STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235324	A. Building B. Wing	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Healthcare Center	1149 West Monroe Rd Saint Louis, MI 48880

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 This citation pertains to MI000125429 Based on observations and interviews, the facility failed to provide a safe, clean and home like environment for all residents, resulting in the potential for spread of infection/disease, fire (extension cord safety) , injury related to cluttered living spaces and rooms were not home like (personalized). Findings include: On 1/23/22 at 12:03 PM, a review of room [ROOM NUMBER] side B presented with an un-made bed with clutter to include personal belongings and beverage cups covering the over-the-bed table, the nightstand, and on the floor. The floor around the bed was dirty with loose debris. Across from the bed were two bags of empty beverage cans, loose shoes, an electrical outlet with adapters to allow multiple devices and extension cords to be plugged in. The room did not reveal any personalization. The bathroom presented with a dark dirt-stained floor around the commode with moderate dirt over the rest of the floor. The room was revisited on 1/25/22 at 9:25 AM with an unchanged presentation. Photographs were taken of the display of clutter and unsanitary conditions of the room. On 1/23/22 at 2:25 PM, an observation was conducted of the shared bathroom between rooms [ROOM NUMBERS]. This bathroom had a shower that was severely soiled with discolored floor borders and a clump of hair near the front corner of the shower. The floor of the toilet area was dirt stained. The room was revisited on 1/24/22 at 9:04 AM and was found to be in the same state with the clump of hair remaining at front corner of the shower. Photographs were obtained. On 1/23/22 at 2:37 PM, an observation of room [ROOM NUMBER] revealed clutter throughout the room, soiled sheets, debris scattered across floor around the room and under the bed. A spilled liquid was puddled on the floor. No personalization of the room was noted. The shared bathroom presented with dirt-stained floor around the toilet and general uncleanliness. The door to the sharps container affix to the wall was open and the glove dispenser was empty. A return to the room and bathroom on 1/24/22 at 9:09 AM revealed the spill on the floor in the resident's room was gone but the clutter, debris, and soiled bedding remained. The bathroom was as previously noted. Photographs were obtained. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/24/22 at 10:34 AM, observation of room [ROOM NUMBER] revealed it to be cluttered with a large trash bag filled with beverage cans. A large box approximately two-foot square and four foot tall was noted in the room. The Resident of the room reported the box was filled with clothes that belonged to another resident. On 1/24/22 at 10:40 AM, an observation of room [ROOM NUMBER] revealed it appeared dirty and cluttered with unfolded clothing in piles. Empty beverage cans and debris were observed on the floor. In an interview conducted 1/23/22 at 3:36 PM, the Nursing Home Administrator (NHA) reported the facility has one full-time and one part-time housekeeping staff members. The NHA reported there is one full-time laundry staff. On 1/31/22 at 8:59 AM, Medical Records (MR) L was observed performing housekeeping duties in room [ROOM NUMBER] with housekeeping cart outside of a room. On 2/10/22 at 9:45 AM, Laundry Staff (LS) CC reported that no housekeeping staff were available that day as the Housekeeper had called in. LS CC reported that office staff will help with housekeeping and laundry sometimes. On 2/10/22 at 10:41 AM, a telephone interview was conducted with Housekeeper (HK) W. HK W reported that she is the only housekeeper. HK W reported that her main job is housekeeping but that she spends about half of her time in laundry. HK W reported she cannot keep up with cleaning the rooms but does as many as she can in a day. HK W reported she is responsible for all the resident rooms, all the bathrooms, and all the common areas. HK W reported that the Certified Nurse Aides are supposed to take care of the linen closets and mop buckets but no one does. HK W indicated she assumed that duty also. HK W reported that it is not possible to clean all the resident rooms in one day and that she goes home upset wishing she could have done more. 39083 On 1/24/22 at 8:45 AM, the exhaust vent in the bathroom of room [ROOM NUMBER] was tested using a paper towel and was unable to pull or hold the paper towel indicating poor ventilation. At this time, the shower chair in the bathroom was observed to be soiled with a brown stain. Additionally, no cove base was observed in room [ROOM NUMBER] to allow for proper floor cleaning. On 1/24/22 at 8:50 AM, hand soap was not provided in room [ROOM NUMBER]. Additionally, the floor was observed to be soiled with food debris around bed A. On 1/24/22 at 8:58 AM, the handsink drain line in room [ROOM NUMBER] was observed to be severely leaking when the faucet was used. At this time, a garbage can was observed to be placed under the drain line to catch the leak. Additionally, a hole was observed in the drywall underneath the hand sink. On 1/22/24 at 9:00 AM, the exhaust vent in the bathroom of room [ROOM NUMBER] was observed to not be functioning, determined by using a paper towel to test the exhaust. On 1/22/24 at 9:08 AM, the exhaust vent in the bathroom of room [ROOM NUMBER] was observed to not be functioning, determined by using a paper towel to test the exhaust. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/22/24 at 12:09 PM, the floor in room [ROOM NUMBER] was observed to be soiled with debris and food crumbs. On 1/22/24 at 12:16 PM, the light fixture, in the hall by room [ROOM NUMBER], was observed to be missing the lens (light shield) On 1/22/24 at 2:53 PM, the floor in room [ROOM NUMBER] was observed to be soiled with debris and food crumbs. On 1/22/24 at 3:05 PM, the floor in room [ROOM NUMBER] was observed to be soiled with debris and an unknown spill. During an interview on 1/25/22 at 12:25 PM, Resident # 23 stated that their window blinds won't go up. At this time, the register cover was observed to be missing. On 1/25/22 at 12:53 PM, Liquid soap was observed to be accumulating into a puddle on the floor in bathroom of room [ROOM NUMBER]. On 1/25/22 at 12:57 PM, the light over bed B in room [ROOM NUMBER] was observed to not be working. A pile of crumbs and soil was observed against the wall, behind bed A. Additionally, the toilet in the bathroom of room [ROOM NUMBER] was observed to have a brown substance smeared on the toilet seat, and an unknown particulate matter covering the toilet seat, which had the appearance of flaked skin. At this time, Maintenance Director Y stated, Eww. No paper towels were provided in the bathroom of room [ROOM NUMBER] and the exhaust vent was observed to not be functioning. On 1/25/22 at 1:02 PM, a box fan, located in room [ROOM NUMBER], was observed to be caked with dust. On 1/25/22 at 1:04 PM, the floor in room [ROOM NUMBER] was observed to soiled with debris and an unknown spill. On 1/25/22 at 1:37 PM, the bathroom floor of room [ROOM NUMBER], was observed to have a layer of unknown dried residue, no paper towels were provided, and the bathroom had a strong odor. The floor of room [ROOM NUMBER] was observed to be generally soiled and gnats were congregated at the trash can. On 1/25/22 at 1:40 PM, the box fan blades, in room [ROOM NUMBER], were observed to be caked in dust. At this time, Resident #6 was queried on how often rooms are cleaned and stated, Never, very rarely do they do the rooms. At this time, the bathroom exhaust vent was observed to not be functioning. On 1/25/22 at 1:45 PM, the exhaust vent in the bathroom of room [ROOM NUMBER] was observed to not be functioning. Additionally, the trash can in the room was observed to be overflowing with briefs. On 1/25/22 at 1:50 PM, a layer of soap scum was observed in the shower of the East hall Shower room. The shower curtain was observed to have multiple stains and the call light cord was observed to be missing from the receptacle. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/25/22 at 2:00 PM, the exhaust vent in the bathroom of room [ROOM NUMBER] was observed to not be functioning, determined by using a paper towel to test the suction. On 1/25/22 at 2:05 PM, the overhead light above bed B in room [ROOM NUMBER] was observed to not be functioning. On 1/25/22 at 3:07 PM, a brown smear was observed on the resident hand sink in room [ROOM NUMBER]. On 1/25/22 at 3:50 PM, the soiled toilet in the bathroom of room [ROOM NUMBER] was observed by the Administrator, who stated, Unacceptable.