls out a lot. CNA KK reported that she waits to provide care until about 20 minutes has passed since R94 is given pain medication, and expressions of pain are reported to the nurse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/21/22 at 8:56 AM another interview was conducted with CNA KK at patient's bedside. When asked about shaving the whiskers on R94's chin, CNA KK indicated the this should be addressed when needed. When CNA KK was told about the many observations that R94 had whiskers on her chin and that R94 had whiskers on her chin at that moment, CNA KK did not respond. Note above that at 4:03 PM, resident still had whiskers on her chin. On 12/21/22 at 9:03 AM an interview was conducted with Unit Manger K. When asked about shaving residents, Unit Manager K indicated that staff should be shaving residents when needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation contains 2 Deficiency Practice Statements. DPS #1 Based on observation, interview, and record review, the facility failed to ensure assistance with placement of a compression sleeve for the treatment of edema for one resident (R39), of one resident reviewed for edema, resulting in verbalized complaints of arm swelling and pain. Findings include: On 12/19/22 at 9:46 AM, R39 was observed in their bed. At that time, an interview was conducted and R39 said facility staff had been promising them a sleeve for their left arm and hand. It was observed R39's left arm and hand were visibly swollen in comparison to their right, and R39 said the swelling had been causing them discomfort and pain. On 12/20/22 at 9:00 AM, R39 was observed in bed asleep. R39's left arm was elevated on a pillow and appeared edematous (swollen) compared to their right. On 12/20/22 at 9:38 AM, a review of R39's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: heart failure, sepsis, and anxiety disorder. R39's Minimum Data Set assessment dated [DATE] revealed R39 was cognitively intact, non-ambulatory, and required extensive assistance from one to two staff members for bed mobility, transferring, wheelchair mobility, toilet use, hygiene, and bathing. Continued review of the record revealed an order dated 11/16/22 for a diagnostic test to rule out a blood clot in the left arm, as well as a Nurse Practitioner note dated 12/13/22 that read, .seen for eval (evaluation) L (left) arm swelling .recent doppler neg (negative) for DVT (blood clot), still swollen despite elevating .LUE (left upper extremity)/hand edema .hand and arm sleeve to be ordered . The record further documented an order from the Nurse Practitioner dated 12/13/22 for a left arm compression sleeve for left arm edema. A review of R39's Medication Administration Records (MAR) and Treatment Administration Records (TAR) was conducted and included an order to ensure the left arm was elevated, but did not include any orders to ensure R39 had a compression sleeve applied. On 12/20/22 at 12:05 PM, R39 was observed sleeping in bed. They were not observed to have a compression sleeve applied to their left arm despite an updated care plan intervention dated 12/20/22 that read, .left arm compression sleeve . On 12/20/22 at 12:10 PM an interview was conducted with Licensed Practical Nurse (LPN) 'B' (R39's assigned nurse) regarding R39's compression sleeve. LPN 'B' checked R39's MAR and TAR and said no orders were on them for a compression sleeve. LPN 'B' was then asked to check R39's order list and confirmed there was an order for the sleeve. LPN 'B' reviewed the order and explained it had not been transcribed correctly to prompt documentation on the MAR or TAR, so nurses would not know to apply the sleeve and document the application. 47128 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DPS #2 Based on interview and record review the facility failed to coordinate care with a hospice agency for one (R27) of one resident reviewed for hospice care. Findings include: Review of the clinical record revealed that R27 was admitted to the facility on [DATE]. Diagnoses include stroke, Alzheimer's disease, hypertension, anxiety, hypothyroidism, depression, and psychotic disorder. Per the the most recent Minimum Data Set (MDS) assessment dated [DATE], the Brief Interview for Mental Status exam (a cognitive assessment) could not be completed as R27 is rarely/never understood. R27 was reported to have long and short-term memory problems. Further review found that R27 was admitted to Hospice JJ on 1/20/21. The hospice benefit election form was not found in the record. The only orders for hospice care on record where the consult and admission orders. The record did not contain a physician's recertification for hospice care. Additional review revealed the following: Last hospice nursing note was from 2/25/22, last IDG (hospice) comprehensive assessment and plan of care was from 12/28/21, and the last hospice progress note was from 3/14/22. No other documentation from the hospice agency was found, including current progress notes; the most recent hospice plan of care; and names and contact information for the hospice staff involved in R27's care. On 12/21/22 at 9:05 AM Unit Manager K was asked to provide documentation from Hospice JJ. She was not able to locate the information, which was indicated