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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34275 Based on observation, interview and record review the facility failed to ensure six residents who attended a confidential Resident Council meeting had the right to vote in the 2022 midterm election. Findings include: On 12/20/22 at approximately 11:30 AM, a Resident Council meeting was held with 14 residents who wished to remain anonymous. The residents were asked if the facility coordinated a plan to ensure they exercised their right to vote in the 11/8/22 Midterm election. Six of the residents who wished to remain anonymous reported that they would have liked to vote in the 11/8/22 Midterm election but were not provided any information, did not complete any documentation to vote absentee or were provided transportation to a voting poll. On 12/20/22 at approximately 3:16 PM, an interview was conducted with Activity Director (AD) N. When asked if they had coordinated a plan to ensure residents who wanted to vote in the 2022 Midterm election, they replied that they printed something on the facility monthly calendar and only heard from two people. None of the persons mention had attended the Resident Council meeting on 11/8/22. AD N was asked to provide the document provided. On 12/21/22 at approximately 4:00 PM, AD N provided a document titled The Daily Chronicle dated 9/23/2022. The front page of the document contained historical information and trivia. The back page had a large word search that covered most of the document and on the lower left corner was a small square box that noted Vote! If anyone would like to receive an absentee ballot, please ask the activity dept and we can assist you! *It should be noted that the note did not give dates of the election or when a ballot needed to be completed. No further documents containing voting information was provided by the end of the survey. On 12/21/22 at approximately 5:07 PM, an interview was conducted with the Administrator. The Administrator was asked if the small note on the 9/23/22 documentation was sufficient enough to ensure that all resident who wished to vote were assisted, as the document may not have been read by those with vision issues and or language barriers. The Administrator reported the facility could have done better in trying to ensure residents who wished to vote were assisted. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Facility document titled Resident Rights (last revised 8/21) was provided and documented, in part, the following: Policy-The facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident contact and responsibilities during the stay at the facility .1. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview and record reviews the facility failed to implement effective methods of communication and translator services for daily communication, to obtain accurate assessments in a language that could be understood by one (R5) of one resident reviewed for communication. Findings include: On 12/19/22 at 10:14AM, R5 was observed sitting up in their wheelchair. An interview was attempted however R5 was responding in another language. At 10:22 AM, Certified Nursing Assistant (CNA) G (the CNA assigned to R5) was interviewed and asked how they are able to communicate with R5. CNA G stated they were unsure it was their first time working with the resident but will go and find out from the nurse. CNA G was then asked how they were able to communicate with the resident all morning and CNA G did not answer. CNA G left to talk to R5's nurse then returned and stated the staff communicates with R5 through the resident's daughter. CNA G' stated (R5's) daughter visits every day. 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 medical record revealed a care plan was not developed or implemented for the communication language barrier. Further review of the care plans documented no interventions for staff to utilize to communicate effectively with R5. On 12/20/22 at 4:44 PM, Social Worker Manager (SWM) A was interviewed and asked how the staff communicates with R5 and SWM A stated the staff communicates with the resident through the resident's daughter. SWM A was then asked how the facility can ensure the facility is receiving accurate, unbiased information without violating the resident rights and protecting the residents health information, SWM A stated they would look into it and follow back up. On 12/21/22 at 9:44 AM, SWM A returned and stated they set up services with a language line solution on 12/20/22 to ensure staff are able to communicate with R5.

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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 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. 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. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 34275 Based on observation, interview, and record review, the facility failed to ensure the Survey Book was easily accessible for residents and failed to inform residents, visitors, and families of the location of the Survey Book, for 14 out of 14 residents who attended the Confidential Group meeting. Findings include: During a Confidential Group meeting that was conducted in the facility on 12/20/22 at approximately 11:30 AM, 14 out of 14 residents who attended the meeting verbalized they were not aware of the location of the Survey Book, what a Survey report was, or that they had the right to inspect the latest Survey results. On 12/20/22 at approximately 3:25 PM, a general tour was made of the facility halls and nursing stations. There was nothing posted that directed residents and/or visitors to the location of the Survey Book. On 12/21/22 at approximately 4:00 PM during an interview with Dietary Manager (DM) CC, DM CC was asked where the Survey Book was located. DM CC headed towards the front of the building, near the nurse's station and asked another staff person (hereinafter Receptionist Staff II) where the Survey Book was located. Staff II looked through many binders at the nurse's station and asked another Staff person where it might be. They were unable to locate the book. On 12/21/22 at approximately 5:15 PM, the Administrator reported that the Survey Book was located in the entrance lobby on a shelf. It should be noted that it would only be accessible to residents if they were to go through the door that required a code to exit to the lobby area. A review of the facility policy titled, Resident Rights (Date revised 8/21) documented, in part, the following: Policy: The facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights .the resident has a right to .Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview and record review the facility failed to honor and implement the advance directive wishes as documented by (R5's) resident representative, one of eight residents reviewed for advance directives. Findings include: On 12/19/22 at 10:14 AM, R5 was observed sitting up in their wheelchair. An interview was attempted however the resident was responding in another language and could not be understood. A follow up interview was conducted with R5's daughter present later that day. 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 a document titled Medical Treatment Decision Form dated 11/20/22, signed by R5 son who is also the resident Durable Power Of Attorney (DPOA) documented in part, . DNR Do Not Resuscitate . I have discussed my health status with my physician. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me . the document was also signed by the physician. Review of the medical record revealed R5's face sheet, profile and clinical record documented the code status as . Full Code . Further review of the medical record documented R5's son as the legal representative for R5. On 12/20/22 at 11:02 AM, Social Services Manager (SSM) A was interviewed and asked the code status of R5. SSM A looked into the electronic medical record of R5 and replied, she is a full code. When asked how that was possible if the resident's legal representative signed the code status as a DNR and SSM A stated they would look into it and follow back up. At this time the DPOA and competency evaluation was requested from SSM A. On 12/20/22 at 1:19 PM, R5's son (resident representative) was interviewed and asked about the DPOA documentation and stated they provided a copy of the DPOA to the facility when their mother was admitted . R5 stated the facility called them today and asked them to bring in another copy. R5 son stated they had full power of attorney for their mother which was valid and in effect. When asked what their wishes were for the code status of R5, R5's son stated in part . I don't want them to give her electric shocks or break her ribs. She should be a DNR I signed that last month. I don't understand . On 12/20/22 at 4:47 PM, SSM A was reinterviewed and asked about the following up status of R5's code status and acknowledged R5's code status should have been classified as a DNR and stated they were awaiting R5's son to bring in the DPOA paperwork. When asked what happened to the original copies of the DPOA paperwork that was provided to the facility upon admission SSM A stated they were unsure of what happened with the documents. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Residents' Rights Regarding Treatment and Advance Directives revised 12/20 documented in part, . On admission the facility will determine if the resident has executed an advance directive, which can designate a DPOAH and/or future healthcare treatment preferences . Upon admission . the advanced directive will be reviewed to ensure advocates, demographics and wishes are current . copies will be made and placed on the chart as well as communicated to the staff .