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 This citation pertains to intake number MI000125541 and MI000125429 Based on interview and record review, the facility failed to prevent the abuse of 1 Resident (R137) of 2 Residents reviewed for abuse, resulting in R137 needing emergency room treatment when R22 hit R137 in the eye. Findings include: R22 Review of R22's face sheet, no date, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: dementia with behavioral disturbance, schizophrenia, unspecified psychosis, anxiety disorder, muscle weakness, difficulty in walking, restlessness and agitation, depression, diabetes mellitus and moderate protein-calorie malnutrition. R 22 was not his own responsible party. Review of R22's Psychiatric Hospital History and Physical Examination dated 11/1/12 revealed, The patient is current resident at (name of this facility). Staff reports that the patient became physically aggressive (throwing, kicking, and attempting to punch a nurse) for asking him to lower his music. The patient continuously raises volume, causing disruption to other residents. The patient tore a metal decoration off the wall and was throwing chips in his room. He has been refusing hygiene care, is restless, and continues to be physically aggressive, per facility, on 11/01/21. Patient is calm and cooperative during examination. Patient is seen within 24 hours of admission. After Past Psychiatric History revealed, As mentioned above, patient has a history of schizophrenia with 4 previous admissions starting at age 25. Details of these admission are unknown. After Personal history revealed, Patient has resided at his current facility for approximately 2-1/2 weeks. Prior to that, he was placed at (name of sister facility) but was sent to the emergency room due to violent behavior and not returned to that facility. Review of R22's Medical Progress Note dated 12/5/21 revealed under history, This is a [AGE] year-old Afro-American gentleman with a past medical history significant for chronic dementia with recurrent behavioral disturbances, chronic schizophrenia, initial Psychiatric hospitalization at [AGE] years old, hypertension, chronic obstructive pulmonary disease, mild chronic renal insufficiency, Type 2 diabetes mellitus, osteoarthritis difficulty ambulation, predominantly wheelchair bound, chronic anxiety, who was in 2 previous sister facilities, although because of behavioral disturbances was frequently sent to the hospital and most recently last month after being treated pharmacologically and seems to be doing fairly good. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of R22's psychiatric consult note dated 12/17/21 revealed, 12/13/21 at 10:00 AM, R 22 was 'slamming his drawer shut in his room at 0800 which irritated his roommate. The roommate went to R22's side of the room and was witnessed being hit on the left forehead area the roommate's closed fist (right hand). R22 had a hold of the roommates left hand. Under assessment and plan revealed, Recommend changing Ativan 1 mg (anxiety medication) every 8 hour PRN (as needed) TID (three times a day) to Klonopin).5 mg (medication for sedation, and anxiety) every 8 hours PRN x 14 days, as resident is already taking Klonopin and would not need two different benzo's (Benzodiazepines, a class of psychoactive medications) ordered. Would recommend having documentation every time PRN dosage is given with behavior note to consider whether or not this medication PRN should be continued, increased scheduled dosage or DC PRN dosage. Review of R22's Medical Progress Note dated 12/26/21 revealed under history, This is a [AGE] year-old Afro-American gentleman with a past medical history significant for chronic dementia with recurrent behavioral disturbances, chronic schizophrenia, chronic obstructive pulmonary disease, mild chronic renal insufficiency, Type 2 diabetes mellitus, osteoarthritis difficulty ambulation, predominantly wheelchair bound, chronic anxiety, previously residing in different facilities and homeless shelters, although because of behavioral disturbances has had recurrent hospitalization s with aggressive and violent behavior towards staff and residents. He was sent to the hospital yesterday with again violent, assaultive behavior with another resident and has returned very cooperative and seems to be doing OK currently. Review of R22's event report dated 12/25/21 at 7:25 AM revealed, resident was observed at 0725 hitting another resident in the face and grabbing onto a gown. Writer immediately separated both residents. (Name of police department) notified and were in at 0735 to speak with both residents and writer Full body skin assessment completed. Small scratch to forehead. Resident denies any pain/discomfort. Md notified and guardian notified via phone and aware of incident. New order to send resident to (name of hospital) ER for eval and treatment. Resident transferred via gurney (name of company) 0845 to (name of hospital) for eval and treat. Administrator notified immediately. Review of R22's progress note dated 12/25/21 at 12:06 PM revealed, Resident returned via ambulance cart to room A, EMT staff reported to this Nurse that resident was very compliant and pleasant with no behaviors. No apparent distress noted, oriented to staff, room and call bell. Review of R22's medical record revealed no behavior tracking documentation in relation to Ativan PRN medication usage as directed in R22 psychiatric consultation dated 12/17/21. Review of R22's care plan revealed he had a care plan for Behavioral Symptoms dated 1/3/22 (10 day after he assaulted R137). Approaches included: keep distance between residents and other during hallucinations. See history listed above as resident had a long history of aggressive behavior prior to the assault on 12/25/21. No interventions were in R22's care plan prior to 1/3/22 to protect other residents from his aggressive behaviors. The facility was not able to locate any documentation that showed they were supervising or had implemented interventions to protect other residents from R22's known aggressive and physical behaviors. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on 2/8/22 at 2:40 PM, the Surveyor followed up on her request for R22's behavior tracking, care plan and any increase in supervision notes. The DON and NHA were not able to locate any behavior tracking notes or notes that R22 was being supervised when he assaulted R137. The DON said behavior tracking notes are kept on the unit in a book. The DON found the behavior tracking book, but she could not locate any notes for R22 or R137. The Surveyor reviewed R22's care plan with the DON and NHA. There was no indication of when R22 needed close supervision or how the facility was going to supervise him when his behaviors escalated. There was no indication what interventions were placed for R22 before he hit R137 or when he returned to the facility after physically assaulting a resident. Upon exit no additional information was provided. Resident #137 Review of R137's face sheet revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Bipolar disorder, Major depressive disorder, pain disorder with related psychological factors, seizures, hereditary and idiopathic neuropathy, and obesity. R137 was his own responsible party. Review of R137's progress note dated 12/25/21 at 7:25 AM revealed, Writer observed another resident hitting this resident in the face and grabbing onto his gown. Writer immediately separated both residents. Full body sin assessment completed with purple bruise to left lower eye areas, scattered scratches to right chest area and resident with c/o pain to right pinky finger, no swelling or redness noted to finger, pink in color. Resident became verbally aggressive with staff after writer assessed resident while stating, its Christmas and I have no family. Staff left resident to calm himself down and called 911 for report of altercation. Cleanse scattered scratches to right chest with soap and water, rinse and lota (unknown) till resolved q (every) shift. Writer asked resident what happened, and resident stated I was coming out of my room to get coffee and as I was propelling through the hallway resident grabbed at me and started hitting me. Review of R137's progress note dated 12/25/21 at 10:42 am revealed, R137 returned from ER at 10:30. Assessment shows bruising/very superficial abrased are to right chest (sp). Area cleansed. No dressing needed. He also shows 0.5 cm bruise under left eye. He states he will ask us for assist to move people-he states he was gently moving the other resident out of his way when the other resident started hitting him. He did have an oxycodone 10 mg (narcotic pain medication) at the ER.