to be in a binder, and said she will look into it. On 12/21/22 at 12:03 PM an interview was conducted with Nurse S. When asked how he communicates with Hospice JJ, Nurse S indicated that he calls Hospice JJ when there are changes in R24's condition and that the hospice staff communicates with facility staff when they visit. When asked about hospice documentation, Nurse S reported that the hospice staff document in their laptop. Nurse S indicated that the binder on unit that contained R27's hospice documents had been missing for about a month. Nurse S indicated that he reported that missing binder, including to Unit Manager K and Hospice JJ staff, on more than one occasion. It had yet to be found or replaced. On 12/21/22 at 12:09 PM Unit Manager K was interviewed again. She indicated that she had been calling the Hospice JJ about the documentation. She was not aware of the missing binder. On 12/21/22 at 12:15 PM an interview was conducted with the DON. When asked about communication with hospice providers, DON explained that the hospice nurses communicate verbally with facility staff when they visit, and that hospice orders are given and then transcribed into the EMR. The DON stated, There are binders containing hospice documentation. The DON was not aware that R27's binder was missing. On 12/21/22 at 1:30 PM Unit Manager K provided R27's hospice binder. All documents showed a print date of 12/21/22. The facility was not able to provide evidence that the hospice records where onsite prior to when they were requested during this survey. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per a facility policy entitled Hospice Services Facility Agreement (revised 12/2021), The following information will be available from the hospice agency: a. The most recent hospice plan of care specific to each resident. b. Hospice election form. c. Physician certification and recertification of the terminal illness specific to each resident. d. Names and contact information for hospice personnel involved in hospice care of each resident. e. Instructions on how to access the hospice's 24-hour on-call system. f. Hospice medication information specific to each resident. g. Hospice physician and attending physician (if any) orders specific to each resident. Per the facility contract with Hospice JJ (dated 6/3/2021) Hospice shall furnish a copy of the Hospice Plan of Care of a Hospice patient upon admission and when updated to the Facility. Hospice shall preform ongoing assessments and periodic reviews of plans of care and conduct interdisciplinary care group meetings and conferences with Facility staff as necessary to coordinate provision of Facility services. Furthermore, this policy states, The Facility shall prepare and maintain medical records for each Hospice patient receiving services pursuant to this Agreement. The patient's medical record shall include, but is not limited to, progress notes, clinical notes, and physician orders describing a record of all services and events.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation has 2 deficient practice statements. DPS#1 Based on observation, interview and record reviews the facility failed to create a hazard free environment for one (R5) of three residents reviewed for accidents. Findings include: On 12/19/22 at 10:27 AM, R5 was observed sitting up in their wheelchair. R5's daughter entered the room and stated that R5 was not supposed to be sitting in their wheelchair alone without staff present due to a fall the resident had that required surgery and because the resident had dementia and a lot of confusion. A sign was observed on the wall above R5's bed that read not to remove chair while resident is in the bed. On 12/20/22 at 8:54 AM, R5 was observed lying in bed on their back awake and not responding to verbal stimuli. R5's bed was positioned against the wall in their room. The opposite side of the bed was observed to have a wheelchair and recliner chair positioned against the open side of the bed that was not positioned against the wall which created a barrier and accident hazard. On 12/21/22 at 9:40 AM, R5 was observed lying in bed with a shower chair propped up against the resident's bed. Review of the medical record revealed R5 was admitted to the facility on [DATE] with diagnoses that included: Aftercare following joint replacement surgery, dementia, cognitive communication deficit, fracture of upper end of unspecified femur and injury of hip. A MDS assessment dated [DATE] documented a BIMS score of 3 which indicated severely impaired cognition and required staff assistance for all ADLs. Review of the preadmission hospital paperwork provided to the facility upon R5's admission documented the resident had a history of falls and was status post ORIF (Open Reduction and Internal Fixation) due to a right femur fracture obtained from a fall. On 12/21/22 at 11:31 AM, the Administrator and Director of Nursing (DON) was interviewed and asked about the chairs observed propped up against R5's bed in the mornings creating barriers to prevent the resident from getting out of the bed and the DON and Administrator stated they have never witnessed the chairs propped up against the residents bed. The Administrator and DON was also asked why there was a notice above the resident's bed that documented to not remove the chair while resident was in bed, both denied to having observed the notice on the wall. The Administrator stated they were headed down to the residents room to review the notice. The DON stated they would look into it and follow back up. At 1:37 PM, the Administrator returned with the facility's Therapy Director (TD) H. The Administrator stated they did see the notice on R5's wall and that R5 will be assessed for a different mattress to prevent falls. The Administrator stated the facility will place a floor mat on the side of the bed and will implement additional interventions to prevent any future falls. The Administrator stated they will ensure this is done immediately. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further explanation or documentation was provided by the DON before the end of the survey. 30675 DPS#2 Based on observation, interview and record review, the facility failed to ensure timely/completed assessments and investigations into falls, and identify and implement appropriate fall interventions for one (R16) of three residents reviewed for accidents, resulting in continued falls and the increased potentials for falls with serious harm and/or injury. Findings include: According to the facility's policy titled, Fall Reduction Policy dated 8/2021: .When any resident experiences a fall, the facility will .Complete a post-fall assessment .Complete an incident report .Document assessments and actions . On 12/19/22 at 11:02 AM, R16 was observed lying in bed and upon approach, closed their eyes. When asked simple questions, R16 did not respond verbally, and proceeded to close their eyes. Multiple attempts to talk with R16 on 12/20/22 were unsuccessful. There were no floor mats observed in use while the resident was lying in bed. Review of the clinical record revealed R16 was admitted on [DATE], readmitted on [DATE] with diagnoses that included: unspecified dementia with other behavioral disturbance, and displaced fracture of distal phalanx of right great toe, subsequent encounter for fracture with routine healing (as of 9/19/22). According to the Minimum Data Set (MDS) assessment dated [DATE], R16 had severe cognitive impairment, no mood or behavior concerns, had no falls since previous assessment of 4/1/22, and required extensive assistance of one person physical assistance with bed mobility and transfers. Review of the fall care plan initiated 4/10/28, revised 9/26/22 documented: I am at risk for falls r/t (related to) diagnosis of fracture, history of falls and poor safety awareness due to dementia. Interventions included: floor mat to right side of bed, initated 5/10/18, revised 7/1/21. High fall risk Anticipate and meet my needs, initiated 4/10/18, revised 7/1/21. This care plan had not been revised to include any review or revision of care plan interventions following R16's fall on 10/26/22. Review of R16's progress notes included: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An entry on 10/26/22 at 11:07 PM by Nurse 'Z' which read, resident was in the room at the time, resident was witnessed sliding out chair onto floor, writer was unable to help quick enough. resident was quickly assisted back in chair from writer and aide. resident was assessed and small abrasion was noticed on pt (patient) right upper leg. no other injuries was observed . An entry on 10/31/22 at 10:02 AM read, .Resident slide <sic> out of chair onto floor. Prior Interventions: Teaching/Educating was provided to lock w/c (wheelchair) and ask for assisting when transfer . On 12/20/22 at 3:51 PM, the Administrator was requested to provide any documentation of incident/accident reports and any investigations for R16 since September 2022. On 12/20/22 at 4:05 PM, the Administrator reported other than a resident to resident incident from 12/11/22, R16 has not had any other incidents. There was no additional documentation of R16's fall provided by the end of the survey. On 12/21/22 at 9:15 AM, an interview and record review was conducted with the Administrator. When asked about the facility's process for reviewing falls, they reported those were reviewed at their interdisciplinary team meetings. The Administrator was informed of the concern that there was no documentation provided for R16's fall on 10/26/22. When asked about the intervention identified in the anti-gravity note to remind the resident to lock their wheelchair and ask for assistance when transferring was appropriate for a resident with severe cognitive impairment, the Administrator reported that was not appropriate and an incident report should have been completed. On 12/21/22 at 1:45 PM, an interview was conducted with Nurse Manager 'K'. When asked about R16's fall on 10/26/22, their anti-gravity note and lack of incident/accident report, Nurse Manager 'K' was unable to recall any specific details or further explanation.