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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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Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to report an injury of unknown origin and an allegation of abuse/neglect to the State Agency for two (R16 and R31) of five residents reviewed for abuse. Findings include: According to the facility's policy titled, Abuse, Neglect and Exploitation dated 3/28/2022: .Reporting of all alleged violations to the Administrator, state agency .within specified timeframes . Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . 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: 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 R16's hospital records included: .Patient is a [AGE] year old female .presenting from ECF (Extended Care Facility) with right foot injury. Noted on XR (X-Ray) at facility to have fracture and sent to ED (Emergency Department) for evaluation. Right great toe has non-displaced fracture with dried blood in area .does not follow directions .Today she nods her head no to every question asked. Physcial <sic> exam shows erythematous and edematous right foot with some dried blood in the area; foot is tender to palpation but has some active ROM (Range of Motion) . Review of the progress notes included a late entry on 9/14/22 at 2:18 PM (from Nurse 'S') for 9/10/22 at 12:00 PM which read, right foot swollen with bruise . An eINTERACT SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers dated 9/10/22 at 2:53 PM, read, Situation: The Change In Condition/s reported on this .Evaluation are/were: Other change in condition Change in skin color or condition .Outcomes of Physical Assessment: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Positive findings reported on the resident/patient evaluation for this change in condition were: Mental Status Evaluation: No changes observed, Functional Status Evaluation: needs more assistance with ADLs, Skin Status Evaluation: Discoloration .Pain Status Evaluation: Does the resident/patient have pain? Yes .Primary Care Provider responded with the following feedback: A. Recommendations: xray right foot . An entry on 9/10/22 at 2:39 PM by Nurse 'S' read, @ 12;00 pm, when resident was up, assigned aide, reported to writer her right foot, assessment initiated, swollen with bruise pain during touch, (Physician 'W'), informed with order stat right foot xray 2 views . An entry on 9/10/22 at 10:44 PM by Nurse 'X' read, patient had x-ray of rt. (right) foot, patient foot reddish blue in certain areas esp. (especially) large toe, appears swollen and warm to touch. patient states it hurts and flinches when she thinks you are going to touch it. x-ray results (alert) in and patient's doctor made aware and result sent to him via text as requested . An entry on 9/11/22 at 3:25 PM by Nurse 'S' read, was informed by co-charge nurse that resident need to transfer to Hospital per Physician 'W', due to non displaced fx. (fracture) right distal and proximal first phalanx. An entry on 9/20/22 4:22 PM by Nurse Manager 'K' read, Resident readmitted w (with)/ Cellulitis to Right Fracture Foot w/scab in healing process. Treatment in place TAO (Treatment as Ordered) to area and leave open to air . On 12/20/22 at 3:51 PM, the Administrator was requested to provide any documentation of incident/accident reports 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. 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). When asked about the injury of unknown origin (bruising and fracture of toe which required hospitalization), the Administrator reported they were not aware of anything like that happening, but acknowledged that should have been reported to the State Agency and an investigation should've been completed. On 12/21/22 at 1:45 PM, an interview was conducted with Nurse Manager 'K'. When asked about R16's foot fracture in September, they reported they were unable to recall any specific details as they were the only manager at that time. Nurse Manager 'K' was informed of the concern that there was no investigation into R16's foot fracture from September and they reported they would follow up. On 12/21/22 at 1:55 PM, Nurse Manager 'K' reported they were able to find an incident report for the unknown bruise on 9/10/22. When asked to review the facility's documentation of an investigation, they reported they were only able to provide the incident report (which had no investigation). When asked if this should have been reported to the State Agency as an injury of unknown origin, Nurse Manager 'K' deferred to the Administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/21/22 at 2:03 PM, Corporate Staff 'I' and Corporate Staff 'Y' were asked about R16's incident report provided by Nurse Manager 'K'. Corporate Staff 'I' reported they were able to print off the incident report and thought they recalled something about a table falling on the resident, but were trying to find other documentation. There was no further documentation or explanation into R16's injury of unknown origin provided by the end of the survey. 41415 R31 Review of the medical record revealed R31 was admitted to the facility on [DATE] with diagnoses that included: contracture of muscle unspecified lower leg, chronic obstructive pulmonary disease and heart failure. A MDS assessment dated [DATE] documented a BIMS score of 15 indicating intact cognition and required staff assistance for all ADLs. Review of a complaint submitted to the State Agency (SA) documented in part, . (R31's name) was shoved to the ground, then picked up and thrown on the bed . (R31's name) did not have injuries from the incident but did have residual pain. This was reported to the facility manager . but unknown what safety steps were taken to protect (R31's name) in the future . This complaint was submitted by law enforcement. On 12/19/22 at 10:03 AM, R31 was observed laying on their left side curled up with their legs contracted and touching their chest area. An interview was attempted and refused by R31. An additional question regarding the above reported incident was asked and R31 stated in part . every time I talk to ya the staff come in here and dogs me out . it (the above incident) was a long time ago. Why are you asking about it now? No, I'm not talking . On 12/19/22 at 2:22 PM, an interview was conducted with R31's daughter (who full co-legal guardianship of R31) regarding the above reported incident and R31's daughter stated in part, No one investigated what happened and the facility never followed back up with us. R31's daughter then stated . my mother can't even move. How she fall out of bed? Her legs are severely contracted . R31's daughter stated her and her brother came up to the facility on the day of the incident and had to call the police because of the allegation made by R31. On 12/20/22 at 2:13 PM, the Director of Nursing (DON) was interviewed and asked about the incident with R31 and the police being involved. The DON stated they were the nurse for R31 that day and when they called the son to inform them of the residents fall the son began to curse her out. The DON stated they ended the call with the family because they started threatening them. The DON stated the daughter (of R31) called the police because she complained that abuse occurred. When asked who they reported that to the DON replied the Administrator and the doctor. The DON recalled the detective coming to the facility to talk to R31 and then questioned the DON. The DON stated . We found out a few days later what it was about (the police coming to the facility). I can't say that it was reported to the state . The DON was asked how the facility found out a few days later what the incident was about? And why the incident was not investigated the day of the incident to find out what the reported allegation was and the DON did not have a response. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/22 at 2:42 PM, the Administrator was interviewed and asked about the alleged incident and if it was reported to the SA. The Administrator stated in part, . Actually she (R31) fell out of bed and she is actually contracted significantly. She fell out of bed. When I talked to the resident she stated she fell out of bed. The daughter was alleging that she (R31) was thrown on the floor and she (the R31's daughter) also stated she would shoot me . The Administrator asked was the alleged allegation reported to the SA and the Administrator stated they felt pretty strong that it was not abuse. At this time the Administrator was asked to provide all documentation of the investigation completed for this incident. No further explanation or documentation was provided by the end of survey.