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F 0607 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 This citation pertains to intake number MI000125541 and MI000125429 Based on interview and record review the facility failed to implement abuse policies to prevent the abuse of 1 Resident R137 of 2 Residents reviewed for abuse, resulting in R137 needing emergency room treatment when R22 hit R137 in the eye. Findings include: R22 Review of R22's face sheet, no date, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: dementia with behavioral disturbance, schizophrenia, unspecified psychosis, anxiety disorder, muscle weakness, difficulty in walking, restlessness and agitation, depression, diabetes mellitus and moderate protein-calorie malnutrition. R 22 was not his own responsible party. Review of R22's Psychiatric Hospital History and Physical Examination dated 11/1/12 revealed, The patient is current resident at (name of this facility). Staff reports that the patient became physically aggressive (throwing, kicking, and attempting to punch a nurse) for asking him to lower his music. The patient continuously raises volume, causing disruption to other residents. The patient tore a metal decoration off the wall and was throwing chips in his room. He has been refusing hygiene care, is restless, and continues to be physically aggressive, per facility, on 11/01/21. Patient is calm and cooperative during examination. Patient is seen within 24 hours of admission. After Past Psychiatric History revealed, As mentioned above, patient has a history of schizophrenia with 4 previous admissions starting at age 25. Details of these admission are unknown. After Personal history revealed, Patient has resided at his current facility for approximately 2-1/2 weeks. Prior to that, he was placed at (name of sister facility) but was sent to the emergency room due to violent behavior and not returned to that facility. Review of R22's Medical Progress Note dated 12/5/21 revealed under history, This is a [AGE] year-old Afro-American gentleman with a past medical history significant for chronic dementia with recurrent behavioral disturbances, chronic schizophrenia, initial Psychiatric hospitalization at [AGE] years old, hypertension, chronic obstructive pulmonary disease, mild chronic renal insufficiency, Type 2 diabetes mellitus, osteoarthritis difficulty ambulation, predominantly wheelchair bound, chronic anxiety, who was in 2 previous sister facilities, although because of behavioral disturbances was frequently sent to the hospital and most recently last month after being treated pharmacologically and seems to be doing fairly good. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	Review of R22's psychiatric consult note dated 12/17/21 revealed, 12/13/21 at 10:00 AM R22 was 'slamming his drawer shut in his room at 0800 which irritated his roommate. The roommate went to R22's side of the room and was witnessed being hit on the left forehead area the roommate's closed fist (right hand). R22 had a hold of the roommates left hand. Under assessment and plan revealed, Recommend changing Ativan 1 mg (anxiety medication) every 8 hour PRN (as needed) TID (three times a day) to Klonopin).5 mg (medication for sedation, and anxiety) every 8 hours PRN x 14 days, as resident is already taking Klonopin and would not need two different benzo's ordered. Would recommend having documentation every time PRN dosage is given with behavior note to consider whether or not this medication PRN should be continued, increased scheduled dosage or DC PRN dosage. Review of R22's Medical Progress Note dated 12/26/21 revealed under history, This is a [AGE] year-old Afro-American gentleman with a past medical history significant for chronic dementia with recurrent behavioral disturbances, chronic schizophrenia, chronic obstructive pulmonary disease, mild chronic renal insufficiency, Type 2 diabetes mellitus, osteoarthritis difficulty ambulation, predominantly wheelchair bound, chronic anxiety, previously residing in different facilities and homeless shelters, although because of behavioral disturbances has had recurrent hospitalization s with aggressive and violent behavior towards staff and residents. He was sent to the hospital yesterday with again violent, assaultive behavior with another resident and has returned very cooperative and seems to be doing OK currently. Review of R22's event report dated 12/25/21 at 7:25 AM revealed, resident was observed at 0725 hitting another resident in the face and grabbing onto a gown. Writer immediately separated both residents. (Name of police department) notified and were in at 0735 to speak with both residents and writer Full body skin assessment completed. Small scratch to forehead. Resident denies any pain/discomfort. Md notified and guardian notified via phone and aware of incident. New order to send resident to (name of hospital) ER for eval and treatment. Resident transferred via gurney (name of company) 0845 to (name of hospital) for eval and treat. Administrator notified immediately. Review of R22's progress note dated 12/25/21 at 12:06 PM revealed, Resident returned via ambulance cart to room A, EMT staff reported to this Nurse that resident was very compliant and pleasant with no behaviors. No apparent distress noted, oriented to staff, room and call bell. Review of R22's medical record revealed no behavior tracking documentation in relation to Ativan PRN medication usage as directed in R22 psychiatric consultation dated 12/17/21. Review of R22's care plan revealed he had a care plan for Behavioral Symptoms dated 1/3/22 (10 day after he assaulted R137). Approaches included: keep distance between residents and other during hallucinations. See history listed above as resident had a long history of aggressive behavior prior to the assault on 12/25/21. No interventions were located in R22's care plan prior to 1/3/22 to protect other residents from his aggressive behaviors. The facility was not able to locate any documentation that showed they were supervising or had implemented interventions to protect other residents from R22's known aggressive and physical behaviors. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on 2/8/22 at 2:40 PM the Surveyor followed up on her request for R22's behavior tracking, care plan and any increase in supervision notes. The DON and NHA were not able to locate any behavior tracking notes or notes that R22 was being supervised when he assaulted R137. The DON said behavior tracking note are kept on the unit in a book. The DON found the behavior tracking book, but she could not locate any notes for R22 or R137. The Surveyor reviewed R22 care plan with the DON and NHA. There was no indication of when R22 needed close supervision or how the facility was going to supervise him when his behaviors escalated. There was no indication what interventions were placed for R22 before he hit R137 or when he returned to the facility after physically assaulting a resident. Upon exit no additional information was provided. Resident #137 Review of R137's face sheet revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Bipolar disorder, Major depressive disorder, pain disorder with related psychological factors, seizures, hereditary and idiopathic neuropathy, and obesity. R137 was his own responsible party. Review of R137's progress note dated 12/25/21 at 7:25 AM revealed, Writer observed another resident hitting this resident in the face and grabbing onto his gown. Writer immediately separated both residents. Full body sin assessment completed with purple bruise to left lower eye areas, scattered scratches to right chest area and resident with c/o pain to right pinky finger, no swelling or redness noted to finger, pink in color. Resident became verbally aggressive with staff after writer assessed resident while stating, its Christmas and I have no family. Staff left resident to calm himself down and called 911 for report of altercation. Cleanse scattered scratches to right chest with soap and water, rinse and lota (unknown) till resolved q (every) shift. Writer asked resident what happened, and resident stated I was coming out of my room to get coffee and as I was propelling through the hallway resident grabbed at me and started hitting me. Review of R137's progress note dated 12/25/21 at 10:42 am revealed, R137 returned from ER at 10:30. Assessment shows bruising/very superficial abrased are to right chest (sp). Area cleansed. No dressing needed. He also shows 0.5 cm bruise under left eye. He states he will ask us for assist to move people-he states he was gently moving the other resident out of his way when the other resident started hitting him. He did have an oxycodone 10 mg (narcotic pain medication) at the ER.