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47128 Based on observation, interview, and record review, the facility failed to provide an effective pain management program for one (R94) of one resident reviewed for pain management, resulting in untreated pain that caused significant discomfort and negatively affected the resident's psychosocial well-being and functional status. Findings include: Review of the clinical record revealed that R94 was admitted to the facility on [DATE]. Diagnoses include unspecified psychosis, schizophrenia, hypertension, and unspecified knee pain. R94 was also reported to have dementia per physician progress notes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that R94 is severely cognitively impaired. Further, the MDS indicated that R94 had not been on a scheduled pain medication regimen nor received PRN pain medication in the 5 days prior to the assessment date, though she was noted to have received non-medication interventions for pain. The following observations we made: On 12/19/22 at 11:03 AM R94 was awake in bed. She was laying on right side in the fetal position, with legs bent at the knees, fully pulled up to chest. She presented as confused, and she was restless and disrobing. On 12/19/22 at 11:28 AM while just outside R94's room, R94 could be heard calling out/screaming and crying while staff were providing care. On 12/19/22 at 1:12 PM: R94 was awake in bed. Same position, with her knees drawn to her chest. No pressure relief between knees. No positioning devices or splints in use. On 12/20/22 between approximately 10:00/10:30 AM R94 could be heard throughout the unit hallway calling out/screaming while staff were providing care. When asked, a CNA reported that R94 was repositioned. On 12/21/22 at 8:42 AM the door to R94's room was closed while staff were providing care. She could be heard calling out/screaming. On 12/20/22 at 10:10 AM an interview was conducted with CNA KK, who described patient as combative. When asked about providing care, CNA KK stated, You can just touch (R94) and she will call out presumably in pain. CNA KK noted that patient is repositioned every two hours. CNA KK reported that she tries to wait provide care until about 20 minutes has passed since R94 is given pain medication, and expressions of pain are reported to the nurse. When asked about providing range of motion exercised with R94, CNA KK indicated that this is attempted, but R94 calls out and becomes combative (scratches and hits). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of R94's care plan read, in part, .I have (acute/chronic) pain .Goal . I will not have an interruption in normal activities due to pain .Interventions/Tasks . Anticipate my need for pain relief and respond immediately to any complaint of pain . Assess my pain in each site using _____ pain scale .I prefer to have my pain controlled by: .(specify: medication, treatment) . Note that the preferred method of pain control was not listed. Review of the Medication Administration Record (MAR) for December: Pain Assessment every shift (verbal or PAINAD scale) every shift for pain -Start Date- 8/10/2022 2300. It should be noted that R94 was determined to be severely cognitively impaired per the MDS assessment done on 11/18/22 and physician notes identified her as having dementia. Also, at least two staff members indicated that they look for non-verbal expressions to assess R94's pain due to R94's cognitive status. Further review of the MAR found Tylenol Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain -Start Date- 09/07/2022 1528 -D/C Date- 12/03/2022 1905 Tylenol Extra Strength Tablet 500 MG (Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain -Start Date-12/03/2022. From December 1th to December 12th, R94 received Tylenol on five occasions. R94 was not noted to have received any pain medication on 12/19/22 despite the observations (described above) that she was calling out/screaming. Furthermore, R94 did not have a routine pain medication in place despite staff reporting that R94 often expresses pain and is combative when receiving care. Review of the progress notes found the following: 11/29/2022 05:51 Nursing Progress Note Note Text: Res awake and yelling most of the night. Unsuccessfully attempted non-pharmaceutical techniques and were unsuccessful. Res continues to disturb roommate. Roommate states that this is an ongoing occurrence. No other interventions were documented. 12/2/2022 07:42 Nursing Progress Note Note Text: Res continues to stay awake all night yelling and screaming. Res denies all c/o pain or dscft. Non medicinal (sic) interventions offered but were unsuccessful. Res room mate confirmed that this is on going .Placed concerns on communication board for nursing staff and management to review. 11/29/2022 05:51 Nursing Progress Note Note Text: Res awake and yelling most of the night. Unsuccessfully attempted non-pharmaceutical techniques and were unsuccessful. Res continues to disturb roommate. Roommate states that this is an ongoing occurrence. No other interventions were documented. (continued on next page)