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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** 39592 Based on observation, interview and record review the facility failed to accurately complete comprehensive Minimum Data Set (MDS) assessments for two (R102 and R31) of 28 residents reviewed for Resident Assessments. Findings include: R102 Review of the closed record revealed R102 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: diabetes, end stage renal disease and peripheral vascular disease. According to the discharge MDS assessment dated [DATE], R102 was discharged to a hospital. Review of progress notes, R102 was discharged from the facility on 10/29/22 to her home. On 12/21/22 at 11:10 AM, the MDS Manager E was interviewed and asked why R102's discharge assessment was coded for the hospital when she was discharged home. MDS E explained it was a mistake, it should have been coded for R102 discharged to home. Review of a facility policy titled, Resident Assessment undated, read in part, .The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity . Information derived from the comprehensive assessment enables the staff to plan care that allows the resident to reach his/her highest praticable level of functioning . 41415 R31 Review of the medical record revealed R31 was admitted to the facility on [DATE] with diagnoses that included: contracture of muscle unspecified lower leg, chronic obstructive pulmonary disease and heart failure. A MDS assessment dated [DATE] documented a BIMS score of 15 which indicated intact cognition and required staff assistance for all ADLs. On 12/19/22 at 10:03 AM, R31 was observed laying on their left side curled up with their legs contracted and touching their chest area. An interview was attempted but refused by R31. Review of the MDS Section K - Swallowing / Nutritional Status dated 10/29/22, documented in part . Feeding tube - nasogastric or abdominal (PEG) . Not checked (No) . Review of the physician orders documented a 30 - 60 mls (milliters) flush of water every shift to maintain tube patency. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician note dated 11/29/22 at 9:04 PM, documented in part . d/w (discussed with) son (son name) today due to discolored/worn peg, he wishes to proceed with peg exchange. Appt with interventional radiology to be made . On 12/21/22 at 12:44 PM, the MDS manager E was interviewed and asked why R31 was not accurately coded on their MDS assessment to reflect that the resident had a PEG tube and MDS E replied the dietician is responsible to complete section K for the resident. At 12:50 PM, Registered Dietician (RD) F was interviewed and asked why R31 was not accurately coded on their MDS assessment to identify the resident's PEG tube and RD F stated they believe the resident was not using the PEG tube at all, however it must have been an error on their part. No further explanation or documentation was provided by the end of survey.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to complete an annual OBRA (Omnibus Budget Reconciliation Act) Level I evaluation to determine if a Level II Evaluation was needed, or if exemption was identified for two (R16 and R23) of five residents reviewed for PASARR's (Preadmission Screen and Resident Review). Findings include: According to the facility's policy titled, Resident Assessment - Coordination with PASARR Program dated 1/2021: .If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD (mental disorder), ID (intellectual disability) or a related condition to the appropriate state designated authority for Level II PASARR evaluation and determination .The Level II resident review must be completed within 40 calendar days of admission .The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority .Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. c. A resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment. According to the State's Level I screening process, a 3877 form is required annually for all residents in a nursing home, regardless of their exemption status. This documentation is also maintained via the State's electronic system. R16 Review of the clinical record revealed R16 was admitted on [DATE], readmitted on [DATE] with diagnoses that included: schizoaffective disorder bipolar type, and unspecified dementia with other behavioral disturbance. Review of the most recent completed PASARR documentation revealed the last 3877 form was completed on 1/22/21 and the 3878 form was completed on 1/25/21. The 3877 form did not include the diagnosis of schizoaffective disorder bipolar type. Additionally, there was no further documentation that these forms had been completed annually. R23 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record revealed R23 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: schizophreniform disorder (added 10/7/21), and Major Depressive Disorder recurrent severe with psychotic symptoms. Review of the most recent completed PASARR documentation revealed the last 3877 form was completed on 1/22/21 and the 3878 form was completed on 1/25/21. There was no further documentation that these had been completed annually. On 12/20/22 at 12:30 PM, an interview was conducted with Social Work Director (SW 'A'). When asked about who was responsible for the facility's PASARR process to ensure timely completion and compliance, SW 'A' reported they were. When asked how often 3877 and 3878 forms should be completed, SW 'A' reported annually and should be scanned in the electronic clinical record. On 12/20/22 at 4:48 PM, another interview was conducted with SW 'A'. When asked about R16's previous 3877 which did not include the diagnosis of schizoaffective disorder bipolar type, SW 'A' was unable to offer any further explanation. At that time, SW 'A' was requested to provide any further documentation to show that R16 and R23 may have had additional PASARR documentation completed for review. There was no additional documentation provided by the end of the survey.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on interview and record review, the facility failed to ensure Preadmission Screening (PAS)/Annual Resident Review (ARR) Mental Illness/Intellectual Disability/Related Conditions Identification (forms DCH-3877 and/or DCH-3878) documents were reviewed, revised, and sent to the local state agency for review and/or evaluation for two (R68 and R94) of five residents reviewed for PASSARs. This deficient practice resulted in the potential for residents to be excluded from receiving necessary care and services appropriate to meet their mental health needs. Findings include: R68 Review of the clinical record revealed R68 was admitted into the facility on [DATE] with diagnoses that included: amyotrophic lateral sclerosis (ALS), schizoaffective disorder, major depressive disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R68 had moderately impaired cognition. The MDS assessment also indicated R68 had no mood or behavior concerns including hallucinations/delusions, received antipsychotic and antidepressant medication for seven of the seven days during this assessment period, had not had a gradual dose reduction (GDR) for the antipsychotic medication, and there was no physician documentation that a gradual dose reduction was clinically contraindicated. Review of the clinical record revealed no PASAAR Level 1 screening completed by the facility upon R68's admission. On 12/20/22 at 12:42 PM, SW A was interviewed and asked about R68's admission PASARR Level 1 screening. SW A explained a Level 1 and an OBRA Level II had just been completed on him, but they had not been done upon admission. When asked if they should have been completed when he was admitted , SW A agreed they should have been done. 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. This MDS assessment also indicated that R94 did not mood or behavior concerns, including hallucinations or delusions in the 7-day period prior to the assessment date. R94 received an antipsychotic 7 out of the 7 days in the assessment period. Review of the clinical record revealed no PASSAR Level-1 screening prior to R94's admission to the facility. (continued on next page)

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

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Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record revealed no PASSAR Level-1 screening prior to R94's admission to the facility. Further review found a social services progress note dated 8/11/22 that read, in part, .What does their PASS-ARR indicate? Do they have a 3878? Is it a 30 day or Dementia exemption?: Dementia exemption . 3878 refers to DCH form 3878, Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification. Note that resident does not have a diagnosis of dementia listed on her list of diagnoses, though it is listed in physician notes. On 12/20/22 at 1:07 PM, an interview was conducted with SW Manager A, who confirmed that she is responsible for managing the PASARR process at the facility. When asked about R94 not having a PASSAR Level-1 screening, SW Manager A stating that she will look into this. No additional information was provided prior to the end of the survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview and record review the facility failed to develop and implement a fall care plan for one resident with a known history of falls (R5) of one resident 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, creating an entrapment. 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 R5's preadmission hospital paperwork provided to the facility upon admission titled ED (Emergency Department) Provider Notes dated 10/12/22 at 10:33 PM, documented in part . vascular dementia . frequent falls . After this hospitalization she sustained a fall . with injuries that included right clavicular fracture and right femur fracture. She underwent ORIF (Open Reduction and Internal Fixation) . Review of the medical record revealed no care plans developed for falls and no interventions implemented to prevent further falls. On 12/21/22 at 11:31 AM, the Administrator and Director of Nursing (DON) was interviewed and asked why there was no fall care plan in place for a resident who has a history of falls and who is also status post ORIF surgery from a fracture sustained from a fall. The DON stated they would look into it and follow back up. No further explanation or documentation was provided by the end of survey.