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 This citation pertains to MI000125429 Based on observation, interview, and record review, the facility failed to access residents and engage residents in meaningful activities resulting in boredom, lack of socialization, lack of self-worth and residents not reaching their highest attainable well-being. Findings: On 1/26/22 at 10:14 AM, an observation was made at the Main dining room which acted as the facility Activities Room. The Activities Schedule reflected an activity of Reminisce was scheduled for 10:00 AM. It was observed that no residents were present. A tour of the facility revealed that no residents were engaged in any Activities facility wide. On 2/7/22 at 2:54 PM, Therapy Director (TD) U reported that the facility hasn't done very many activities in a long time. TD U reported the facility will do an occasional event but no regular activities. On 2/3/22 at 12:34 PM, an interview was conducted with Social Worker (SW) A. SW A reported that besides her duties as a Social Worker she is also works as a Certified Nurse Aide (CNA) and is the facility Activities Director. SW A reported the facility does not have any Activities on the weekends stating , I can't be here every day. During an interview conducted 1/26/22 at 10:00 AM, Activities Aide (AA) M reported she started at the facility 1/11/22 and works part time weekdays 9:00 AM to 1:30 PM. AA M reported her responsibilities include taking the smokers outside at 9:00 AM and 1:00 PM. AA M reported she will do Bingo but doesn't know what else is available for the residents other than coloring. AA M reported that Resident's #5, #6, and #7 (R5, R6, R7) who are smokers, complain to her about the lack of Activities. AA M reported that the previous day during Bingo a resident was disruptive, and the Activity had to be canceled. AA M reported she and most of the residents left the Dining Room where the Activity was being held. AA M reported she got in trouble by a nurse because a resident was left in the Dining Room by herself. AA M stated I didn't know I wasn't supposed to leave her alone and indicated no one told her the resident required supervision. Resident #8 (R8) R8 was admitted to the facility 5/20/05. The Minimum Data Set (MDS) dated [DATE] revealed R8 was in a persistent vegetative state and displayed total dependence on staff for all care. The Care Plan for R8 for Activities reflected Resident will express satisfaction with daily routine and leisure activities and Encourage resident to become involved with activities. While R8 is not able to actively participate no environmental enhancements to her room were noted such as music being played. It was observed that R8 was in her bed during survey hours from the onset of the survey of 1/23/22 until 2/10/22. Review of the Electronic Medical Record (EMR) Progress Notes from 10/2/22 to 1/31/22 did not reveal that R8 had been out of bed and provided passive involvement in a group setting, even during the holidays, or that an individual activity had been attempted such as reading to R8. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #32 (R32) The MDS dated [DATE] reflected R32 had a BIMS score of 6 which indicated cognitive impairment. Observed in the room of R32 was a four-wheeled walker and a wheelchair without foot pedals which indicated the Resident was capable of mobility. During the survey that began on 1/23/22 with an exit date of 2/10/22 R32 was not observed dressed and out of bed during survey hours until the exit date. R32 was observed in bed, with the room always darkened, undressed without a shirt, and unshaven. On 2/7/22 at 2:54 PM, an interview was conducted with Therapy Director (TD)U. TD U reported that R32 used to be very social and would sit at his doorway and talk to everyone. TD U reported that R32 would walk around the facility all the time. In an interview conducted 2/9/22 at 1:19 PM with Social Worker (SW) A, SW A who also works as the Activities Director and as a CNA, reported she started at the facility in September of 2021. SW A reported she did not know why R32 doesn't get out of bed. Review of the comprehensive Care Plan for R32 revealed interventions that were not observed to be implemented during the survey to include: Allow resident to express feelings and desires, Encourage resident to become involved with activities, Provide materials of interest (e.g., Magazines,needlework, etc.) Offer (R32) painting and coloring material, and Offer frequent conversation as often as possible during room visits. Resident #11 (R11) Review of the MDS for R11 revealed the Resident was severely cognitively impaired and required total care from staff. On 1/24/22 at 2:52 PM, R11 was observed in her room in her scoot chair self-propelling aimlessly around the room. A similar presentation was observed on 1/25/22 at 10:57 AM when R11 was self-propelling in her room and halls. No engagement by staff or Activities was noted. On 1/25/22 at 3:13 PM, R11 was observed in her scoot chair in the bathroom doorway trying to get into the bathroom. Her roommate, R7, reported that R11 had been there for an extended period. Again, on 1/26/22 and 1/31/22 R11 was observed aimlessly wandering in her scoot chair. During the survey R11 was never observed to be engaged by staff or Activities. Resident #30 (R30) On 1/25/22 at 11:19 AM, R30 was observed in a scoot chair at the corner of the East Hall by the nurse's station leaning out with her face close to the wall. Noted multiple staff passing by without engaging. At 2:54 PM, R30 remained in her scoot chair in the hall. R30 responded to yes and no questions indicating she was aware when she was being engaged. R30 was never observed being engaged by staff or Activities during the survey. Resident #15 (R15) (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS dated [DATE] revealed R15 suffered moderate cognitive impairment and sometimes understands. On 1/25/22 at 10:49 AM, during an encounter with the Director of Nursing (DON) in the room of R8, R15, who was the other resident residing in the room, was observed as dressed on her bed. R15 was observed to yell out occasionally. As R15 continued to yell out the DON turned on the television by R15 and reported that R15 will settle down if the TV is turned on. Later this day at 3:19 PM, R15 remained lying flat on her bed with the television on. R15 was never observed to be engaged in any passive or active Activity other than a television during the survey. During an interview with the facility Social Worker (SW) A on 2/1/22 at 10:08 AM, SW A said said she was not provided an orientation or expectations for resident council meeting. SW A said she did meet with the residents a few times to discuss things like food. SW A she was not aware the purpose of the meeting was for residents to share their concerns and attempt to resolve their concerns. During the interview SW A provided a few notes. One note revealed, Resident Council Minutes for 6/30/21 that showed 7 residents attended. Old businesses listed included more activities and outings . There was no information to indicate if the old business had been resolved. There was no indication what the concern concerns were or any discussion during this meeting.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 39083 This citation contains two deficient practice statements. DPS #1 Based on observation, interview, and record review, the facility failed to properly monitor and maintain safe water temperatures, resulting in the high likelihood of scalding, resulting in an immediate jeopardy for all 38 residents in the facility. The Administrator was notified of the Immediate Jeopardy: [DATE] at 2:46 PM of the Immediate Jeopardy that was identified on [DATE] at 8:45 AM of the Immediate Jeopary that began on [DATE] when the facility stopped logging temps. The Facility was requested for a written plan of correction for abatement: [DATE] at 2:46 PM Facts Supporting Immediate Jeopardy: On [DATE] at 8:45 AM, the hand sink for room [ROOM NUMBER] was measured using a Thermapen digital probe thermometer and found to be at 120.8 degrees Fahrenheit. On [DATE] at 8:50 AM, the hand sink for room [ROOM NUMBER] was measured using a Thermapen digital probe thermometer and found to be at 135.0 degrees Fahrenheit. During an interview on [DATE] at 8:55 AM, Maintenance Director Y was informed of the high water temperatures at the tested hand sinks and stated they will see what is wrong with the water. On [DATE] at 8:56 AM, the hand sink for room [ROOM NUMBER] was measured using a Thermapen digital probe thermometer and found to be at 134.8 degrees Fahrenheit. On [DATE] at 8:58 AM, the hand sink for room [ROOM NUMBER] was measured using a Thermapen digital probe thermometer and found to be at 130.5 degrees Fahrenheit. During an interview on [DATE] at 9:30 AM, Maintenance Director Y stated that they turned down the water temperature at the mixing valve. At this time, water temperature monitoring logs were requested and Maintenance Director Y stated that they were recently hired, and they only have one day of water temperature monitoring for [DATE]. On [DATE] at 9:50 AM, the hand sink for room [ROOM NUMBER] was measured using a Thermapen digital probe thermometer and found to be at 134 degrees Fahrenheit. During an interview on [DATE] at 9:52 AM, Maintenance Director Y was queried on why the water temperature was still high and stated the mixing valve was lowered but the hot water still needs to be flushed out, but was called away to another task. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:37 AM, assisted with the Administrator, the hand sink for room [ROOM NUMBER] was measured using a Thermapen digital probe thermometer and found to be at 108 degrees Fahrenheit. During an interview on [DATE] at 2:12 PM, Maintenance Director Y confirmed the water heater providing excessive hot water affected rooms 30 through 39. On [DATE] at 3:02 PM, the hand sink for room [ROOM NUMBER] was measured using a Thermapen digital probe thermometer and was found to be at 123 degrees. Fahrenheit. At this time, Maintenance Director Y was informed other areas of the building were affected by hot water. During an interview at [DATE] at 3:50 PM, Maintenance Director Y stated that he turned the mixing valve down for the newly observed high water temperatures affecting the remainder of the rooms. During an interview on [DATE] at approximately 1:45 PM, the Director of Nursing provided the Surveyor with the specific information of the resident records showing the following residents demonstrated low cognition level as evidenced by BIMs scores, and are independently ambulatory or can independently propel, resulting in a high likelihood of accidental exposure to excessive water temperatures: Resident 29; BIMS - 04 Resident 10; BIMS - 08 Resident 25; BIMS - 09 Resident 17; BIMS - 03 Resident 28; BIMS - 99 According to the facility's water temperature monitoring logs, the facility has monitored water temperatures on [DATE], [DATE], [DATE], and [DATE]. According to the facility's, ROOM WATER TEMPERATURE, log, dated [DATE], bathrooms for rooms #'s 1, 2, 5, 6, 22, 24, and 25 were monitored. According to the facility's policy, Water Temperatures, Safety of, revised [DATE], it notes, Policy Interpretation and Implementation 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 F, or the maximum allowable temperature per state regulation. 2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. 3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor. 5. Direct-care staff will be informed of risk factors for scalding/burns that are more common in the elderly, such as: a. Decreased skin thickness; b. Decreased skin sensitivity; c. Peripheral neuropathy; d. Reduced reaction time; e. Decreased cognition; f. Decreased mobility; and g. Decreased communication. Facility Removal Plan [Facility] submits the following Credible Allegation of Compliance outlining the measures it has completed to remove the findings of immediate jeopardy to resident health and safety identified by the survey team regarding the facility's failure to maintain water temperatures at a safe level. [Facility] believes that as of [DATE], the measures it has implemented are sufficient to demonstrate that residents are receiving adequate prevention measures. 1. Identification of Residents Affected or Likely to be Affected: While all residents have the potential to be affected, the affected area was identified in all residents' rooms. Beginning [DATE] - Completed water checks of all affected areas to ensure water temperatures were below 120 [degrees] F. No deficits were found. Beginning [DATE] - NHA conducted a review of all incident reports confirming that there have been no incidents of resident burns since [DATE]. Beginning [DATE] - NHA conducted a review of Resident Council minutes confirming that there have been no complaints at this meeting about water temperatures [DATE]. Beginning [DATE] - NHA confirmed with DON that there have been no resident complaints/grievances filed regarding water temperatures since [DATE] 2. Actions to Prevent Occurrence/Recurrence: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon receiving notice of elevated tap water temperature, the facility took the following actions: Beginning [DATE] - Maintenance staff made adjustments to mixing valves to lower water temperatures below 120 [degrees] F. Beginning [DATE] - A review with the Maintenance director revealed temperatures were above 120 [degrees] F. Maintenance director reported that upon discovery of elevated temps he adjusted water mixing valves and retakes the water temp, he acknowledged that he did not document any corrective action, and notified the NHA. We identified ways to improve the tool used for documentation and updated this form with explanation of changes noted below. Beginning [DATE] - Implemented a revised Maintenance Radom Weekly Test Report Log which includes checking of water temps to include the following: o Clear instruction that read as follows: Complete random weekly checks listing the room number and documenting temperatures of tap water. Temperatures shall be no more than 120 [degrees] F. Discrepant findings will be remedied immediately. o Added signature lines for the Director of Maintenance or designee and Administrator to review. Beginning [DATE] - Maintenance staff completed a water temp audit of all resident rooms finding no temps above 120 [degrees] F. Beginning [DATE] - Maintenance to increase monitoring of all residents rooms to twice daily until such time that QAPI committee determines the issue to be resolved and safe to return to weekly checks. Beginning [DATE] - The NHA provides mandatory face-to-face education with competency testing to the Maintenance Staff regarding safe temperature requirements and updated log. 3. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: [DATE] On [DATE], the State Agency verified the facility had initiated their IJ removal plan. Although the Immediate Jeopardy was removed on [DATE] the facility remained out of compliance with a scope of widespread and severity of No actual harm with the potential for more than minimal harm that is not immediate jeopardy due to sustained compliance not being verified by the state agency. 28101 This citation pertains to MI000125429 DPS #2 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, interview, and record review the facility failed to provide a safe route/area for independent residents to smoke, to keep one resident's oxygen tank full when up in her wheelchair, respond timely to an emergency alarm, provide safety equipment for residents when smoking and provide a safe smoking environment when multiple residents were smoking together resulting in the potential for serious harm or death. Findings include: Review of R4's face sheet, no date, revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: acute respiratory failure with hypoxia, muscle weakness, difficulty in walking, unsteady on feet, diabetes mellitus II, and obesity. R4 was her own responsible party. On [DATE] at 11:15 AM, R4 was wheeled into the main dining room for the resident council meeting with the State. R4 was in a wheelchair with a portable oxygen tank on the back. After 10 to 15 minutes of being in the meeting R4 said she was short of breath and thought her oxygen tank had run out. The Surveyor asked the kitchen staff to get help for R4 and report it was an emergency as her oxygen tank was empty. When staff did not immediately respond to the request the Surveyor pulled the emergency cord in the main dining room. After one minute when staff did not respond the Surveyor went into the hall and yell to the Certified Nurse Aides that R4 needed oxygen and it was an emergency. A certified nurse aide came to the main dining room with a new oxygen tank, but she was not able to connect the regulator to the new tank as when she attempted to tighten the connection the tank made a loud hissing noise. A licensed nurse came to the main dining room to assess R4 but she was unable to get her pulse oxygen reading as the meter had a dead battery. R4 had to be transported back to her room and placed back on her electric oxygen concentrator. Once R4 was back on oxygen in her room she returned to her baseline breathing and calmed down. On [DATE] at 12:00 noon the Surveyor reported the oxygen emergency and lack of response to verbal request for medical assistance and no response to the emergency call alarm to the Director of Nursing (DON) and Nursing Home Administrator (NHA). The CNA's reported they did not respond to the alarm because they had never heard the alarm before. The DON and NHA said they would investigate the situation and start education. On [DATE] at 1:00 PM the DON said she started education on the portable oxygen tanks. The DON said she met with the oxygen supplier, and they told her some tanks need o rings. The company provided them with additional o rings. The DON took the Surveyor to the supply room and new o rings were in the room. After going to the supply room, the DON went to R4's room. R4's oxygen tank on her chair was empty and R4 said it was the same tank she had yesterday. The DON attempted to put a new tank on R4's wheelchair but it leaked air out just like the one had done in the meeting on [DATE]. The DON had to go to the supply room to get an o ring before she could connect R4's regulator to her tank. R4 let the DON know that she always wanted a functional tank so in an emergency she could safely get out of her room. Resident #6 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R6's face sheet, no date, revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: hemorrhagic disorder due to extrinsic circulating anticoagulants (blood thinners), acquired absence of left leg above the knee, diabetes mellitus, anxiety disorder, post-traumatic stress disorder, chronic pain, peripheral vascular disease, and localized edema-RLE (right lower extremity). Review of R6's Resident Safe Smoking Agreement dated [DATE] revealed, 6. I understand that if I am an independent smoker that I MUST completely exit the property for all unsupervised smoking. 