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

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observation, interview, and record review, the facility failed to treat 3 Residents with dignity (R4, R6,and R8) of 4 Residents reviewed for dignity, resulting in R6 feeling frustrated and like a second-class citizen when she has to leave the facility property to smoke and, R4 being frustrated with being left soiled for long periods of time and R8 having chin whiskers (reasonable person embarrassment). Findings include: Resident #6 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 8/21/21 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 be 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. (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 - Few	During an interview with the Nursing Home Administrator (NHA) on 1/26/22 at 2:00 PM, the Surveyor explained that Residents that were their own responsible party had expressed frustration that staff could smoke in the visitor parking lot, and they had to go in their wheelchair out to the main road about 1/4 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 residents who 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 1/26/22 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 2/3/22 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 1/4 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 2/7/22 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. Review of the facility smoking policy, no date, revealed, Resident Safety. 2. Residents may not smoke in the designated area except during specified smoking times under staff supervision. Resident may not sign themselves out on LOA (leave of absence) to smoke. If a resident signs out LOA, s/he must leave the property. 3. In the event that it would not be safe for residents to go to the designated smoking area outside the building, smoking privileges will be temporarily suspended for all the residents until resolved. Conditions requiring suspension of smoking privileges include but are not limited to: Temperature below 32 degrees F, Heavy rain, wind or snow, Severe weather watch or warning, Other environmental or law enforcement considerations. 15. Residents who violate the smoking policy will be discharged immediately or given a 30 day discharge. 31771 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. R4 was her own responsible party. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 reported 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 prior and that an office staff member responded. R4 said that the staff member told her the Certified Nurse Aide (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 feel forgotten. On 1/25/22 at 11:08 AM, CNA P reported that R4 bought her own mechanical lift sling because the facility is short of bariatric slings. CNA P reported if R4 wants to get out of bed and they have enough staff they will get the R4 up. On 1/25/22 at 11:17 AM at the supply room at the East Hall CNA DD reported the facility is short of bariatric slings. CNA DD was at the supply room to retrieve a bariatric sling and reported that the one she took was the last one. CNA DD: indicated the sling was not for R4. On 2/7/22 at 11:33 AM, review of R4's room revealed no sling in the room. R4 said the sling must be in Laundry. On 2/10/22 at 11:32 AM, an observation and interview were conducted with R4 in her room. R4 remained in bed and reported her sling is still in the laundry. No sling was observed in the room. R4 said that staff say I refuse (to get out of bed), I don't. I hate that they say that. I just want to get out of bed sometimes. R4 was visibly upset. On 2/10/22 at 11:51 AM, Laundry Staff CC confirmed that the sling purchased by R4 was drying in the laundry area. On 2/10/22 at 11:57 AM, the DON was informed that R4 does not have a sling in her room to allow her to get out of bed. The DON reported R4 has a history of making allegations of neglect and has a record of it. This record was requested at this time. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/10/22 at 12:10 PM, the NHA provided a Facility Reported Incident file that R 4 allegedly had made an allegation of neglect. The NHA was informed that an ongoing list of allegations was expected and not a one-time report. The NHA was asked if any grievance forms had been submitted or completed for R4. The NHA reported that he did not think so. The NHA suggested the surveyor review the (Electronic Medical Record (EMR)) Progress Notes for R4. The EMR Progress Notes from 10/11/21 until 2/10/22 were reviewed. No documentation was found that reflected R4 had refused to get out of bed. On 2/7/22 at 2:54 PM, an interview was conducted with Therapy Director (TD) U. TD U reported that R4 was evaluated by therapy to use the sit to stand device. TD U reported she was not aware staff were using a sling ordered by the Resident for mechanical lift transfers. TD U Was informed that R4 obtained a sling for her own use. TD U reported she had not been asked to evaluate the sling to see if it would accommodate and fit R4. TD U reported that slings must be compatible with the specific mechanical lift. TD U reported that she was aware that the facility was short of slings for the mechanical lift. R8 Review of R8's face sheet, no date, revealed she was [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: autoimmune thyroiditis, chronic viral hepatitis B and C, gastrostomy malfunction (feeding tube), diabetes mellitus, tracheostomy, contractures hands and elbows. She was not her own responsible party. On 1/26/22 at 10:44 AM, R8 was observed to have chin whiskers. On 2/07/22 at 10:11 AM, R8 still had whiskers on her chin.

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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** 28101 Based on observation, interview, and record review, the facility failed to inform a resident and a resident's responsible party of recommendations made by a specialist in one (Resident #7), resulting in the resident and/or responsible party not being able to make treatment decisions based on the resident's medical status. Findings include: 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 medication pass on 1/25/22 at 3:20 PM, R7 reported that she had pain in her face at a 10 on a 1-10 scale. R7 said she had trigeminal neuralgia and the medication Tegretol was not able to control her pain anymore. R7 said she had surgery years ago and the pain had come back. She said Doctor I said he could not give her a higher dose of Tegretol, and this was very upsetting. R7 reported she waited until the last minute to take her Tegretol as she can only take it 3 times a day and as it gets time for the next dose the pain gets out of control 3 times day. R7 told the surveyor about her past suicide attempts and reported this pain makes her want to end it. Review of R7's electronic medical records revealed a Neurology note dated 5/26/21 that revealed the neurologist recommended Gamma Knife consultation related to R7's trigeminal neuralgia pain. During an interview with the facility Social Worker (SW) A on 1/26/22 at 3:37 PM, SW A reviewed R7's neurology notes in the medical record. A Neurology note dated 5/26/21 was located that recommended Gamma Knife consult related to trigeminal neuralgia pain. SW A said she was not the SW in the facility in May and was not aware of how the SW at the time followed up with medical consultation recommendations. SW A was not able to locate any notes in R7's medical record that indicated anyone including R7's Physician I had followed up with the May 26th, 2021, Neurologist recommendations. SW A said she had been taking R7 to her outside appointments since October 2021. SW A was able to find some handwritten notes that she had made after R7 went out to doctors since October 2021. SW A did not scan these notes in the medical record or document the recommendations in R7's medical record. SW A did not document informing R7's guardian O or physician I about the recommendations. SW A said she drives the residents to appointments, works as a Certified Nurse Aide (CNA) when the facility is short staffed and was not provided any training of expectations for follow-up or documentation when residents have outside appointments. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with R7's legal guardian BB on 1/25/22 at 4:50 PM, BB expressed frustration with R7's Physician I not being able to control R7's trigeminal neuralgia pain. The guardian was aware that the Tegretol was affecting R7's blood sodium levels but BB was not aware of what the Neurologist recommendations were or what else could be done to control the trigeminal neuralgia pain. BB said no one had ever discussed a medical procedure called Gamma Knife with her to control the pain. BB said the facility does not share the neurology recommendations with her and they have not had enough staff for someone to sit down with her to review R7's medical records. During a telephone interview with R7's Physician I on 1/26/22 at 10:00 AM, Physician I said he was not aware that R7's trigeminal neuralgia pain was out of control. Physician I said he had R7 on the highest dose of Tegretol he could. Physician I had a pharmacist conference call into the telephone conversation, and he confirmed that Physician I was giving a higher dose of Tegretol than was recommended for trigeminal neuralgia. Physician I denied any knowledge of R7's neurologist recommending a procedure called Gamma Knife. Physician I said the facility contacted him about the Gamma Knife procedure today and he would do the referral today. Review of R7's Neurology consult note dated 9/27/21 at 4:13 PM revealed, The patient has also continued to have right facial pain. She was on a much higher dose of Tegretol, but it was decreased and currently is on Tegretol 200 mg, 1 and 1/2 tablet bid (twice a day). Her sodium has drifted down from 135 to 124 today. She is quite upset that her Tegretol was decreased. She repeated said that she would never go off of it as that is the only medication which helped her trigeminal neuralgia pain. Her Tegretol level was 15.2 on 6/7/21. Review of R7's physician progress notes revealed Physician I had notes in R7's medical record every month since 6/20/21 to 1/16/22, except for September 2021 no note was located. The note dated 6/20/21 (about 3 weeks after the Neurologist recommended a Gamma Knife consultation related to R7's trigeminal neuralgia pain) revealed no indication Physician I had reviewed the Neurologist recommendations or was aware that a referral was needed for R7 to receive a Gamma Knife consultation. Under Plan revealed, 8. Trigeminal neuralgia. We will treat with her current medication's and follow symptomatically and follow with neurology as well as need. Physician I's notes date 7/17/21, 8/14/21, 10/10/21, documented the same thing as the note 6/20/21. Review of R7's. Physician I's note dated 11/8/21 item 8 was changed slightly to read, Trigeminal neuralgia, intermittently symptomatically and follow up with neurology for further suggestions, might have to increase her analgesics if need. Physician I's note 12/5/21 revealed, 8. Trigeminal neuralgia, still symptomatic, continue Tegretol, follow symptomatically and neurology follow up. Physician I's note dated 1/16/22 revealed, 8. Trigeminal neuralgia, still symptomatic, awaiting further recommendations from Neurology. We will treat with her current analgesics, including Tegretol, follow her level biochemically, and follow symptomatically and follow with further neurology recommendations as well. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R7's Psychiatric Evaluation dated 3/10/21 revealed under history of present illness, The patient is a [AGE] year old female with a past medical history of progressive multiple sclerosis diagnosed ,d+[DATE] years ago, currently wheelchair bound at baseline, having peripheral neuropathy with generalized severe pain, status post spinal cord simulator implant having history of severe mood disorder including major depressive disorder severe and recurrent with multiple suicide attempts in the past that included ingestion of antifreeze, having cardiac arrhythmias with a history of___(unknown) tachycardia, history of psychosis with psychotic features, chronic anxiety, trigeminal neuralgia, chronic pain syndrome on low dose methadone, GERD, and chronic constipation as well as neurogenic bladder with implants and suprapubic catheter, migraine headaches, polyneuropathy, hypertension, chronic nicotine ingestion.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 28101 Based on interview and record review, the facility failed to implement routine meetings where residents can organize to discuss group concerns and resolve concerns, resulting in ongoing resident concerns and frustration. Findings include: During an interview with the facility Social Worker (SW) A on 2/1/22 at 10:08 AM, SW A said she started working at the facility on 9/1/22. SW A said she was not provided an orientation or expectations for resident council meetings. SW A said she did meet with the residents a few times to discuss things like food. SW A said 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 with SW A on 2/1/22 at 10:08 AM, SW A provided a few notes. One note revealed, Resident Council Minutes for 6/30/21 that showed 7 residents attended. Old businesses listed: more activities and outings, open a facility store for all residents and a questionnaire with all residents. There was no information to indicate if the old business had been resolved. There was no indication what the concerns were or any documentation of the matters discussed during this meeting. 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 for not responding to their concerns. Residents were not aware of a formal process to address their concerns and said that 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 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** 31771 Based on interview and record review, the facility failed to document 1 Resident's (R32) code status of 7 Residents reviewed for advanced directives, resulting in the potential for R32's wishes/rights not being followed in the event her heart was to stop. Findings include: Resident #32 (R32) originally admitted to the facility on [DATE] with diagnoses that included: Medically Complex Cardiopulmonary Conditions and Manic Depression. The Minimum Data Set (MDS) dated [DATE] reflected R32 has a BIMS score of 6 out of 15 which indicated the Resident is cognitively impaired. R32 had a court appointed guardian. Review of the Advance Directive for R32 reflected No Code Do Not Resuscitate No CPR. The document was signed by a facility representative and the Durable Power of Attorney on [DATE]. Review of the EMR Face Sheet, the initial screen that appears when accessing the electric file for R32, reflected the resident is Full Code. Further review of the EMR Doctor's Orders (DO) revealed each page displays Full Code at the top of the page although no DO for a code status was identified. On [DATE] at 2:47 PM an interview was conducted with Social Worker (SW) A. SW A acknowledged that the current Advance Directive in the EMR did not match the displayed code status.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on interview and record review, the facility failed to provide residents that received showers privacy when the facility shower room was not functioning, resulting in residents being frustrated and potential embarrassment when they were receiving personal care. R87 Review of R87's face sheet revealed he was a [AGE] year-old male that was admitted on [DATE] and had diagnoses that included: heart block, acute and chronic respiratory failure, alcohol abuse, pacemaker, and morbid obesity. He was his own responsible party. On 1/31/22 at 10:58 AM, R 87 reported that the facility shower room was not working so the facility regularly used the shower in his room to shower other male residents. On 2/10/22 at 9:40 AM, Certified Nurse Aide (CNA) V reported that the shower in the room of R87 was used for other male resident showers for months due to the facility shower room not functioning. CNA V reported that the shower in the shared bathroom of rooms [ROOM NUMBERS] were used for female showers. 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, and diabetes mellitus. R 4 was her own responsible party. R7 Review of R7's face sheet, no date, revealed R 7 was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: Multiple sclerosis, major depressive disorder, anxiety disorder, and chronic pain syndrome. R7 was cognitively intact. On 2/10/22 at 11:32 AM an interview was conducted with R7 who resided in room [ROOM NUMBER] and R4 who resided in room [ROOM NUMBER]. Both Residents acknowledged that their shared bathroom was used for female resident showers. R4 reported Hospice and other staff would just bring (residents) through without asking to come through her room to the shared bathroom to shower female residents. R7 reported she was usually asked and stated, what are you going to say?, indicating that if she refused to allow traffic in her room then other female residents would not receive a shower. On 2/10/22 at 12:23 PM, Facility Maintenance Director (FMD) Y reported that he was sent by a sister facility to repair the shower in the facility shower room. FMD Y indicated he did not know how long the shower had not been functioning but that it was repaired about December 23, 2021. FMD Y reported he did not know how facility residents were receiving their showers.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 28101 Based on interview and record review, the facility failed to implement a grievance procedure for residents concerns to be resolve, resulting in ongoing concerns and frustrations. Findings include: During an interview with the facility Social Worker (SW) A on 2/1/22 at 10:08 AM, SW A said she started working at the facility on 9/1/22. SW A 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 with SW A on 2/1/22 at 10:08 AM, SW A provided a few notes. One note revealed, Resident Council Minutes for 6/30/21 that showed 7 residents attended. Old businesses listed: more activities and outings, open a facility store for all residents and did questionnaire with all residents. 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. 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.