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to implement interventions to prevent wounds for one (R94) of four residents reviewed for wounds resulting in the formation of six wounds, four of the wounds, bilateral hips and bilateral feet, with eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) and two of the wounds, bilateral inner knees, that were observed in direct contact with each other. Findings include: On 12/19/22 at 11:03 AM, R94 was observed lying on her right side with her legs bent and pulled up to the chest (fetal position). An open wound, linear, pink base, was observed on R94's right medial knee, where R94's left knee came into direct contact together as there was no pillow between R94's legs. An open wound, circular, black, approximately three inches in diameter was observed on R94's left hip. Blood was observed on R94's sheets and gown. R94 was lying on a scoop mattress, no pressure reducing low air mattress was observed. No foam boots were on R94, or observed in the room, her feet were in direct contact with the mattress. On 12/19/22 at 11:19 AM, Certified Nursing Assistant (CNA) R was interviewed and asked about R94's open wound on her left hip and the blood on her sheets and gown. CNA R explained she had told the nurse there was not dressing on R94's hip, but she might have forgot as the nurse was in the middle of narcotic medication count. It should be noted that nurses count narcotic medications at shift change, which was 7:00 AM. On 12/19/22 at 11:52 AM, 12:23 PM and 1:12 PM, R94 was observed lying on her right side in a fetal position. No pillow was observed between her legs. No foam boots were on her feet. Review of the clinical record revealed R94 was admitted into the facility on [DATE] with diagnoses that included: psychosis, schizophrenia and hypertension. According to the Minimum Data Set (MDS) assessment dated [DATE], R94 had severely impaired cognition and required the extensive assistance of staff for activities of daily living (ADL's). The MDS also indicated R94 did not have any pressure ulcers. Review of a Braden Scale for Determining Pressure Ulcer Risk dated 12/7/22, R94 scored 9.0, indicating Very High Risk for pressure ulcers. Review of a Wound Progress Note dated 12/2/22 read in part, .LOCATION: Left hip; TYPE: Blister; DESCRIPTION: Wound base shows pink granulation tissue with approximately 15% dry necrotic epithelial tissue which is partially attached . DIMENSIONS: 2.2 cm (centimeters) x 3.5 cm by UTD (unable to determine). There is no tunneling or undermining . Plan: .PRESSURE OFFLOAD STRATEGY . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	According to the National Pressure Injury Advisory Panel (NPIAP) a Stage 2 Pressure Injury is defined as, Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister . Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel . A Stage 3 Pressure Injury is defined as, Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible . If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Review of a Wound Progress Note dated 12/9/22 read in part, .LOCATION: Left Hip; DIMENSIONS: Wound status declined, 3.5 cm x 6.0 cm by UTD . Plan: PRESSURE OFFLOAD STRATEGY . Review of a Wound assessment dated [DATE] read in part, .Left trochanter (hip) . 7.2 x 6.5 x UTD . 100% Eschar . Review of R94's plan of care revealed no impaired skin integrity care plan only a risk for impaired skin integrity care plan revised 8/14/22 that included the interventions to, .Assist me to turn &/or reposition routinely during CNA round while in bed . Please lift, do not slide me. Utilize an assistive device as applicable to decrease friction . On 12/21/22 at 9:15 AM, Licensed Practical Nurse (LPN) K was interviewed and asked about R94's left hip wound. LPN K explained she had observed a new wounds to R94's right hip, right inner knee and right greater toe the night before. LPN K was asked if R94 had any wounds on her coccyx. LPN K explained that since R94 was legs were contracted, she could not lay on her back, she only laid on her sides. On 12/21/22 at 9:25 AM, wound care was observed with LPN K. R94 was observed lying on her left side in a fetal position. No pillow was observed between her legs. LPN K was asked why R94 did not have a pressure reducing mattress. LPN K explained she would talk to the doctor about getting one. When asked if R94 should have a pillow between her legs to keep them from rubbing against each other, LPN K explained there should be a pillow. Observation of R94's left hip revealed a circular wound, approximately 3-3.5 inches in diameter, completely obscured with black eschar. R94's left lateral foot revealed a circular wound, approximately 0.5 inches in diameter completely obscured with black eschar. R94's right hip revealed a wound, approximately 1.5 x 0.5 inches, completely obscured with black eschar. R94's right medial foot, directly on a small bunion, revealed a circular wound approximately 0.5 inches in diameter, completely obscured with tan eschar. R94's right medial knee revealed an open wound with a pink base approximately 1. 5 x 1 inches. Observation of R94's left medial knee revealed an undocumented open wound with a pink base that was approximately 3 x 1 inches. It should be noted the wounds on R94's medial knees were exactly where her legs touched from lying in a fetal position. Review of a Weekly Skin Sweep dated 12/21/22 by LPN K for R94 revealed .LEFT MEDIAL KNEE/BLISTER; RIGHT KNEE INNER/BLISTER; RIGHT GREATER TOE/SCAB/BLISTER; Right trochanter (hip) BLISTER; Left trochanter (hip) BLISTER; LEFT MEDIAL KNEE/BLISTER . (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/21/22 at 1:47 PM, LPN K was asked if she had seen a blister on any of R94's wounds documented on the Weekly Skin Sweep. LPN K explained she had not. When asked if any staff member had told her they had seen a blister on any of R94's wounds, LPN K explained it had not been reported by any staff member. No furter docmentation was provided by the facility by the end of the survey.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure urinary catheter care for two residents, (R#'s 20 and 254) of two residents reviewed for urinary catheter care. Findings include: A review of an undated facility provided document regarding catheter care was reviewed, however; the policy provided only explained the steps used to provide catheter care, not the facility's responsibility to routinely provide the care. R20 On 12/19/22 at approximately 12:30 PM, R20 was observed in their bed. It was observed R20 had a urinary catheter drainage bag hanging on side of the bed. At that time, R20 granted permission to observe their suprapubic catheter (a catheter inserted directly into the bladder from the lower abdomen) insertion site. It was observed the suprapubic catheter tubing had unidentifiable debris dried along it's length and the insertion site appeared moist with a urine odor. R20 was asked if staff ever cleaned the area or the tubing and said it was not done regularly. On 12/20/22 at 4:03 PM, a review of R20's clinical record revealed they most recently readmitted to the facility on [DATE] with diagnoses that included: stroke, hemiparesis, multiple sclerosis, neuromuscular dysfunction of the bladder, urinary retention, and presence of a suprapubic catheter. A review of R20's physician orders, Medication Administration Records (MAR) and Treatment Administration Records (TAR) for October, November, and December 2022 was conducted and did not reveal any evidence suprapubic catheter care had been routinely provided. R254 On 12/20/22 at 10:44 AM, a review of R254's closed clinical record was conducted and revealed they originally admitted to the facility on [DATE], most recently readmitted [DATE] and discharged on [DATE]. R254's diagnoses included: neuromuscular dysfunction of the bladder, high blood pressure, paraplegia, dysphagia. R254's orders upon admission on 8/24/22 thru their discharge on 11/18/22 included an order to monitor urinary catheter output, however; no orders were included for providing any type of hygienic urinary catheter care. On 12/20/22 at 2:25 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding documentation of urinary catheter care. The DON said the care should be signed off as completed every shift on the resident's MAR or TAR.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview and record review the facility failed to provide adequate care for residents with PEG (Percutaneous Endoscopic Gastrostomy) tubes in 2 of 2 resident (R31 and $43) reviewed for a PEG tubes, resulting in the potential for complications and weight loss. Findings include: R31 Review of the medical record revealed R31 was admitted to the facility on [DATE] with diagnoses that included: contracture of muscle unspecified lower leg, chronic obstructive pulmonary disease and heart failure. A MDS assessment dated [DATE] documented a BIMS score of 15 indicating intact cognition and required staff assistance for all ADLs. On 12/19/22 at 10:03 AM, R31 was observed laying on their left side curled up with their legs contracted and touching their chest area. An interview was attempted and refused by R31. Review of a physician note dated 11/29/22 at 9:04 PM, documented in part . d/w (discussed with) son (son name) today due to discolored/worn peg, he wishes to proceed with peg exchange. Appt with interventional radiology to be made . Review of the physician orders documented a 30 - 60 mls (milliters) flush of water every shift to maintain tube patency. Further review of the physician orders revealed no order to assess, monitor or care for the PEG site. Review of the care plans revealed no care plan or interventions implemented to care for the residents PEG tube. On 12/20/22 at 12:05 PM, the Director of Nursing (DON) was interviewed and asked If R31 should have orders and a care plan to assess and care for the resident's abdominal PEG tube and the DON replied yes. The DON stated they would look into it and follow back up. No further explanation or documentation was provided by the end of survey. 47128 R43 Review of the clinical record revealed that R43 was admitted to the facility on [DATE]. Diagnoses include seizures; stroke; hemiplegia and hemiparesis (muscle weakness or partial paralysis); encephalopathy; dysphagia (swallowing difficulty); protein-calorie malnutrition; dementia; and adult failure to thrive. The most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that R43 is severely cognitively impaired. Per this assessment, R43 received 51% or more of total calories via a feeding tube, with an average daily fluid intake of 501cc or more. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/22 at 9:33 AM R43 was observed resting in bed on her back with the head of the bed elevated. The tube feeding pump was running with a flow rate of 80ml an hour, which matched the rate written on the formula bottle, and a flush rate of 60ml an hour. The flush rate was not written on the bag. Review of the record revealed the following orders for the tube feeding: Enteral Feed Order .two times a day TF via pump; Jevity 1.5 via PEG at 80mL/hr for 18hours (1440ml), Provides 2160kcal, 91g protein/day, and 1094ml free water .-Start Date 05/19/2022 and Enteral Feed .two times a day for Enteral Feeding autoflush water at 75mL/hr while TF is running .-Start Date 09/01/2022. These orders were also reflected on R43's Medication Administration Record (MAR) for December 2022, with administration starting at 4:00 PM and ending at 10:00 AM. A review of the most recent nutrition assessment dated [DATE] read, in part, .Current TF regimen: 1440 ml Jevity 1.5 @ 80 ml/hr x 18 hr with 75ml/hr x 18 hr free H2O autoflush; provides 2160 kcal, 91g PRO, & 2444 ml free H2O (1093 ml from formula + 1350 ml autoflush). On 12/20/22 at 9:42 AM R43 was observed with Unit Manager K present. Unit Manager K read that the tube feeding pump was set to a flow rate of 80ml an hour and flush rate of 60ml an hour. When asked about the flush rate, Unit Manager K check the order and confirmed that it should be set to 75ml an hour. A facility policy entitled Care and Treatment of Feeding Tubes (revised on 12/2020) reads, in part, It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .1. Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush .7. Tube feeding and medication administration: .e. Administer enteral formula, medications and flushes per physician's order.