9. I understand that if I violate or do not comply with the smoking policy and/or smoking agreement, I will b subject to suspension and or loss of smoking privileges and/or involuntary discharge. 13. Violation will be considered a threat to resident health and safety and will be grounds for involuntary discharge from the facility in accordance with State and Federal rules and regulations. During an interview with the Nursing Home Administrator (NHA) on [DATE] at 2:00 PM the Surveyor explained that Residents that were their own responsible party had express frustration that staff could smoke in the visitor parking lot, and they had to go in their wheelchair out to the main road about ,d+[DATE] mile on the icy driveway (no sidewalk) to smoke. The NHA confirmed staff were able to smoke on the facility property, but residents had to leave the property to smoke if they did not go out at the supervised times with the other residents. The NHA confirmed they do not assist any residents outside to smoke if it is below 32 degrees outside. They only assist resident smoke 3 times a day. The NHA said there was nothing he could do about it as he had checked with his supervisor, and this was the corporate policy. I asked if his supervisor and the corporation was aware that the route residents had to take in their wheelchair was not safe and was a great distance. The NHA assured me his supervisor and the corporation were aware of the hazards and again told me he was not able to change company policy. On [DATE] at 2:00 PM the staff smoking area was observed to be clear of snow/ice and salted. The area had a cigarette receptacle for disposal. The area was sheltered as it was surrounded on 3 sides by the facility building. On [DATE] at 1:00 PM R6 was observed outside in her wheelchair headed to the main road to smoke. The Surveyor had just returned to the facility and the ,d+[DATE] route R6 had to maneuver in her wheelchair was covered with snow and ice. R6 said the facility was not assisting residents to smoke today because it was colder than 32 degrees. R6 said smoking helps her clear her head and she did not want to get kicked out, so she had to go to the main road to smoke. On [DATE] at 10:00 AM R6 said over the weekend she was allowed to smoke in the resident smoking area but today they changed the code to the door going to the smoking area so she would have to go out to the main road again to smoke. R6 said it makes her feel like a second-class citizen when she is not able to smoke when she needs to in a safe area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a facility scheduled assisted smoking time on [DATE] at 9:10 AM the following safety concerns were observed. 10 Residents were assisted to an area outside the that had 3 sides covered with traps and a covered top. All residents except one were in wheelchairs. There was one employee helping, Activity Aide (AA) M. AA pushed one resident in her wheelchair without foot pedals over 20' to get her into the sheltered area. The space in the shelter did not allow for more than an inch or 2 of space between each resident. All the residents smoked at the same time. Several of the residents struggled to flick off the hot ashes to the ground and held the hot ashes over their flammable clothing and/or close to another resident's flammable clothing. R15 was brought out to the shelter in her wheelchair after all the other residents had been assisted with a cigarette. AA said to the residents she did not know what kind of assistance R15 needed. R15 did not speak or give AA any communication for her needs. Several residents spoke up and said you need to put a smoking apron on R15 and hold her cigarette because she will try to put it all the way in her mouth. AA put a smoking apron on R15 and handed her a lit cigarette. R15 put the cigarette in her mouth past the filter and smoked it until the ashes reached her fingers. R15 did not flick her ashes. AA took the cigarette from R15 when it was smoked ,d+[DATE] way as the ashes had reached her finger. AA put R15's cigarette out and gave R15 a new cigarette and did the same thing. AA lit all the residents' cigarettes but only did not help any resident hold their cigarette. R15 was the only resident that used a smoking apron. While the residents all smoked AA used a vape cigarette to smoke. R7 Review of R7's face sheet, no date, revealed, she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: Multiple sclerosis, major depression, anxiety disorder, chronic pain, neuromuscular dysfunction of the bladder, insomnia, idiopathic peripheral autonomic neuropathy, myocardial infarction (heart attack), and trigeminal neuralgia (severe chronic pain in a facial nerve that starts on the brain). R7 had a legal guardian. During the smoking observation on [DATE] at 9:10 AM, R 7 did not use a smoking apron. R7 hand poor hand control of the cigarette and held the hot ashes over a fussy blanket that was over her legs. R7 did not have a smoking apron on when she was smoking. Review of R7's smoking care plan dated [DATE] revealed, Some difficulty holding cigarette and occasionally drops ashes on lap. Smoking may be determined by the assessment and medical needs of the resident deemed by the physician and medical staff. Under approach dated [DATE] revealed, must wear smoking apron. Review of R7s Smoking Risk assessment dated [DATE] the assessment rated her at 1 (minimal problem) for Drops cigarette/cigar butts or matches on floor, furniture, self or others; burns fingertips; smokes near oxygen. The assessment did not assess for the ability to flick hot ashes, light a cigarette, or put out the cigarette. R15 Review of R15's smoker care plan dated [DATE] revealed, unable to smoke safely smoke cigarettes due to history of burning her own fingers. Uses an electronic vape. Resident shows no interest in going outside to smoke at this time but is still an option for her. [DATE] Resident has started to smoke safely, she is to be watched assisted by staff when smoking and is to wear smoking apron when handling smoking materials. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R15 s Smoking Risk assessment dated [DATE] the assessment rated her at 0 (no problem) for Drops cigarette/cigar butts or matches on floor, furniture, self or others; burns fingertips; smokes near oxygen. The assessment did not assess for the ability to flick hot ashes, light a cigarette, or put out the cigarette. There was no indication R15 was not able to determine how far to safely put a cigarette in her mouth and did not change finger placement when the ashes reached her fingers. During an interview with the Director of Nursing (DON) on [DATE] at 11:00 AM the DON said she was not aware R15 still smoked, she was not aware AA was not providing the smoking aprons or assisting the residents smoke as directed in the resident's care plans, she was not aware AA was vaping while the residents smoked, she was not aware of the lack of space between residents when all residents smoked at the same time. The DON said she would start education immediately and AA would be providing smoking aprons and safety when residents smoked.

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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 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 This citation pertains to MI000125429 Based on observation, interview, and record review the facility failed to provide sufficient number of staff to consistently meet the physical and psychosocial needs of the residents, resulting in pressure ulcers, lack of showers/basic activities of daily living, pain and frustration. Findings: The Facility Assessment that was provided by the facility reflected handwritten signatures of facility administration at the bottom of the front page and dated 11/10/21. Review of the Facility Assessment reflected Page 3 Part 1 Our Resident Profile. 