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F 0656 Level of Harm - 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** 28101 This citation pertains to intake number 125541 This citation has 2 Deficiency statements. DPS #1 Based on interview and record review, the facility failed to implement a care plan to prevent 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. R22 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 0656 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 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 0656 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. 31771

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 31771 Based on observation, interview, and record review, the facility failed to provide basic activities of daily living (shower and grooming) for 2 dependent Residents (R5 and R32) of 2 Residents reviewed for activities of daily living, resulting in both residents being unkept in appearance and R5 being frustrated. Findings include: R5 R5 was admitted to the facility 12/22/20 with diagnoses that included: History of Stroke, Hemiplegia (paralyzed or weakness to one side of the body), and Asthma. Review of the Minimum Data Set (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. R5 reported he is scheduled to have showers twice a week and that the facility is grossly understaffed indicating this is a contributing factor for not being given regular showers. R5 presented as unshaven and with unkept, greasy hair. On 1/26 at 9:15 AM and at 11:21 AM, R5 was observed in his room in a wheelchair. His appearance remained as previously noted as in need of a shower and unkempt. On 2/03/22 at 4:14 PM, R5 reported he has had one shower since last interviewed on 1/27/22. R5 reported he was supposed to get a shower today at 2:00 PM but no one came to get him. On 2/7/22 at 1:21 PM, a request was made for the shower sheets of R5 from October 1, 2021 to present. The Director of Nursing (DON) reviewed a binder and provided a shower sheet for R5. The DON reported she would check other areas for additional shower sheets. 2/7/22 at 2:21 PM, The DON reported she had no other shower sheets for R5. Review of the Shower Sheets provided by the DON for R5 reflected the Resident had showers on 8/30/21, 9/6/21, and 9/23/21. The next shower documented was a refusal by R5 on 12/16/21. No other provided documentation of showers or refusals was reviewed except for a shower sheet that a shower was given on 1/27/22. No documentation reflected that R5 had a shower on 2/3/22 as he reported he expected. R32 R32 was admitted to the facility 9/23/19 with diagnoses that included Asthma, Manic Depression, and Diabetes Mellitus. The MDS dated [DATE] reflected R32 had a BIMS score of 6 which indicated cognitive impairment. The MDS reflected was able to walk in his room with oversight and cueing of one staff member and required the assistance of one staff member for personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 day of survey exit. R32 was always observed in bed, with the room always darkened, undressed without a shirt, and unshaven including on: 1/24/22 at 12:07 PM and 3:03 PM, 1/25/22 at 11:02 AM and 2:54 PM, 1/26/22 at 9:00 AM, 1/31/22 at 9:30 AM and 11:21 AM, and 2/7/22 at 8:42 AM. Observed in the Resident's room was a four-wheeled walker and a wheelchair without foot pedals which indicated the Resident was capable of mobility. 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. TD U reported that a while back an accusation was made by a staff member that the Resident had acted inappropriately. TD U reported that ever since then R32 rarely gets out of bed. TD U reported that the facility doesn't do very many activities except for special events and that the facility does not have a Restorative program as the facility doesn't have the staff for that. In an interview conducted 2/9/22 at 1:19 PM with Social Worker (SW) A. SW A who works as the Activities Director and as a CNA reported she did not know of the incident with R32. SW A reported she did not know why R32 doesn't get out of bed. When the shower sheets were requested for R5 the same was requested for R32. Review of the shower sheets for R32 provided by the DON reflected that R32 had a shower 12/3/21 and 12/20/21. No further documentation of shower was provided of showers given either before or after these dates. No further documentation was provided by survey exit for R5 or R32.

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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 0684 Level of Harm - 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** 31771 Based on interview and record review, the facility failed to meet professional standards and provide quality care related to diabetic care of 3 Residents (R18, R36, R5) of 5 diabetic residents reviewed, resulting in poor blood sugar control and potential for serious medical complications. Findings include: R18 Resident #18 (R18) was admitted to the facility 11/12/20 with diagnoses that included Chronic Obstructive Pulmonary Disease. Review the Minimum Data Set (MDS) assessments for 5/21/21 and 8/21/21 did not reflect a diagnosis of Diabetes Mellitus. A diagnosis of Diabetes Mellitus is reflected in the MDS dated [DATE]. This MDS also reflected a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the Resident was cognitively intact. The medical record reflects R18 can make her own medical decisions. Review of the Care Plan for R18 did not reveal a Care Plan for Diabetes Mellitus. The Care Plan did reflect a Nutrition Status Care Plan (page 8). However, this Care Plan did not reflect the diagnosis of Diabetes Mellitus or any interventions that focused on diabetic care, treatment, or education. The Goal and Approach (interventions) reflected a focus of weight management, meal assistance and swallowing. One intervention implemented 8/17/21 reflected Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of the Doctor's Orders reflected on 7/21/21 an order was entered for HGBA1C (every) three months. Review of the laboratory results for R18 reflected an HGBA1C result on 9/13/21. This indicated that the next HGBA1C was to be drawn on or about 12/13/21. However, review of the medical record did not reveal that an HGBA1C had been completed since 9/13/21. On 2/10/22 at 8:54 AM, the Director of Nursing (DON) acknowledged that the HGBA1C was not, and still has not been obtained as ordered. On 2/8/21 at 10:37 AM, an interview and record review were conducted with R18 in her room. R18 reported she does not receive a diabetic meal. R18 reported if it is on the printed menu she receives it. R18 reported she gets sweets, such as brownies with her meals. R18 provided a copy of her meal ticket that she reported came with her meal the morning of 2/8/22. This meal ticket was reviewed and reflected it was a breakfast ticket and indicated LCS (Low Concentrated Sweets) and No Sweets. R18 reported for a nighttime snack she is provided ice cream and chocolate milk. R18 reported she has never talked to a Dietician and that she has questions and concerns. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/9/22 at 11:11 AM, a telephone interview was conducted with Registered Dietician (RD) AA. RD AA reported she started at the facility as the Registered Dietician in August of 2021. RD AA reported she has never physically been in the facility or seen any facility residents face to face. RD AA was asked, from a professional standards perspective, if it was acceptable to assess and document on residents without seeing the residents face to face. RD AA reported she was told by her corporate superior it was ok. RD AA reported that the RD is responsible for the high risk residents to include diabetics and residents that receive nutrition by tube feedings. RD AA reported she doesn't think she has to be in-house for this. RD AA reported she is in contact with the Certified Dietary Manager (CDM) and is supposed to oversee the CDM eight hours a month but did not give an explanation how this was accomplished remotely. AD AA indicated that R18 is non-complainant with maintaining a diabetic lifestyle. RD AA indicated she was not aware that R18 was overdue on her labs. RD AA reported diabetic residents will be provided the same meals offered other residents just in smaller portions. On 2/9/22 at 1:05 PM, an interview was conducted in the facility kitchen with Cook/ Dietary Aide (CDA) Z. CDA Z was asked if diabetic residents receive the same size portions as other residents. CDA Z reported residents will only get different size portions If their healthcare professional orders like half portions. Review of the Doctor's Orders for R18 revealed an order entered 11/23/21 for (Low Concentrated Sugar) regular texture thin liquids diet. The order did not specify smaller or half portions. Review of the Electronic Medical Record (EMR) Progress Notes reflected a Quarterly Assessment documented by RD AA on 8/17/21 which acknowledged R18 was a new diabetic, had diabetic education from the CDM (7/28/21) and that Pre (sic) documentation resident is non-compliant of diet restriction; orders out 1-2x /wk; pizza, burgers and other fast food. The next Dietary documentation in the Progress Notes reflected a (remote) Annual Assessment entered by RD AA on 11/23/21 which indicated the Resident had no skin breakdown and no edema noted. This Annual Assessment included the same line from 8/17/21 of, Pre (sic) documentation resident is non-compliant of diet restriction; orders out 1-2x /wk; pizza, burgers and other fast food. The Progress Notes from the time of the remote Quarterly Assessment on 8/17/21 to the remote Annual Assessment by RD AA on 11/23/21 were reviewed. The review revealed two entries. The first entry on 8/24/21 at 9:07 PM reflected that R18 Was working hard to adjust diet to maintain (blood sugar) readings. A second Progress Note entry reflected on 10/20/21 at 8:52 PM that R18 was non-complainant with food and drink. This entry did not specify if this was food ordered from outside the facility by R18 or if this was from the offered evening snack. No other documentation was found in the Progress Notes that reflected R18 was non-complaint or had received further dietary education during that time. Neither the Quarterly or Annual Assessment documentation completed by RD AA reflected a review to ensure a Care Plan was in place that addressed generic or personalized interventions for a new diabetic Resident. Review of the EMR for R18 did not reveal any Physician documentation since 8/14/21. An EMR Nursing Progress Note of 9/12/21 at 10:38 PM revealed a Physician encounter with R18 when the Resident asked about weight loss. The nursing documentation reflected the Physician instructed the Resident speak with the Dietician. However, no order for a Dietary consult was found or is a Dietician encounter documented except for the remote Annual Assessment completed by RD AA on 11/23/21. No further Dietary documentation is noted as of 2/10/22. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/9/22 at 11:43 AM, a telephone interview was conducted Medical Director (MD) I MD I reported he had evaluated R18 five or six times since August of 2021. MD I was informed no documentation was found the EMR of these encounters. MD I reported he did not know that the lab test for the HGBA1C had not been completed and indicated he would have addressed an abnormal value if the result had been provided to him. Review of the history of the Doctors Orders for R18 from 7/19/21 to 2/10/22 reflect 83 DO changes and administrations of insulin apart from the Medication Administration Record (MAR) (Levemir- 49 changes, Novolog - 25 changes, NPH- 9 changes). These adjustments and administrations were implemented in response to continued and successive elevated blood sugar test results. No documentation was found in the Progress Notes that staff had informed or discussed with the Resident the change in types of insulin or the frequent ordered dose adjustments. The laboratory result for the HGBA1C of 9/13/21 was 10.1 with a normal range considered by the lab to be 4.3 to 6.0. The HGBA1C lab ordered by the Dr. that was to be repeated in three months was not obtained despite alleged monitoring by the Physician, Nursing and Dietary. The Physician alleged encounters and evaluations of the Resident since 8/14/21 but no documentation of these encounters were provided by survey exit. The EMR reflects one face to face by the CDM of Dietary when the Resident was first diagnosed with diabetes in July 2021. RD AA reported she did not assess R18 in-person. RD AA documented a Quarterly and Annual assessments remotely documenting persistent non-compliance of the Resident without basis found in the EMR Progress Notes. Furthermore, no Plan of Care by any discipline had been established to address treatment of the disease process, the alleged resident non-compliance, or to provide and persevere with education to assist the Resident reach the maximum potential. R36 Review of R36's face sheet, no date, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Acute myocardial infarction (heart attack), Morbid (severe) obesity, acute respiratory failure, sepsis due to streptococcus pneumoniae, neuromuscular dysfunction of bladder (neurological condition of the bladder), difficulty walking, anxiety disorder, sleep apnea and peripheral vascular disease. During record review on 2/9/22 at 4:00 PM, the Surveyor notified the Nursing Home administrator (NHA) that blood sugars and laboratory results were not located in R36's medical record. Review of R36's Medication Administration Record (MAR) for February 2022 revealed R36 had a blood sugar taken on 2/9/22 at 11:00 PM that read 430 (high, normal is 70-110) and a blood sugar was taken on 2/10/22 at 7:00 AM that read 317 (high, normal is 70-110). On 2/10/22 at 8:40 AM, the Director of Nursing (DON) verified R36 had not had any finger stick blood sugar readings since last November as the nurse writing orders only ordered blood sugars for 7 days and no one caught the error. The DON said R36 did not have an A1C (laboratory test for blood sugar monitoring) in the last year. The DON said she took R36 blood sugar when she became aware last night, notified the physician, ordered an A1C and verified all other residents that were diabetic were getting blood sugar readings. The DON was not aware R36's blood sugar was 430 at 11:00 PM on 2/9/22 and was not aware that there was no record of the nurse call the physician at 11:00 PM when R36's blood sugar was 430. The DON was asked to provide the laboratory findings and any information on physician notification of the 430 blood sugar on 2/9/22 at 11:00 PM. Upon exit no laboratory findings or physician notification were provided. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R36's progress note dated 2/9/22 at 6:20 PM revealed a note electronically signed by the DON, Blood sugar check 347, New order recd. (received) Review of R36's Medication Regimen Review dated 2/1/22 at 12:00 PM revealed the note was signed by Pharmacist N that documented, The resident's medication regimen contained no new irregularities. Review of R36's Medication Regimen Review dated 1/4/22 at 10:03 that documented, The resident's medication regimen contained no new irregularities. Review of R36's Medication Regimen Review for December 2021 was not located in R36's medical record. Review of R36's Medication Regimen Review dated 11/02/21 at 1:50 PM that documented, The resident's medication regimen contained no new irregularities. During a telephone interview with Pharmacist N on 2/10/22 at 9:30 AM, he confirmed that he did R36 pharmacy review on 2/1/22 and he should have verified nursing was monitoring R36's blood sugar, the readings and his A1C. The Pharmacist also verified nursing and the physician should have been monitoring R36's blood sugars and A1C. Pharmacist N did not offer any reason for this error. Review of the facility job description titled Registered Dietitian dated 7/1/17, revealed under, Responsibilities and Duties: Reviews menus meeting requirements for variety and rotation of menu items. Completes consults for at risk residents including but not limited to tube feeders, TPN, ESRD, diabetics, complex wounds, and develops plan of care. Monitors resident weights and participates in resident weight committee at each facility quarterly or more frequently. Participates in QAPI Committee at each facility quarterly or more frequently. Monitors and reviews MDS (Minimum Date Set) assessments and care plans for at risk residents completed by facility staff. Monitors facility compliance with food safety and sanitation practices monthly and provides feedback to NHA (Nursing Home Administrator) and Kitchen Manager. R5 Review of R5's face sheet, no date, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: hemiplegia, unspecified affecting right dominant side, and chronic obstructive pulmonary disease. Review of the dietary note for R5 entered by Registered Dietician (RD) AA on 1/25/22 at 1:26 PM. The entry reflected it was an Annual nutritional status. The entry reflected a current body weight of 116 .6 ponds (lbs.) and that the Resident's weight was trending downward. The documentation reflected that R5 will refuse meals (related to) outside side and items in room. The entry reflected that R5 denied any chewing or swallowing problems and that no skin breakdown or edema were noted. It was noted that the following text appeared exactly was entered on 8/17/21, and unknown UBW, POC goal for weight within 115-130# Diet is NASP is being tolerated. Feeds self with tray set up in room, Current intakes are variable of 0 -100% mostly 76 -10% of meals pre (sic) nursing, Denies any chewing /swallowing issues, Resident has natural teeth. Skin with no breakdowns (sic), no n/v/c/d, no edema noted. These statements indicate that RD AA had discussed nutrition with R5 and did not observe any skin issues or edema. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/3/22 at 4:14 PM, R5 reported he has not talked to an RD. R5 reported he doesn't know of an RD or met anyone with the name of the RD. On 2/9/22 at 11:11 AM, a telephone interview was conducted with Registered Dietician (RD) AA. RD AA reported she started at the facility as the Registered Dietician in August of 2021. RD AA reported she has never physically been in the facility or seen any facility residents face to face. RD AA was asked, from a professional standards perspective, if it was acceptable to assess and document on residents without seeing the residents face to face. RD AA reported she was told by her corporate superior it was ok.

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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** 31771 Based on observation, interview, and record review, the facility failed to implement interventions to prevent, assess and treat 2 Residents (R21 and R23) wounds, resulting in R21 developing a stage 4 pressure ulcer and R23 developing multiple areas of skin breakdown and experience pain related to skin break down. Findings include: R21 R21 was originally admitted to the facility 10/8/19. Current diagnoses included Cardiopulmonary conditions and Alzheimer's disease. The Minimum Data Set (MDS) dated [DATE] reflected R21 was severely cognitively impaired, was at risk for the development of pressure sores but did not have any pressure sores or other skin conditions at the time of this MDS assessment. The MDS reflected R21 was totally dependent on staff for bed mobility, eating, and toileting. On 1/25/22 at 9:27 AM, the Director of Nursing (DON) reported that R21 has a Stage Three pressure sore that appeared around a month ago. The DON reported this pressure sore was not reflected on the facility 802 or the 672 forms provided to the survey team on 1/23/22. Review of the MDS dated [DATE] reflected R21 has a Stage Four pressure sore. Review of the Electronic Medical Record (EMR) for R21 revealed a Admission Body assessment dated [DATE] at 11:23 PM that reflected R21 had returned from the hospital. The document reflected R21 did not have any pressure sores, rashes, or bruises. The document reflected No skin issues noted. The EMR Weekly Skin Assessment for R21 dated 12/4/21 at 2:28 AM reflected an Induration - coccyx and that this area was Non-Blanchable. A Care Plan was initiated on 12/4/21 that reflected the Problem of a Pressure Sore and Resident has a pressure ulcer to right buttock. Review of the EMR Progress Notes did not reflect measurements were obtained and documented. Review of the EMR for measurements of the pressure sore revealed an entry on 12/22/21 at 7:53 AM that R21 noted to have large open wound area to buttocks but no measurements were documented. On 1/1/22 at 7:25 AM an entry reflected a measurement of 6.5 x 2.5 (assume centimeters (cm)). The next wound measurement documentation located was an entry dated 1/31/22 at 4:49 PM with a notation of Recorded as Late Entry on 2/1/22 at 4:51 AM. The entry reflected that the wound measured l (length)- 6.8 cm x W (width) - 5.0cm with slough . no depth recorded. The measurement entered on 2/1/22 reflected an increase of 0.3 cm in length and a doubling of the width measurement. Review of the EMR Progress Notes for R21 reflected an entry from Registered Dietician (RD) AA dated 12/7/21 at 10:51 AM that revealed Skin with no breakdowns which indicated RD AA was not aware that a pressure sore had been identified on 12/4/21. The entry reflected a weight loss concern for R21 but that there would be no change of the nutritional plan. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/9/22 at 11:11 AM, a telephone interview was conducted with RD AA. RD AA reported she started at the facility as the Registered Dietician in August of 2021. RD AA reported she has never physically been in the facility or seen any facility residents face to face. RD AA reported that the RD is responsible for the high risk residents. R23 R23 was originally admitted to the facility 11/6/20 with diagnoses that included: History of Stroke, Heart Failure, and Respiratory Failure. The Minimum Data Set (MDS) dated [DATE] reflected R23 was totally dependent on staff for bed mobility and transfers. Section M of the MDS reflected R23 was at risk for the development of pressure sores but did not have any pressure sores or healed pressure sores at the time of this MDS assessment. Review of the Electronic Medical Record (EMR) of R23 revealed each Weekly Skin Assessment from 11/25/21 to 1/20/22 reflected Reddened - buttocks- (treatment) in place. No further findings are documented. Review of the Prescription Order for R23 dated 11/29/21 revealed Triple Antibiotic ointment with instructions of cleanse excoriated areas to upper back and buttocks with soap and water, rinse and pat dry and apply (Triple Antibiotic Ointment twice a day) until resolved. Review of the General Order for R23 dated 12/30/21 reflected Magic Butt Cream with the special instructions to apply Magic Butt cream (twice a day and as needed). The shower and bath sheets provided by the facility with dates 11/11/21, 12/9/21, 12/16/21, 12/23/21, and 1/6/21 were reviewed. The format of the shower and bath sheets were divided into quarters for four separate dates. Each quarter depicts a human figure front and back. Below the figure is written Skin condition: None: Or Explain with blank lines to add any pertinent findings if the staff providing the care observes any skin conditions. Review of the shower and bath sheets for the above dates did not reflect any skin conditions were documented. The last shower and bath sheet was completed on 1/13/22 reflected a bed bath was given noting many small sores on body. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/24/22 at approximately 4:00 PM, an observation was conducted in the room of R23 for review of the Resident's skin. Staff present were Registered Nurse (RN) K and the DON. R23 appeared unkempt with greasy hair. R23 was not wearing a brief. R23 had a catheter and tubing that was not anchored to the bed. Noted yellow urine and white sediment in the tubing of the catheter. The R23 was turned with assistance onto his right side. The left buttocks presented with five open areas and surrounding excoriation and moisture associate skin damage (MASD). The right buttocks appeared red and noted several open areas. In total there were eight open areas of various sizes. RN K washed the buttocks with soap and water using a washcloth. Blood was noted on the washcloth with wiping. The large wound near the lower inner buttocks appeared to have slough that was removed with the wiping of the entire buttocks. This wound began to actively bleed prompting RN K to hold pressure to the area. Subsequently the wounds were measured beginning on the left upper lateral buttocks to the inner lower right buttocks and measured as follows: Wound #1) 1 centimeter (cm) x 1.3 cm, Wound #2) 0.8 cm x 1.2 cm, Wound #3) 0.6 cm x 1.4 cm, Wound #4) 1.5 cm x 2.7 cm, Wound #5) 1.7 cm x 2.7 cm, #6) 2.3 cm x 2.6 cm x 0.2 cm deep. This wound was located peri-rectal and appeared to be characteristic of a Stage II pressure sore. On the right buttocks across from wound #6 was the open wound that had been actively bleeding. This wound, #7), measured 2.4 cm x 2.8 cm x 0.3 cm deep and appeared as a Stage II pressure sore. Wound #8) on the right side measured 1cm x 1 cm. The wounds were addressed, and RN K assisted in rolling R21 to his other side. However, this was done without changing her gloves and hand sanitizing. On 1/25/22 at approximately 2:00 PM, an interview was conducted with R23 in his room. R23 reported he cannot remember the last time he was up in a wheelchair. R23 reported that there was no point in it as his bottom feels like shredded meat. R23 reported he cannot self-propel the wheelchair and usually just sits next to the bed. R23 reported he doesn't like to sit in his wheelchair because they leave me up for over two hours because they don't have time to help me. R23 reported when he is in bed staff prop him up on his side to keep pressure off his backside.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on observation, interview, and record review, the facility failed to assess and provide care and services to prevent the loss of range of motion for one resident (Resident #8 (R8)) and ensure no further loss of range of motion, resulting in R8 having severe range of motion loss and severe restriction of all mobility with the potential for further loss of ROM. Findings include: 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 that the resident was comatose. The medical record also revealed R8 had a tracheostomy. The Minimum Data Set (MDS) dated [DATE] revealed R8 was in a vegetative state and displayed total dependence on staff for all care. On 1/25/22 at 10:06 AM, audible rattling breath sounds were heard in the hall coming from the room of R8. Upon entry R8 was observed lying on her back with the head of the bed raised. R8 had slid down with just her shoulders and head elevated. The Director of Nursing (DON) was summoned who entered the room with LPN E. While repositioning R8 bilateral foot drop was observed. While staff performed incontinence care on R8 it was observed that both legs were extended and stiff with the right leg crossed over the left leg. It was observed that two staff were required to separate the Residents stiff legs to remove the wet brief. It was noted that, with difficulty and by bending the legs of the resident at the knees, that the two staff were able to apply a clean brief to the Resident. Review of the Care plan for R8 reflected a Care Plan and Problem of Resident has contractures to bilateral hands/elbows related to chronic comatose condition .with a goal of the resident will be clean and well groomed. The Care Plan reflected interventions to include Provide gently (Range of Motion (ROM)) daily with Care and Provide PT/OT or restorative program as needed. This Care Plan did not reveal any ROM to be conducted with the arms or legs of the R8. 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 through the next review date of 4/14/2022. An intervention documented as implemented on 1/13/21 reflected Locomotion Wheelchair use with 1 person. No other Care Plan problem or focus was found related to improving, maintaining, or protecting the range of motion of the other joints to include the lower extremities for R8. During the Recertification Survey conducted from 1/23/22 through 2/10/22, R8 was never observed to be in her wheelchair. The Resident's wheelchair remained stored in her room on the far wall across from her bed. On 2/9/22 at 8:23 AM, an interview was conducted with the DON. The DON was asked when was the last time R8 was out of her bed. 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). (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Review of the shower sheet for R8 reflected that, before the shower on 2/5/22. Prior to this the Resident had last 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 Therapy has not performed any recent evaluations of R8. TD U reported R8 uses anti-contracture devices called carrots for her hands. TD U reported the facility does not have a Restorative Program stating, they 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.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 31771 Based on observation, interview, and record review, the facility failed to store, label, implement use of, maintain, and monitor respiratory equipment for four facility Residents (R8, R36, R4, and R87) resulting in the potential for cross- contamination of oxygen devices and hypoxia and the potential for all facility residents with oxygen needs to have this need unmet. Findings: R8 Review of the medical record reflected R8 was originally admitted to the facility 5/20/05 with diagnoses that included: Acute and Chronic Respiratory Failure and had a Tracheostomy. The medical record reflected the Resident is comatose and has a history of recurrent pneumonia. On 1/23/22 at approximately 12:25 PM an observation was conducted in the room of R8. An oxygen concentrator was observed at bedside with attached undated oxygen tubing and a simple oxygen mask. The undated tubing and mask were not observed to be in protective storage but were draped over and hanging down from a nearby shelving unit. Resident #36 (R36) Review of the EMR reflected (R36) was admitted to the facility 11/16/20 with diagnoses that included: Diabetes Mellitus, Hypertension, and Sleep Apnea. The medical record reflected Doctor's Orders (DO) and Care plan interventions that reflect the Resident has a Continuous Positive Airway Pressure device that is to be used nightly. On 1/23/22 at approximately 12:15 PM and on 1/25/22 at 9:36 AM observations and interviews were conducted with R36 in his room. A CPAP device was observed on bedside nightstand next to a one gallon uncapped container of spring water. The undated tubing and headgear with an attached CPAP mask were observed to be coiled and draped over the nightstand and not in protective storage. R36 reported he is to use the CPAP device nightly but that he only wore it about four out of seven days a week. R36 indicated that he needed assistance on donning the headgear and mask. R36 reported that no other staff understand the device except RN K so he does not wear it unless RN K is working. Review of the Progress Note for R36 from 9/1/21 to 2/10/22 did not reveal any documentation regarding the CPAP device to include application concerns or if R36 had refused to wear the device. Review of the medical record did not reveal this had not been a regular task to be completed for the resident. Resident #4 (R4) On 1/23/22 at 2:25 PM, an observation and interview were conducted with R4 in her room. R4 was observed to be wearing a nasal cannula oxygen delivery device which was attached to an oxygen concentrator running at 3 liters per minute (lpm). It was observed that the tubing was dated 1/12/22. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/7/22 at 11:33 AM in the room of R4 an oxygen tank in a holder was observed on the back of the Resident's wheelchair. The valve of the oxygen tank was determined to be in the on position and the tank gauge reflected an empty reading. At 1:21 PM that day (2/7/22) the Director of Nursing (DON) was informed of R4's empty wheelchair tank. On 2/10/22 at 11:32 AM the oxygen tank on the back of R4's wheelchair was observed to be empty with the gauge reading zero in the on position. The DON was informed of this at 11:57 AM on that day. Resident #87 (R87) R87 was admitted to the facility3/25/21 with diagnoses that included: History of Acute and Chronic Respiratory Failure, Hypoxemia (low oxygen saturation in the blood) Dyspnea (difficulty in breathing), Obstructive Sleep Apnea, and Dependence on enabling Devices (Bilevel Positive Airway Pressure (BIPAP)) Review of the DO for R87 reflected the Resident was to receive supplemental oxygen at 5 liters per minute (lpm) and was to use the BIPAP device at bedtime and as needed. On 1/31/22 at 10:58 AM, an observation was conducted with R87 in his room. A BIPAP device with a port for attachment to supplemental oxygen was noted on a nightstand with undated tubing and a mask laying on a nightstand not in protective storage. Also observed was oxygen concentrator with a humidification device that was empty of water and an undated attached oxygen tubing delivering oxygen at 5 lpm. On 2/3/22 a request for made to the DON for policies and procedures related to oxygen tubing and devices to include use and storage. On 2/9/22 at 3:44 PM, the DON completed the delivery of the requested documents and reported an oxygen service was in this day and provided guidance on CPAP cleaning and changing of filters. The DON reported she did not believe staff had previous guidance on this. The DON also reported that the donning of CPAP devices for resident was not a documented task. The policy numbered NP001 provided by the facility titled CPAP/BiPAP last revised 4/27/2018 was reviewed. The policy reflected a section with the heading of Preparation which indicated 1. Only a nurse or respiratory therapist should administer oxygen through a Positive Airway Pressure (PAP) mask system. The section of the policy titled Equipment and Supplies reflected 4. Humidification system if indicated, sterile water which directs the use of sterile water and not the use of spring water as observed for R36 or as an empty humidification chamber as observed for R87. The section of the policy with the heading of Steps in the Procedure reflect the process for ensuring the sterile water is at the proper level which indicated the sterile water level is to be monitored. Also, the policy directs that staff are to ensure that the mask is the proper fit, and the resident is comfortable. The policy also reflects, 7. Review machine settings to ensure proper parameters are correct. And 8. Attach pulse oximeter to the resident and obtain reading. The section with the heading of Documentation reflects Document the following in the resident's medical record . The policy revealed 6 steps outlining what is to be documented in the resident's medical record which indicated the donning of BiPAP, and CPAP devices is a task to be documented contrary to the statement given by the DON during the interview conducted 2/9/22 at 3:44 PM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy numbered NP002 provided by the facility titled Oxygen Administration last revised 4/27/2018 was reviewed. The policy revealed a section with the heading of General Guidelines which reflected 1. d that nasal cannulas will be changed and dated, and that masks will be changed and dated weekly. The Steps in the Procedure section revealed 9. Humidity bottles (bubblers) are therapeutic if the flow rates are greater than 4 (liters) or above . This indicated that the empty humidification bottle for R87 is, in effect, no humidification for the Resident's Doctor Ordered oxygen delivery rate of 5 lpm.

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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** 28101 Based on observation, interview, and record review, the facility failed to effectively treat 1 Resident's pain (R7), resulting in R7 experiencing excruciating pain daily. Findings include: 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 medication pass on 1/25/22 at 3:20 PM, R7 reported that she had pain in her face at a 10 on a 1-10 scale. R7 said she had trigeminal neuralgia and the medication Tegretol was not able to control her pain anymore. R7 said she had surgery years ago and the pain had come back. She said Doctor I said he could not give her a higher dose of Tegretol, and this was very upsetting. R7 waited until the last minute to take her Tegretol as she can only take it 3 times a day and as it gets time for the next dose the pain gets out of control 3 times day. R7 told the surveyor about her past suicide attempts and reported this pain makes her want to end it. During a telephone interview with R7's legal guardian BB, BB expressed frustration with R7's Physician I not being able to control R7's trigeminal neuralgia pain. The guardian was aware that the Tegretol was affecting R7's blood sodium levels but BB was not aware of what the Neurologist recommendations were or what else could be done to control the trigeminal neuralgia pain. BB said no one had ever discussed a medical procedure called Gamma Knife with her to control the pain. BB said the facility does not share the neurology recommendations with her and they have not had enough staff for someone to sit down with her to review R7's medical records. During a telephone interview with R7's Physician I on 1/26/22 at 10:00 AM, Physician I said he was not aware that R7's trigeminal neuralgia pain was out of control. Physician I said he had R7 on the highest dose of Tegretol he could. Physician I had a pharmacist conference call into the telephone conversation, and he confirmed that Physician I was giving a higher dose of Tegretol than was recommended for trigeminal neuralgia. Physician I denied any knowledge of R7's neurologist recommending a procedure called Gamma Knife. Physician I said the facility contacted him about the Gamma Knife procedure today and he would do the referral today. Review of R7's electronic medical records revealed a Neurology note dated 5/26/21 that revealed the neurologist recommended Gamma Knife consultation related to R7's trigeminal neuralgia pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview with the facility Social Worker (SW) A on 1/26/22 at 3:37 PM, SW A reviewed R7's neurology notes in the medical record. A Neurology note dated 5/26/21 was located that recommended Gamma Knife consult related to trigeminal neuralgia pain. SW A said she was not the SW in the facility in May and was not aware of how the SW at the time followed up with medical consultation recommendations. SW A was not able to locate any notes in R7's medical record that indicated anyone including R7's Physician I had followed up with the May 26th, 2021, Neurologist recommendations. SW A said she had been taking R7 to her outside appointments since October 2021. SW A was able to find some handwritten notes that she had made after R7 went out to doctors since October 