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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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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 30675 Based on observation, interview and record review, the facility failed to display current nurse staffing information that was readily accessible for all 98 residents as well as visitors in the facility, resulting in the likelihood of necessary staffing information not being available to residents and visitors. Findings include: On 12/19/22 at 10:20 AM, through 12/21/22 at 10:00 AM, the daily staff postings available to residents and visitors were observed to be unchanged and remained dated 12/15/22. On 12/21/22 at 10:34 AM, an interview was conducted with the Administrator. When asked who was responsible to ensure the daily staff postings were posted daily, the Administrator reported that should be done daily by the scheduler who was not currently at the facility. The Administrator was informed of the observations that the daily staff posting had not been updated since 12/15/22 and they reported they would follow up. No further documentation or explanation was provided by the end of the survey.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review, the facility failed to provide medically related social services to address behavior management, end of life care, and coordination of community services for annual mental health evaluations for four (R23, R43, R94 and R62) of four residents reviewed for social services, resulting in the increased potential for unaddressed physical, mental, and psychosocial needs of the resident. Findings include: R23 On 12/19/22 at 10:07 AM, R23 was observed lying in bed, asleep facing towards the wall (left side of the bed is against wall/window side of room). Linens were bunched up on floor under the window and hospital gown bunched up on windowsill. The walls were heavily soiled with grayish/brownish colored debris (as if something exploded, sprayed all over). The floors appeared heavily soiled with dirt/debris. On 12/19/22 at approximately 10:30 AM, discussion with direct care staff identified R23 has behaviors of smearing feces and food throughout the room. When asked where that would be documented, they reported they told the nurse or documented under the task section of the electronic clinical record. Review of the clinical record revealed R23 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: anxiety disorder, schizophreniform disorder (added 10/7/21), and Major Depressive Disorder recurrent severe with psychotic symptoms. According to the Minimum Data Set (MDS) assessment dated [DATE], R23 had no communication concerns, had severe cognitive impairment (scored 6/15 on Brief Mental Status Exam/BIMS), had no mood concerns, had no hallucinations/delusions, had behaviors of rejecting care 1 to 3 days during this 7 day review period, received antipsychotic medication for 7 days during this 7 day review, had no gradual dose reduction (GDR) attempted and indicated the physician documentation that a GDR was clinically contraindicated was on 9/19/22. Review of the nursing progress notes included some recent behaviors which documented: An entry on 12/4/22 at 9:43 PM, .patient aide was trying to prepare patient for adl (activities of daily living) care because he was incontinent of bowel and bladder. patient was refusing to get out of bed so that his linen could be changed. when writer tried to talk with patient about having adl care he stated its nothing wrong with my pants and bed. When the aide walked toward his bed to assist him patient tried to kick her in the stomach refusing to allow her to come near. patient was left alone for a while and writer attempted again to no avail. An entry on 12/1/22 at 7:25 AM, .Res (Resident) observed putting feces in the sink in the bathroom he shares with other residents. This is not residents first occurrence smearing Bm (bowel movement) all around the bathroom. When asked why he chose to do this res ignored this writer. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An entry on 11/28/22 at 10:21 PM, .Resident refused x3 to get cleaned up, after having a bowel movement and playing in it.all staff tried to have resident clean up or take a shower, resident refused and became combative . Review of the kardex (information available to direct care staff) identified behaviors of wandering or statements of wishing for death or wanting to die. The section for Behavior/Mood directed staff to Document observed behavior and attempted interventions on (electronic record). There was no identification of any past or current monitoring to address R23's recently noted combative/violent behavior, smearing of feces. Review of the most recent social service progress note dated 9/28/22 at 5:04 PM documented: .Writer attempted to complete SS (Social Service) assessment with resident in room, resident declined participation. Resident stated, I would if I wanted to.Resident dx (diagnoses) include Major Depressive D/O (disorder), Vascular Dementia w(with)/ Behavioral Disturbance, Schizophreniform D/O, and AnxietyD/O. Resident has a hx (history) of violent behavior. No aggressive behavior noted. Resident prescribed Aripiprazole 5mg PO (by mouth) @ bedtime. Writer will attempt to assess at a later time. There was no additional social service progress notes available for review, or that social work had been informed/aware of the documented behaviors with nursing staff. Review of the GDR documentation from 9/19/22 included a psych consultation (most recent as of this review) which documented, .Per staff patient has been calm and cooperative, without s/s (signs or symptoms) of depression, anxiety and no behavioral issues reported .GDR Clinically contraindicated for Antipsychotic Treatment related to dementing illness and associated behavioral symptoms. A GDR is contraindicated at this time because target symptoms have not been sufficiently relived <sic> by non-pharmacological interventions or other psychoactive medications . It should be noted this is the same verbal for all residents reviewed each GDR considerations (duplicate/canned statement). The Assessment & Plan further documented, .Schizophreniform disorder .Plan: Patient appears stable, no behavior issues reported or noted. No acute s/s of anxiety, depression, or psychoses noted and reported by staff . There were no resident specific targeted behaviors identified throughout this assessment. On 12/20/22 at 11:00 AM, an interview was conducted with the Social Work Director (SW 'A'). When asked to identify what R23's resident specific targeted behaviors were and where that would be documented, SW 'A' reported staff would document on the behavior task section in the electronic clinical record. SW 'A' was asked to review that documentation and confirmed for the past 30 days (maximum look back period available for review) there were no behaviors identified. When asked what were R23's specific behaviors, SW 'A' offered no further response. When asked to review the psych consultation to identify what specifically they were monitoring specific to R23, SW 'A' reviewed the psych consultation from 9/19/22, confirmed the same concern and reported they would look to see if there was any other documentation available. No further documentation was provided by the end of the survey. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/22 at 12:30 PM, SW 'A' was asked how often R23 was seen by psychiatry and whether the psych services participated in any sort of behavioral management program. SW 'A' reported they did not and R23 was last seen by psych on 9/19/22. SW 'A' reported that their psych services saw residents quarterly and they had just been to the facility today, but R23 was not seen. When asked if they were aware of any recent behaviors such as smearing feces or hitting staff, SW 'A' reported they were not. SW 'A' was asked to review the most recent social service evaluation and reported that was done on 9/28/22 and prior to that was not until 12/28/21. When asked why there had been no assessment from SW during that time, they reported they were not able to offer any explanation. When asked to review R23's Behavior Management Program Review and Symptom Analysis dated 10/3/22, SW 'A' confirmed this only identified the following behaviors: Resident does not exhibit motivation for grooming and hygiene Resident declines medication Resident declines psychotropic medications SW 'A' was asked about what was discussed and/or reviewed at behavior management and they reported they came together as an interdisciplinary team to discuss what they've been doing to help alleviate the behavior and that would be noted under the progress notes. When asked why they were not informed of the recent behaviors documented, SW 'A' was unable to offer any further explanation. SW 'A' was asked to provide any additional documentation to address R23's specific behaviors and interventions. There was no further documentation provided by the end of the survey. 