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	235187	A. Building B. Wing	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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F 0697 Level of Harm - Actual harm Residents Affected - Few	12/2/2022 13:44 Social Service Progress Note Note Text: Writer spoke with resident's son, (Name), r/t change in condition. (Son) was concerned about pain control for resident. Writer notified him of prescribed pain medication. Family requests an increase in pain medication and a hospice consult. Nursing and Physician notified. Writer will continue to monitor and follow-up. 12/3/2022 17:30 Nursing Progress Note Note Text: patient visited by son today and was concerned about his moms pain mangement (sic). doctor called and new order received for pain medication . 12/19/202215:52 Therapy Notes Note Text: Approached the patient multiple times to do the PT eval sed (sic) to decrease ROM in BLE and to improve positioning. Patient was resistive and combative during the eval. Unable to complete the eval. Informed nursing and will approach the patient later for therapy evaluation. No intervention to address pain was document. PRN Tylenol was not given per the MAR. Regarding behavior issues/combative behaviors, the Behavior Task form (where CNAs document), no behavior issues (e.g., combativeness) were reported from 12/1/22 to 12/21/22, yet staff reported this as a frequent issue, when interviewed regarding pain and provision of care. Review of physical therapy notes revealed that R94 received physical therapy services from 10/10/22 to 11/5/22. The evaluation completed by Therapy Director H on 10/10/22 indicated that R94 was referred to physical therapy as .Nursing reported that patient's bilateral LE is getting contracted and not letting the aides/nursing touch her legs because of pain R94 was found not to be contracted but was determined to have limited range of motion in her bilateral lower extremities. Clinical implications read, in part, .Patient was evaluated by PT and the patient c/o severe pain in BLE with ROM in BLE and the patient was screaming in pain. The CNA reported that the resident is combative/resistive during ADL care and do not let them do any ROM to BLE during ADL care. The writer requested the PM & R PA and Physician to consider giving some scheduled pain medication to decrease her pain to participate in ADL care and therapy . R94 was discharged on [DATE] with a functional maintenance program to be provided by CNAs 2-3 times a week for ROM BUE/BLE during ADL care. On 12/20/22 at 1:25 PM Nurse LL was interviewed regarding pain management. Nurse LL reported that R94 receives Tylenol for pain and that she tried to medicate her before working with her. Nurse LL was directed to the MAR to show that patient does not have routine medication and rarely receives PRN Tylenol. Nurse LL stated, I've asked about getting her something stronger and indicated that the doctor doesn't want to put her on anything due to R94's age and size. Nurse LL reported that a hospice consult is pending. Hospice consult was ordered 12/5/22, but the consult had not been completed at the time of this interview nor by the end of the survey. On 12/21/22 at approximately 12:20 PM DON was interviewed regarding pain management. When asked about using a self-report, numeral scale to assess a severely cognitively impaired resident's pain, DON indicated that she would expect such residents to call out during if in pain. DON further indicated use of non-verbal assessment of pain. On 12/21/22 at 2:19 PM Therapy Director H was interviewed regarding R94 receiving physical therapy. Therapy Director H reported that he tried to evaluate the R94 on 12/20/22 for service, however she became combative due to pain. Therapy Director H stated that he wrote a note in a binder on the unit for the attending physician. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	PT. When discussing the fact that R94 was consistently overserved in the fetal position with her legs bent at the knees and fully pulled up to her chest, Therapy Director H reported that patient is not contracted. He indicated that her legs can be stretched out when pain is treated. Therapy Director H indicated that he recommended routine pain medication, though he stated that he was told that R94's age is a concern. Therapy Director H referenced the pending hospice consult. On 12/21/22 at approximately 2:40 PM Unit Manager K was interviewed at the nurses' station. Unit Manager K was not aware that a note was left for the physician by Therapy Manager H regarding R94's pain management. Unit Manager K provided the physician's binder and the note, dated, 12/19/22, was located with the assistance of Therapy Manager K. When asked about follow-up with the physician, Unit Manager K stated that the physician had yet to visit for the week. Unit Manager K indicated that they usually call physician to address needs, and she explained that the physician was last contacted on over the weekend as R94's son was concerned about pain. On 12/21/22 at 4:03 PM Therapy Director H and another physical therapist were observed trying to extend R94's left knee after she had been given pain medication. R94 called out and cried whenever the physical therapists tired to straighten her knee, and Therapy Director H indicated that R94 was resisting attempts to straighten her knee. At one point, R94 yelled, My knee! Non-pharmalogical attempts to address this were not effective. Therapy Director H indicated that splinting was considered, but R94's skin integrity and risk for wounds was a concern. The physical therapists were not able to fully extend R94's knee. Therapy Director H indicated that if R94 received more medication, she would be able to