1.2 reflected an average daily census of 37 - 39 residents. Page 9 Staffing Plan 3.2 reflected a table that indicated Evaluation of overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident's needs. The table reflected the facility required Licensed nurses providing direct care- 4 - 6, Nurse aides - 2 - 4. Further review of the Facility Assessment did not reveal documented numbers of staff required to meet the needs of the residents for each shift. The Facility Assessment revealed methods and factors to consider when determining facility staffing without any documentation of what the needs of the facility were determined to be. Review of the facility Resident Census and Condition of Residents report (form 672) dated 1/23/22 reflected the facility had 38 residents of who 22 were occasionally or frequently incontinent of bladder, 32 were in a chair most or all the time and 3 residents could ambulate independently. The 672 also reflected that 8 residents were dependent on staff for eating and that an additional 3 residents required assistance with meals for a total of 11 residents the facility identified as needing assistance during meal times. On 1/23/22 at 9:25 AM, on entrance to the facility it was observed that the facility was staffed with two nurses and three CNAs. On 1/23/22 at 10:50 AM, no current Nurse Staff Posting was located. On 1/23/22 at 12:20 PM, Certified Nurse Aide (CNA) T reported the facility had been short staffed for about two months and that she was routinely finding residents wet in the morning. On 1/23/22 at 2:40 PM, CNA EE reported that the facility is short bariatric sheets and, due to a shortage of laundry staff, the CNAs have to wash the sheets or use two flat sheets in place of a bariatric sheet. CNA EE reported that sometimes the night shift has just one nurse and one CNA. CNA EE reported she and others receives texts asking them to come to work, Please come, we have no one. Review of the facility staffing schedule reflected the facility was commonly staffed with two floor nurses and two Certified Aides during the day shift. Subsequent staffing reflected that the Director of Nursing (DON) was often one of the two floor nurses. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 1/23/322 at 3:32 PM, an interview was conducted with the NHA and the DON. It was reported that about a month prior a number of facility staff left for higher pay at a sister facility leaving the facility in need of additional staff. The DON reported the facility currently had two Agency nurses but at times the night shift will have four hour blocks of only one nurse and one Certified Nurse Aide in the facility. The NHA reported that the facility had an active recruitment program but did not have any likely current candidates. The NHA was asked if he had initiated an emergency staffing plan based on the Facility Assessment. The NHA stated I need to go through it and activate it. Then the NHA reported he hadn't determined if staffing was at a critical stage. However, the NHA reported that the corporate office was aware the facility had a staffing issue but did not indicate that a plan was in progress other than an advertisement on the internet. Review of the Staffing Sheets provided by the facility reflected: 1/9/22, 1/12/22 and 1/18/22 there was one nurse and one CNA for the night shift, on 1/10/22 there was one nurse for day shift, afternoon shift, and night shift, and on 1/14/22 there was one nurse on the day and night shift, but the Staffing Sheet did not reveal a nurse for the afternoon shift. On 1/24/22 the facility schedule board was reviewed for staffing. The board reflected one nurse and two CNA's until 2:00 PM when a third CNA would arrive. The DON reported she was working as a staff nurse in addition to her DON duties. On 1/31/22 the facility schedule board reflected two nurses and two CNAs for the day shift with the DON working as a staff nurse in addition to her DON duties. The schedule board reflected one nurse was scheduled to work the night shift. On 2/2/22 at 9:13 AM, the facility schedule board was reviewed for staffing. The board reflected two nurses and two CNAs with one CNA being the facility Social Worker (SW) A. The schedule board reflected no nurses were scheduled for the night shift at the time of this review. On 1/24/22 at 11:22 AM, CNA P reported the facility tries to have three Certified Nurse Aides (CNA) on the day shift but that it is usually two CNA's. On 1/26/22 at 8:47 AM, the staff schedule board was reviewed. The schedule board reflected two nurses were working the day shift with the DON as one of the floor nurses. The schedule board reflected that the facility would be staffed with just one CNA from 7:00 PM until 10:00 PM. On 2/10/22 at 12:26 PM, Licensed Practical Nurse (LPN) B reported prior to this survey she worked the night shift and worked many nights with just one CNA. LPN B reported she went to contingency status because of the workload she just couldn't do it anymore. R21 R21 was admitted to the facility 10/8/19. The Minimum Data Set (MDS) dated [DATE] reflected R21 was severely cognitively impaired, was totally dependent on staff for bed mobility, and was at risk for developing pressure sores. The MDS reflected no pressure sores or skin issues at that time. On 1/25/22 the DON reported that R21 had developed a Stage Three pressure sore. The MDS dated [DATE] reflected R21 had a Stage Four pressure sore The Electronic Medical Record (EMR) reflected that on 1/31/22 this pressure sore measured 6.8 centimeters (cm) by 5 cm with slough. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	R23 R23 was admitted to the facility 11/6/20. The MDS dated [DATE] reflected R23 was totally dependent on staff for bed mobility, did not have any pressure sores at the time of this MDS but was at risk for developing pressure sores. On 1/24/22 at approximately 4:00 PM an observation of a skin assessment of R23 revealed eight measurable open areas on the buttocks not previously identified. The DON reported she did not know how long R23 had these areas. In an interview conducted 1/25/22 at approximately 2:00 PM, R23 reported he did not like to be in his wheelchair because his bottom Feels like Shredded meat and they leave me up for over two hours because they don't have time to help me. R5 R5 was admitted to the facility 12/22/20 and, due to a history of a stroke, had Hemiplegia (paralyzed or weakness to one side of the body). Review of the MDS dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 14 which indicated the Resident was cognitively intact. On 1/24/22 at 10:34 AM, an interview was conducted with R5 in his room. R5 reported he had not had a shower in three weeks due to the facility being grossly understaffed. R5 presented as unshaven and with unkept, greasy hair. On 2/7/22 at 1:21 PM a request was made for the shower sheets of R5. Review of the shower sheets provided by the DON reflected R5 had showers on 8/30/21, 9/6/21, and 9/23/21. The next shower documented was a refusal by the R5 on 12/16/21. Documentation of a shower on 1/27/22 was noted. On 2/3/22 at 4:14 PM, R5 reported was supposed to get a shower today at 2:00 PM but no one came to get him. No other documentation of showers or refusals was provided by the facility. R32 R32 was admitted to the facility 9/23/19, The MDS dated [DATE] reflected R32 was cognitively impaired. This survey began on 1/23/22 with an exit date of 2/10/22. R32 was never observed dressed and out of bed until the day of exit. R32 was observed in bed, with the room always darkened, undressed without a shirt, and unshaven. Multiple observations were documented of R32 in bed as described above. On 2/7/22 at 1:21 PM a request was made to the DON for shower sheets of R32 from October 1, 2021, to present. The shower sheets provided by the DON for R32 reflected the Resident had a shower 12/3/21 and 12/20/21. No further documentation that R32 was provided of showers given either before or after these dates. On 2/7/22 at 2:54 PM, an interview was conducted with Therapy Director (TD)U. TD U reported that R32 used to be very social and would sit at his doorway and talk to everyone. TD U reported that following an alleged incident with a staff member R32 rarely gets out of bed. In an interview conducted 2/9/22 at 1:19 PM with Social Worker (SW) A. SW A who works also as the Activities Director and as a Certified Nurse Aide (CNA) reported she did not know of an incident and that she did not know why R32 doesn't get out of bed. R8 Review of the medical record reflected R8 was originally admitted to the facility 5/20/05 with diagnoses that included: Contractures of bilateral hands and elbows, and a Tracheostomy., The (MDS) dated [DATE] revealed R8 was in a vegetative state and displayed total dependence on staff for all care. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 1/25/22 at 10:06 AM, the DON was summoned to the room of R8 due to audible rattling breath sounds. While repositioning R8 with Licensed Practical Nurse (LPN) E bilateral foot drop was observed. R8 was observed to have both legs, stiff, and with the right leg crossed over the left leg. Two staff were required to separate the Residents stiff legs to remove the wet brief. The Care Plan for R8 reflected interventions to include Provide PT/OT or restorative program as needed. The Care Plan for (Activities of Daily Living (ADL)) Functional/Rehabilitation Potential initiated 1/13/21 reflected a goal of The resident will achieve maximum functional ability with an intervention of Locomotion Wheelchair use with 1 person. During the Recertification Survey conducted from 1/23/22 through 2/10/22 R8 was never observed to be in her wheelchair. On 2/9/22 at 8:23 AM during an interview the DON reported she believed R8 was last out of bed when she had a shower on the past Saturday (4 days prior on 2/5/22). Review of the shower sheet for R8 reflected that, before the shower on 2/5/22, the Resident received a shower on 1/11/22. On 2/7/22 at 2:54 PM, an interview was conducted with Therapy Director (TD) U. TD U reported the facility doesn't have a restorative program as they (the facility) don't have the staff for that. TD U reported she not seen R8 up in her wheelchair and indicated that staff do not get R8 or other residents out of bed as in the past. R4 Review of R4's face sheet, no date, revealed R4 was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: acute respiratory failure, muscle weakness, unsteady on feet. Diabetes mellitus II, and obesity. R 4 was her own responsible party. On 1/23/22 at 2:25 PM, an interview was conducted with R4 in her room R4 reported staff do not get her out of bed when she wants to sit in her recliner. R4 said that she missed a visit with her mother before Christmas because there wasn't a lift sling available to get her out of bed. R4 said that during the time when her mother attempted to visit visitors were not allowed to resident rooms and met, instead, in a designated area in the facility due to COVID 19 restrictions. R4 said the facility did not have a mechanical lift sling for her, so she ordered her own sling online. R4 said the sling she ordered on her own arrived after Christmas of 2021. A bright blue sling was noted on the recliner chair nearby. R4 said when staff don't want to get her up, she is told the battery for the mechanical lift is not charged. On 1/24/22 at 9:01 AM, R4 said that she cannot tell when she voids. R4 said that staff will check and change her only twice a day with the first time in the afternoon then again about 11:00 PM. R4 said she was not changed at 11:00 PM last night and was wet now. It was observed that R4 was wet at this time. R4 indicated this is frustrating for her. On 1/25/22 at 2:52 PM, R4 said last night she wanted to get out of bed. R4 said that staff told her they will get her up if they have time. R4 stated I guess they didn't have time as R4 remained in bed. On 1/31/22 at 10:51 AM, R4 was observed in her recliner chair. R4 said she had not been changed yet today. R4 said she used her call light about an hour ago and that an office staff member responded. R4 said that the staff member told her the CNA was on break and that she would let the CNA know R4 needed care. It was noted that the call light was not on during this observation. R4 indicated the light had been turned off and she Feels forgotten. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During the resident council task on 2/1/22 at 11:00 AM, 7 of 7 residents shared that the facility was not addressing their concerns. They all voiced care concerns and frustration with the facility not responding to their concerns. Residents were not aware of a formal process to address their concerns and said in the meeting concerns are not addressed or resolved. Concerns that they all shared were not enough staff which was causing them to go for more than a week without a shower, rooms not mopped or cleaned, and long waiting times to get their needs met. 28101 During the resident council task on 2/1/22 at 11:00 AM, 7 of 7 residents shared that the facility was not addressing their concerns. They all voiced care concerns and frustration with the facility not responding to their concerns. Residents were not aware of a formal process to address their concerns and said in the meeting concerns are not addressed or resolved. Concerns that they all shared were not enough staff which was causing them to go for more than a week without a shower, rooms not mopped or cleaned, and long waiting times to get their needs met.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 This citation pertains to MI000125429 Based on interview and record review, the facility failed to implement a system to ensure all staff had the necessary competencies and mandatory training to provide care for all facility residents, resulting in the potential for skills not being current and not having full understanding of facility procedures. Findings: In an interview and record review on [DATE] at 3:00 PM, the Nursing Home Administrator (NHA) reported all staff training is contained in a binder on many topics that include mandatory training. Review of the contents of the binder that was approximately six inches thick revealed the binder was not organized in a fashion one could determine if mandatory training had been completed. The topics and sign sheets were inserted into the binder over time. To determine if a specific employee had completed a required training would include searching each sign sheet for each separate training once identified within the six inch binder. After receiving the afore mentioned binder, a file folder was provided that the NHA reported held the competency checks for nurses and Certified Nurse Aides (CNA). The contents of the folder provided by the NHA was reviewed. The competency checklist for Registered Nurse (RN) K was reviewed and is similar to other nurse competency checklists in the folder provided by the facility. This checklist reflected 227 topics or tasks that the competency that RN K had completed on [DATE]. That 227 topics or tasks could be addressed in one shift brings into question the accuracy and completeness of the facility competency program. The final page of the checklist titled Staff Nurse Competency Observers Signature Page did not reveal that any observers of the competency testing had signed. Only the Nurse Manager and the employee signed the undated page. The CNA checklist titled Nurse Tech Competency Checklist for CNA R reflected 191 topics and tasks and was also arrow-lined top to bottom. This CNA checklist was like other CNA checklists provided by the facility. No other competency, skills review, documentation of completed mandatory training of nursing or CNA staff, or summary that these were completed was provided by the facility. Review of the Employee File for Social Worker A, who was also the Activities Director and had worked as a CNA during the survey, did not reveal a Certified Nurse Aid certificate (later provided) or that a competency or clinical checklist had been completed. The Employee File did not reveal the required yearly education had been completed. In an interview conducted [DATE] at 1:19 PM, SW A reported she started at the facility in September of 2021. SW A reported she has a current CNA certificate. SW A reported that she has not had any CNA training or competency check at the facility. SW A reported she had all that before she started at this facility. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Employee File for Registered Nurse (RN) K did not reveal any competencies or education. The file reflected the last Abuse Training was completed in 2019. Review of the Employee File for Certified Nurse Aide (CNA) R revealed a CNA certificate that expired on [DATE]. The file did not reflect any current competencies or education.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 This citation pertains to MI000125429 Based on interview and record review, the facility failed to implement a verifiable system to ensure that the Certified Nurse Aide (CNA) staff had the necessary competencies and mandatory training to provide care for all facility residents, resulting in the potential for skills not being current and not having full understanding of facility procedures to include Abuse, Dementia Care and Resident Rights. Findings: In an interview and record review on [DATE] at 3:00 PM, the Nursing Home Administrator (NHA) reported all staff training is contained in a binder on many topics that include mandatory training. Review of the contents of the binder that was approximately six inches thick revealed the binder was not organized in a fashion one could determine if mandatory training had been completed. The topics and sign sheets were inserted into the binder over time. To determine if a specific employee had completed a required training would include searching each sign sheet for each separate training once identified within the six inch binder. Review of the Employee File for Social Worker A, who was also the Activities Director and had worked as a CNA during the survey, did not reveal a competency or clinical checklist had been completed. The Employee File did not reveal the required 12 hours of yearly education. In an interview conducted [DATE] at 1:19 PM, SW A reported she started at the facility in September of 2021. SW A reported she has a current CNA certificate. SW A reported that she has not had any CNA training or competency check at the facility. SW A reported she had all that before she started at this facility. Review of the Employee File for Certified Nurse Aide (CNA) R revealed a CNA certificate that expired on [DATE]. The file did not reveal any current competencies or evidence of the required 12 hours of education. The NHA failed to provide any evidence of a system of documentation to verify a minimum of 12 hours of training of all facility CNAs based on mandatory training and performance reviews.