47128 R43 Review of the clinical record revealed that R43 was admitted to the facility on [DATE]. Diagnoses include seizures, stroke, dementia, depression, and paranoid schizophrenia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that R43 was severely cognitively impaired. Further review of the clinical record revealed that the last Preadmission Screening/Annual Resident review (PASARR) for Mental Illness/Intellectual Disability/Related Conditions, Level 1 Screening (form DCH-3877) was completed on 6/28/2021 with a determination that R42 is exempt from level 2 screening per DCH form 3878, Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification. On 12/20/22 at 1:07 PM an interview was conducted with SW Manager A, who confirmed that she is responsible for PASARR coordination. When asked about the PASARR for R43, SW Manger A confirmed that the last PASARR level one screen was on 6/28/21 and a current PASARR was not in R43's record. No explanation was offered as to why the information was missing. Per State rules as described on the Office of Specialized Nursing Home's website, In addition, persons residing in a nursing facility who are seriously mentally ill and/or have an intellectual / developmental disability are required to undergo a similar review annually . (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per a facility policy entitled, Resident Assessment-Coordination with PASARR Program (revised 1/2021), The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. Furthermore, the policy states, All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening . The policy does not indicate that screening be completed annually, which is contrary to State rules. R62 Review of the clinical record reviewed that R62 was admitted to the facility on [DATE]. Diagnoses include end stage kidney disease, diabetes, heart failure, hypothyroidism, and hyperlipidemia. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated that R62 was cognitively intact. On 12/20/22 at 9:57 AM an interview was conducted with R652 regarding advance directives. In this conversation, R62 reported that she wants to be an organ donor and/or donate her body to science. She stated that she told SW Manager A, about this on more than on occasion. Review of the clinical record revealed no documentation regarding R62's wishes to be an organ donor and/or donate her body to science. On 12/20/22 at 12:53 PM an interview was conducted with SW Manager A. When asked about R62's wishes for organ and/or whole-body donation, SW Manager A stated that she was not aware of this. When informed that R62 stated that she expressed her wishes to SW Manager A, SW Manager A did not have a response. 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. Review of the clinical record revealed that R64 did not have an advance directive in place. A social services progress note dated 8/11/22 stated, in part, .Is there a DPOA/guardian? Have copies? Request copies? Is DPOA activated? Need to start process?: No DPOA/Guardian awarded. Resident will benefit from a legal decision maker r/t impaired cognition . The record did not contain any documentation indicating that guardianship was in process or had been addressed. Additional record review revealed a social service progress note dated 12/2/22 stating, in part, .Family requests an increase in pain medication and a hospice consult. Nursing and Physician notified. An ID Review note dated 12/13/22 stated, in part, .SW to follow regarding hospice . An order for a hospice consultation was written on 12/5/22. There was no documentation in the clinical record indicating that this consultation had taken place. An interview was conducted with SW Manager A on 12/20/22 at 12:56 PM. SW Manager A indicated that R94 does not have a decisionmaker, and she had addressed guardianship with the son. SW Manager A indicated that the son told her he is working on it. When informed that R94's clinical record lacks documentation regarding these discussions, SW Manager A did not have an explanation. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During this interview, SW Manager A indicated that R94 might be admitting to hospice care, and she confirmed that a hospice consult order was written on 12/5/22. SW Manager A was not sure when the order was sent to the hospice agency. When asked why there is a delay in getting the hospice consult completed, SW Manager A, suggested that the consult might have already been completed, and that documentation would be in the nursing notes. When SW Manager A, was told that this information was not found in the clinical record, SW Manager A, stated that she would follow-up. No additional information was provided prior to the end of the survey. Per a facility policy entitled, Residents' Rights Regarding Treatment and Advance Directives (revised 12/2020), It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive .1. On admission, the facility will determine if the resident has executed an advance directive, which can designate a DPOAH and/or future healthcare treatment preferences, and if not, determine whether the resident would like to formulate an advance directive .5. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to ensure the attending physician reviewed and acknowledged recommendations and irregularities identified by the consultant pharmacist during medication regimen reviews for two (R27 and R68) of five residents reviewed for Medication Regimen Review (MRR). Findings include: According to the facility's policy titled, Medication Regimen Review dated 3/2022 documented: .The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities .The pharmacist shall communicate any irregularities to the facility in the following ways: a. Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs. b. Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing . Written communications from the pharmacist shall become a permanent part of the resident's medical record .Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. R27 Review of the clinical record revealed R27 was admitted into the facility on [DATE], readmitted on [DATE] with diagnoses that included: Alzheimer's disease, generalized anxiety disorder, cognitive communication deficit, severe dementia with other behavioral disturbance, Major Depressive Disorder recurrent, and psychotic disorder with delusions due to known physiological condition. According to the Minimum Data Set (MDS) assessment dated [DATE], R27 had long and short-term memory impairment with severely impaired cognitive skills for daily decision making, had no mood concerns, no hallucinations or delusions, no behaviors, received antipsychotic, antianxiety and antidepressant medication for seven of the seven days during this assessment period, had not had a gradual dose reduction (GDR) for the antipsychotic medication. Review of the pharmacy recommendations revealed an irregularity identified on 11/11/22. There was no documentation available in the clinical record of what the specific irregularities/recommendations were and whether they had been addressed. Review of documentation of the Physician/Prescriber Response provided by the Director of Nursing (DON) revealed: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The recommendation dated 11/11/22 was regarding R27's use of antipsychotic medication and read, .Re: QUEtiapine Fumarate Tablet 50 MG (Milligrams) Give 50 mg by mouth at bedtime .Please consider a gradual dose reduction if appropriate .CMS (Centers for Medicare/Medicaid Services) guidelines require a gradual dose reduction (GDR) twice in 2 separate quarters with at least 1 month between attempts within the first year and then once per year thereafter. (If a GDR is contraindicated, please document the clinical rationale to support current therapy) . The section of the form for the Physician/Prescriber Response was marked with a slash through AGREE and the signature read, Verbal and the date was left blank. On 12/21/22 at 3:00 PM, the DON was asked about the documentation on the pharmacy recommendation, specifically when and who had completed that and the DON reported they had been unable to find the actual forms provided so they contacted the pharmacy today to provide and they had spoken to the physician. When asked what the process was, the DON reported they get the recommendations in an email, placed those in the physician's books, and the nurses and unit managers would follow up with any agreements and make those changes in the clinical record. When asked why this wasn't completed until today, they reported they were only in their roles for about two months and was unable to offer any further explanation. When asked if the Medical Director was involved, if there were concerns identified about other physician's not responding to recommendations, the DON reported they weren't sure. 39592 R68 Review of the clinical record revealed R68 was admitted into the facility on [DATE] with diagnoses that included: amyotrophic lateral sclerosis (ALS), schizoaffective disorder, major depressive disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R68 had moderately impaired cognition. The MDS assessment also indicated R68 had no mood or behavior concerns including hallucinations/delusions, received antipsychotic and antidepressant medication for seven of the seven days during this assessment period, had not had a gradual dose reduction (GDR) for the antipsychotic medication, and there was no physician documentation that a gradual dose reduction was clinically contraindicated. Review of the pharmacy recommendations revealed irregularities were identified on: 10/23/21, 11/16/21, 2/19/22, 3/25/22, 5/24/22, 6/15/22, 11/11/22 and 12/10/22. There was no documentation available in the clinical record of what the specific irregularities/recommendations were and whether they had been addressed. Review of documentation of the Physician/Prescriber Response provided by the DON revealed: The recommendation dated 11/16/21 was for Triple Antibiotic Plus Ointment 1%. The box was marked Agree, Verbal in the Signature line, and it was undated. The recommendation dated 5/24/22 was for Apixaban. The box was marked Agree, the Signature and Date lines were left blank. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The recommendation dated 11/11/22 was for Melatonin. The box was marked Disagree, no rational was given, Verbal was in the Signature line, and it was undated.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to ensure one (R68) of five residents reviewed for unnecessary medications had adequate monitoring and documentation of specific targeted symptoms/behaviors/non-pharmacological approaches for continued use of psychotropic medication (antidepressant and antipsychotic). Findings include: On 12/19/22 at 10:00 AM, R68 was observed lying in bed. R68 was asked about care at the facility. R68 explained he did not have any concerns. Review of the clinical record revealed R68 was admitted into the facility on [DATE] with diagnoses that included: amyotrophic lateral sclerosis (ALS), schizoaffective disorder, major depressive disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R68 had moderately impaired cognition. The MDS assessment also indicated R68 had no mood or behavior concerns including hallucinations/delusions, received antipsychotic and antidepressant medication for seven of the seven days during this assessment period, had not had a gradual dose reduction (GDR) for the antipsychotic medication, and there was no physician documentation that a gradual dose reduction was clinically contraindicated. Review of R68's medications revealed the following psychotropic medications: Bupropion (antidepressant) 150 mg one time a day, start date 9/7/21 Mirtazapine (antidepressant) 7.5 mg at bedtime, start date 4/28/22 Quetiapine (antipsychotic) 100 mg one time a day, start date 9/8/21 Quetiapine 400 mg at bedtime, start date 9/7/21 Sertraline (antidepressant) 100 mg one time a day, start date 9/8/21 Trazadone (antidepressant) 150 mg at bedtime, start date 9/7/21 Review of R68's Antidepressant or Mood Stabilizer care plan revised 3/21/22 revealed interventions that read in part, .Document on (electronic medical record) and report to social work prn (as needed) ongoing s/sx (signs and symptoms) of depression . Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness . Review of R68's anti-psychotic medication care plan revised 3/21/22 revealed interventions that read in part, . Monitor/record/report to Social Worker/RN/LPN/MD prn side effects and adverse reactions of psychoactive medications . Review of R68's Behavior 30 day Look Back revealed no behaviors documented. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R68's progress notes revealed no behaviors or s/sx of depression or psychosis documented. Review of R68's psychiatric progress notes dated 12/16/21, 1/20/22, 3/17/22, 4/28/22, 7/11/22 and 9/19/22 revealed all notes describe R68 as being calm and cooperative and there being no documentation of behaviors. On 12/21/22 at 12:35 PM, Social Worker (SW) A was interviewed and asked if there was any documentation of R68 behaviors. SW A explained there was no documentation of R68 having hallucination and no behaviors were documented. On 12/21/22 at 3:08 PM, the facility's contracted Psychiatrist, Dr. P was interviewed by phone and asked about the continued use of psychotropic medications and the lack of documented behaviors. Dr. P explained when someone from the psychiatric team would go to the facility, they would talk to SW and the nurses because there was usually a lack of documentation of behaviors. Review of a facility policy titled, Behavior Management Program revised 12/2020 read in part, .Assessment: a. Behaviors shall be identified through the RAI (Resident Assessment Instrument) process and through staff interaction. b. Further assessments to identify and manage behaviors may be conducted. c. Identified behaviors should be evaluated for frequency, duration, intensity and pattern. d. The Interdisciplinary Team should decide which residents need a behavior management program by evaluating the documented behaviors. e. The plan of care should be reviewed at least quarterly and as needed for continued need of behavior management and appropriate interventions .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39592 Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate greater than 5%, with two medication errors out of 25 opportunities for error, resulting in a 8% error rate. This deficient practice affected two (R90 and R35) of three residents observed for medication administration. Findings include: R90 On 12/19/22 at 9:20 AM, Licensed Practical Nurse (LPN) J was observed preparing morning medications for R90. LPN J placed seven medication into a medication cup. LPN J was then observed to enter R90's room and offer him the seven medications. R90 refused to take the medications, and all seven medication were observed wasted into a sharps container. On 12/19/22 at 12:29 PM, reconciliation of R90's medications revealed LPN J had signed that R90 had refused Folic Acid 1 mg (milligram). Folic Acid 1 mg was not one of the observed seven medications LPN J had offered to R90. On 12/21/22 at 4:58 PM, the Director of Nursing (DON) was interviewed and asked if a medication had to be offered to a resident before it could be marked off as refused. The DON explained that yes, if the Folic Acid had not been offered, it should not have been marked as refused. Review of a facility policy titled, Medication Administration - General Guidelines dated June 2019 read in part, .Medications are administered as prescribed in accordance with good nursing principles and practices . The Five Rights (Right Resident, Right Drug, Right Dose, Right Route, and Right Time) are applied for each medication being administered. A triple check of these Five Rights is recommended at three steps in the process of preparation of a medication for administration . 41415 R35 On 12/19/22 at approximately 9:30 AM, Licensed Practical Nurse (LPN) B was observed preparing the morning medications for R35. LPN B was observed to have prepared Miralax powder utilizing a plastic clear medication cup instead of the Miralax bottle cap as documented on the bottle. LPN B filled the medication cup with 25 cc of Miralax powder and poured the powder in the resident's water. The nurse was observed to have administered the cup of water that contained the Miralax to R35. Review of R35's physician orders documented in part, . GlycoLax powder (Miralax) . Give 17 gram by mouth one time a day for constipation . The resident was administered more than the prescribed dose. On 12/21/22 at 4:58 PM, the DON was asked how the nurses should measure the Miralax powder and stated the nurses should be using the purple top of the Miralax bottle to ensure an accurate dose.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41415 Based on observation, interview and record review the facility failed to ensure expired medications and tubersol solution were removed from the facility's supply room and discarded per the facility's policy for one of two medication storage rooms reviewed. Findings include: On 12/21/22 at approximately 12:55 PM, the [NAME] hallway medication storage room was reviewed with Clinical Regional Director (CRD) I. Upon observation a Milk of Magnesia bottle with an expiration date of 8/2022 was identified as the only Milk of Magnesia bottle on the supply shelf. Review of the storage room refrigerator contained a tubersol solution vial with the open date of 10/19/22. When asked the CRD I acknowledged that both the Milk of Magnesia and tubersol vial should have been discarded per the facility's policy. CRD I stated they would follow up on it immediately. Review of a facility policy titled Medication Storage In The Facility dated June 2019, documented in part . Outdated . medications . are immediately removed from the medication supply, disposed of according to procedures for medication disposal, and reordered .