extend her knee. Review of a facility policy entitled Pain Management (revised on 12/2020) reads, in part, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Policy Explanation and Compliance Guidelines: The facility utilizes a systematic approach for recognition, assessment, treatment and monitoring of pain. Recognition: 1. In order to help a resident attain or maintain his/her highest practicable level of well-being and to prevent or manage pain, the facility should: a. Recognize when the resident is experiencing pain, including nonverbal expressions of pain and identify circumstances when the pain is anticipated .Pain Management and Treatment: .6. If the resident's pain is not controlled by the current treatment regimen, the practitioner should be notified. Monitoring: a. Reassess patients with pain regularly for effectiveness and/or adverse consequences (e.g., constipation, sedation). b. If re-assessment findings indicate pain is not adequately controlled, revise the pain management regimen and plan of care as indicated.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 30675 Based on observation, interview, and record review, the facility failed to ensure food was held in a manner to ensure food was served at preferred temperatures, with the potential to affect all residents that receive food from the kitchen. This deficient practice resulted in dissatisfaction with the meals provided and the increased potential for reduced intake and weight loss. Findings include: According to the facility's policy titled, Food Quality and Palatability dated 7/23/2021: .Food will be palatable, attractive and served at a safe and appetizing temperature . On 12/19/22 at 12:05 PM, observations of the facility's lunch meal prep were conducted with the Certified Dietary Manager (CDM 'CC'). CDM 'CC' reported the lunch tray line usually started around 12:15 PM. The main lunch menu consisted of salmon, mashed potatoes, spinach, corn and corn bread. The always available options were hamburger, hot dog, grilled cheese and peanut butter and jelly sandwich. CDM 'CC' also reported that there were fish nuggets as requested by a few residents. When asked if the facility utilized plate warmers, CDM 'CC' reported they did not. They further reported the meals were prepared and plated in the kitchen, then placed in the food carts for distribution to the floors for the dining room and resident rooms. At 12:15 PM, food temperatures were obtained and there were no concerns with the initial serving temperatures. At 12:30 PM, the first meal tray was placed in a food storage cart. At 1:32 PM, the last meal tray was placed in a food storage cart and observed being delivered to the 1 [NAME] unit. At 1:53 PM, the last meal tray was pulled to be served. At that time, CDM 'CC' was requested to obtain food temperatures which included: Small container of strawberry yogurt = 59.1 degrees Fahrenheit (F) Mashed potatoes with gravy = 116.4 degrees F Mechanical soft beef = 101.9 degrees F Pureed fish = 93.3 degrees F Carrots = 91.8 degrees F On 12/19/22 at 2:00 PM, CDM 'CC' was asked about whether they were aware of any food concerns and reported they were. They reported there were some issues with how fast staff delivered the food trays once they reached the floors and it was an issue they were constantly working on. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	34275 Review of the facility's Resident Council minutes provided by the facility from 8/3/22 to 11/20/22 identified multiple environmental concerns, food concerns including not filling up coffee cups, food not being cooked or provided as requested. On 12/20/22 at 11:30 AM, a confidential interview was conducted with 14 members who reported they either sometimes or frequently attended the resident council meeting in the facility. During the confidential group meeting it was reported by multiple residents that food was an ongoing concern. Examples provided included, residents not always receiving what they requested, not receiving full cups of coffee and the food often was cold. Several residents reported that snacks sometimes are not passed out. The residents also noted that prior to the facility being taken over by another company they were able to contact the kitchen via either their phone or the facility phone to express concerns and/or make requests. On 12/20/22 at approximately 3:16 PM an interview was conducted with Activity Director (AD) N. When asked whether certain issues including food, environment and staffing issues had been addressed, AD N reported that she was aware of the concerns and noted that they had been forwarded to the Dietician, Administrator and other staff members. On 12/21/22 at approximately 4:04 PM, an interview was conducted with Dietary Manager (DM) CC. When asked if they were aware of the grievances/concerns expressed by the Resident Council, DM CC noted that they were. She expressed that they had been working on concerns but thought in terms of food temperatures it is our of her hands once the food leaves the kitchen and it is up to the staff to ensure it is served timely. With respect to other issues pertaining to food she did not that if food received is not in good standing then it is returned and alterations in the menu are made.