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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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30675 Based on observation, interview, and record review, the facility failed to ensure drinkware were properly stored and staff utilized adequate handwashing during meal preparation. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 12/19/22 between 12:05 PM-1:53 PM, during an observation of the kitchen with Certified Dietary Manager (CDM 'CC'), the following items were observed: There were several plastic crates with clear drinkware observed stored stacked (some stacked three to four cups high). The inside of the cups were observed with moisture and not dried adequately. CDM 'CC' was asked about the storage of the cups and reported those should have been put in drying racks and not stored in that manner. According to the 2013 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, (A) Except as specified in (D) of this section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; Dietary Staff 'GG' was observed at the meal prep tray line plating up food trays. Dietary Staff 'GG' was observed going back and forth, handling the food carts to take to the outside of the kitchen and then resuming plating up food, without hand washing in between. Dietary Staff 'GG' was also observed to repeatedly touch their surgical face mask and forehead with their bare hands, without hand washing or utilizing hand sanitizer. According to the 2013 FDA Food Code section 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: .(E) After handling soiled equipment or utensils;

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34275 Based on observation, interview, and record review, the facility failed to implement an effective Quality Assurance & Performance Improvement (QAPI) program that identified quality issues and implemented appropriate plans of action to correct quality deficiencies and maintain sustained compliance. This failure had the potential to affect all residents that resided in the facility. Findings include: An annual recertification survey was conducted from 12/19/22 through 12/21/22 and several deficiencies were identified by the onsite survey team including issues pertaining to the environment which was evidenced by soiled floors; dirty linens, privacy curtains, and resident equipment, some that were caked with fecal matter, dirty and unkept bathrooms and shower rooms with fecal matter noted on the toilet seat and on the tiles and issues pertaining to food palatability and temperature. On 12/21/22 at approximately 4:59 PM, the facility Administrator was interviewed regarding the facility's QAPI program. The Administrator reported the QAPI committee meets on the third Wednesday of each month. When queried about whether concerns related to the resident environment (cleanliness of the facility and leaking water into resident's rooms and other locations in the facility) were identified as a concern through the QAPI process, the Administrator reported housekeeping issues were identified by facility via the resident council and general observations at the facility. The Administrator reported that the facility was operating on a skeleton crew and was in the process of hiring staff including housekeeping as the facility was down to only four housekeepers. When asked if they were aware of food concerns expressed by the residents, the Administrator noted that they were aware of the concerns expressed by residents and again and that they were in process of making managerial improvements. Review of a facility policy titled, Quality Assurance and Performance Improvement read in part, .Develop and implement appropriate plans of action to correct identified quality deficiencies . Regularly review and analyze data . and act on available data to make improvement .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41415 Based on observation, interview and record review the facility failed to consistently maintain an ongoing Infection surveillance system and ensure infection control standards and practices were consistently followed by the facility staff, this had the ability to affect all 98 residents residing in the facility at the time of survey as well as staff and visitors. Findings include: Review of the facility's Infection Control Surveillance program revealed the following: October 2022- No analyzation of the facility's infections or data report developed to review and present to the facility's QAPI (Quality Assurance & Performance Improvement) team. December 2022- No documentation of the facility's infections and no tracking or mapping of the facility's infections were currently documented. On 12/21/22 at 12:06 PM, the Infection Control Nurse who also serves as the facility's Infection Control Preventionist (ICP) L was interviewed and asked for the October data report which consists of the facility's infections, infection trends and patterns and the summary and analysis of infections and number or residents who developed infections, ICP L stated they would look into it and follow back up. At 12:32 PM, ICP L returned and stated they could not find documentation of the October 2022 analyzation of the facility's infections and data report. ICP L stated they had just recently taken over the role as the facility's Infection Preventionist and in October 2022 the facility's Director of Nursing (DON) was overseeing the Infection Control Program. On 12/21/22 at 1:11 PM , the DON was interviewed and asked why the facility did not complete an analyzation of the facility's infections for the month of October 2022 and the DON did not have a reply. The DON was then asked how the facility was able to properly and timely identify infections, clusters and outbreaks if the facility is not logging, tracking, mapping infections and completing observations of staff infection control practices in the facility to readily be able to identify, prevent, report, investigate and control the facility's infections and communicable diseases considering there was no documentation provided for the infection control surveillance for December 2022 and the DON did not have a response. No further information or documentation was provided by the end of survey.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on record review and interview the facility failed to continuously implement an antibiotic stewardship program that included consistent implementation of protocols for appropriate antibiotic use for three (R's 8, 47 and 12) of five residents reviewed for the antibiotic stewardship program. Findings include: According to the Center for Disease Control's (CDC) The Core Elements of Antibiotic Stewardship for Nursing Homes, dated 2015: .Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use .Antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics when followed over a year .studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic- resistant organisms .Infection prevention coordinators have key expertise and data to inform strategies to improve antibiotic use. This includes tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections .Identify clinical situations which may be driving inappropriate courses of antibiotics such as asymptomatic bacteriuria or urinary tract infection prophylaxis and implement specific interventions to improve use . Review of the facility's Antibiotic Stewardship Program revealed the following: R8 Review of a Physician noted dated 8/30/22 at 6:25 PM, documented in part . history of recurrent UTIs - prophylactic antibiotic he was apparently prior to coming to the hospital - was stopped by Hospital team - to be monitored . R8 was admitted to the facility on [DATE] and Bactrim 400-80 MG (milligram) tablet, once a day was started on 9/2/22 for a Chronic UTI (Urinary Tract Infection). Review of the medical record revealed no documentation on why the antibiotic was restarted or that it was reviewed for appropriateness. R47 R47 was admitted to the facility on [DATE] with Keflex 500 mg for a UTI, which was reviewed and deemed appropriate. Review of the physician orders revealed on 10/28/22, Macrobid 100 MG capsule twice a day for five days was started for a UTI. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record and progress notes documented no explanation or justification for need of the Macrobid administration. R12 Review of Nursing note dated 11/21/22 at 6:33 AM, documented in part . At around 530am resident was sitting in his wheelchair in front of the nurses station. He asked the staff for sandwich. After that staff tried to take him to his room but resident refused. He wants to stay in front of the nurses station. After a few minutes 911 came and the resident was already in his room. I talked to the 911 and they said that the resident called them and told them that he wants to go to the hospital. 911 was informed that the resident had done this a few times in the past and it's a behavioral problem. 911 went to see the resident and they asked him why he wants to go to the hospital and he claimed that he fell . He also said something about his leg. 911 asked if he is responsible for himself. Writer went to the desk to print the profile. When I came back 911 was already transferring him to the stretcher. They said that there's nothing they could do if he is responsible for himself and he wants to go to the hospital . Review of a Physician order dated 11/21/22 at 3:01 PM, documented in part . seen following return for <sic> ER (emergency room) . per report Pt (patient) positive for UTI started on ABX (antibiotic) . Keflex 500 mg BID (twice a day) x 5 days . Review of the medical record revealed no documentation from the hospital such as labs, urinalysis or culture reports that identified a UTI. Further review of the medical record revealed no documentation of the review of appropriateness of the antibiotic prescribed. On 12/21/22 at 12:06 PM, the Infection Control nurse who also serves as the facility's Infection Control Preventionist (ICP) L was interviewed and when asked stated the facility utilizes McGeer criteria for antibiotic use. ICP L was then asked if R's 8, 47 and 12 antibiotics was reviewed for appropriateness and if the antibiotic met criteria. ICP L stated they would look into it and follow back up. At 12:32 PM, ICP L returned and stated they could not provide any documentation of either antibiotics for R's 8, 47 or 12 to have been reviewed for appropriateness. No further explanation or documentation was provided by the end of survey.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Perform COVID19 testing on residents and staff. 34275 Based on interview and record review the facility failed to track and maintain accurate documentation of the facility's outbreak investigation/testing for both staff and residents. Findings include: Review of the community transmission was noted as High (red) for the months of December 2022. During an entrance conference with the Administrator on 12/19/22 at approximately 9:05 AM, it was reported that the last person to have COVID-19 in the building was Nurse CC on 12/13/22. COVID-19 testing documentation from 12/13/22 to present for both staff and residents were requested. The Administrator reported that the facility had new Infection Control Preventionist (ICP) hereinafter ICP L that recently started employment at the facility a few weeks ago, and she would be able to assist. On 12/21/22 at approximately 1:56 PM an interview and record review were conducted with ICP L who was asked as to the protocol following a positive staff person on 12/13/22. ICP L reported that the facility decided to do a full hours sweep and all staff and residents started to receive testing two times per week starting on 12/13/22. As for residents, ICP L reported testing results would be located in the electronic record. A review of some of the resident's charts including, but not limited to R24 and R9, revealed no indication of COVID-19 testing after 12/13/22. A second request for any documentation/log that would verify testing for both residents and staff was requested at this time. ICP L suggested talking with Staff NN. On 12/21/22 at approximately 2:59 PM, Staff NN was asked for documentation pertaining to COVID 19 testing for both staff and residents. Staff NN called another Staff person who noted that results for residents would be in their electronic record. On 12/21/22 at approximately 3:29 PM an interview and record review were conducted with Clinical Regional Director (CRD) I. When looking through resident's electronic records, CDR I was not able to locate testing results in the resident's chart. On 12/21/22 at approximately 4:06 PM, a second interview was conducted with ICP L. ICP L provided an unorganized pile of COVID-19 test results for both staff and residents. When asked how they were able to determine who received the testing and who did not, ICP L reported that she was new to the facility, realized that things needed to be more organized and would start to work on a better system. No further documentation was provided before the end of the Survey. (continued on next page)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Infection Prevention and Control Program (revised 12/20) documented, in part, the following: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases .the designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures . No facility policy(s) pertaining specifically to COVID-19 testing was provided by the end of the Survey. A CDC (Centers for Disease Control and Prevention) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During COVID 19 Pandemic (updated 9/23/22) recommended, in part: .Asymptomatic patients with close contact with someone with SARS-COV-2 infection should have a series of three viral tests for SARS-COV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after exposure) and if negative, again 48 hours after the first negative test and if negative, again 48 hours after the second negative test. This will typically be on day 1 (where date of exposure is day 0) , day 3 and day 5.