2021. SW A did not scan these notes in the medical record or document the recommendations in R7's medical record. SW A did not document informing R7's guardian O or physician I about the recommendations. SW A said she drives the residents to appointments, works as a Certified Nurse Aide (CNA) when the facility is short staffed and was not provided any training of expectations for follow-up or documentation when residents have outside appointments. SW A said she started the referral for R7 to have the Gamma Knife consultation today. Review of R7's Neurology consult note dated 9/27/21 at 4:13 PM revealed, The patient has also continued to have right facial pain. She was on a much higher dose of Tegretol but it was decreased and currently is on Tegretol 200 mg, 1 and 1/2 tablet bid (twice a day). Her sodium has drifted down from 135 to 124 today. She is quite upset that her Tegretol was decreased. She repeated said that she would never go off of it as that is the only medication which helped her trigeminal neuralgia pain. Her Tegretol level was 15.2 on 6/7/21. Review of R7's physician progress notes revealed Physician I had notes in R7's medical record every month since 6/20/21 to 1/16/22, except for September 2021 no note was located. The note dated 6/20/21 (about 3 weeks after the Neurologist recommended a Gamma Knife consultation related to R7's trigeminal neuralgia pain) revealed no indication Physician I had reviewed the Neurologist recommendations or was aware that a referral was need for R7 to receive a Gamma Knife consultation. Under Plan revealed, 8. Trigeminal neuralgia. We will treat with her current medication's and follow symptomatically and follow with neurology as well as need. Physician I's notes date 7/17/21, 8/14/21, 10/10/21, documented the same thing as the note 6/20/21. Review of R7's. Physician I's note dated 11/8/21 item 8 was changed slightly to read, Trigeminal neuralgia, intermittently symptomatically and follow up with neurology for further suggestions, might have to increase her analgesics if need. Physician I's note 12/5/21 revealed, 8. Trigeminal neuralgia, still symptomatic, continue Tegretol, follow symptomatically and neurology follow up. Physician I's note dated 1/16/22 revealed, 8. Trigeminal neuralgia, still symptomatic, awaiting further recommendations from Neurology. We will treat with her current analgesics, including Tegretol, follow her level biochemically, and follow symptomatically and follow with further neurology recommendations as well. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of R7's Psychiatric Evaluation dated 3/10/21 revealed under history of present illness, The patient is a [AGE] year old female with a past medical history of progressive multiple sclerosis diagnosed ,d+[DATE] years ago, currently wheelchair bound at baseline, having peripheral neuropathy with generalized severe pain, status post spinal cord simulator implant having history of severe mood disorder including major depressive disorder severe and recurrent with multiple suicide attempts in the past that included ingestion of antifreeze, having cardiac arrhythmias with a history of_____(unknown) tachycardia, history of psychosis with psychotic features, chronic anxiety, trigeminal neuralgia, chronic pain syndrome on low dose methadone, GERD, and chronic constipation as well as neurogenic bladder with implants and suprapubic catheter, migraine headaches, polyneuropathy, hypertension, chronic nicotine ingestion.

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F 0710 Level of Harm - Actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on interview, and record review, the facility failed to have a physician supervise and follow up a medical recommendation to treat pain effectively for one Resident R7, resulting in R7 having excruciating pain daily. Findings include: 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 medication pass on 1/25/22 at 3:20 PM, R7 reported that she had pain in her face at a 10 on a 1-10 scale. R7 said she had trigeminal neuralgia and the medication Tegretol was not able to control her pain anymore. R7 said she had surgery years ago and the pain had come back. She said Doctor I said he could not give her a higher dose of Tegretol, and this was very upsetting. R7 waited until the last minute to take her Tegretol as she can only take it 3 times a day and as it gets time for the next dose the pain gets out of control 3 times day. R7 told the surveyor about her past suicide attempts and reported this pain makes her want to end it. Review of R7's electronic medical records revealed a Neurology note dated 5/26/21 that revealed the neurologist recommended Gamma Knife consultation related to R7's trigeminal neuralgia pain. During an interview with the facility Social Worker (SW) A on 1/26/22 at 3:37 PM, SW A reviewed R7's neurology notes in the medical record. A Neurology note dated 5/26/21 was located that recommended Gamma Knife consult related to trigeminal neuralgia pain. SW A said she was not the SW in the facility in May and was not aware of how the SW at the time followed up with medical consultation recommendations. SW A was not able to locate any notes in R7's medical record that indicated anyone including R7's Physician I had followed up with the May 26th, 2021, Neurologist recommendations. SW A said she had been taking R7 to her outside appointments since October 2021. SW A was able to find some handwritten notes that she had made after R7 went out to doctors since October 2021. SW A did not scan these notes in the medical record or document the recommendations in R7's medical record. SW A did not document informing R7's guardian O or physician I about the recommendations. SW A said she drives the residents to appointments, works as a Certified Nurse Aide (CNA) when the facility is short staffed and was not provided any training of expectations for follow-up or documentation when residents have outside appointments. During a telephone interview with R7's legal guardian BB, BB expressed frustration with R7's Physician I not being able to control R7's trigeminal neuralgia pain. The guardian was aware that the Tegretol was affecting R7's blood sodium levels but BB was not aware of what the Neurologist recommendations were or what else could be done to control the trigeminal neuralgia pain. BB said no one had ever discussed a medical procedure called Gamma Knife with her to control the pain. BB said the facility does not share the neurology recommendations with her and they have not had enough staff for someone to sit down with her to review R7's medical records. (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with R7's Physician I on 1/26/22 at 10:00 AM, Physician I said he was not aware that R7's trigeminal neuralgia pain was out of control. Physician I said he had R7 on the highest dose of Tegretol he could. Physician I had a pharmacist conference call into the telephone conversation, and he confirmed that Physician I was giving a higher dose of Tegretol than was recommended for trigeminal neuralgia. Physician I denied any knowledge of R7's neurologist recommending a procedure called Gamma Knife. Physician I said the facility contacted him about the Gamma Knife procedure today and he would do the referral today. Review of R7's Neurology consult note dated 9/27/21 at 4:13 PM revealed, The patient has also continued to have right facial pain. She was on a much higher dose of Tegretol but it was decreased and currently is on Tegretol 200 mg, 1 and 1/2 tablet bid (twice a day). Her sodium has drifted down from 135 to 124 today. She is quite upset that her Tegretol was decreased. She repeated said that she would never go off of it as that is the only medication which helped her trigeminal neuralgia pain. Her Tegretol level was 15.2 on 6/7/21. Review of R7's physician progress notes revealed Physician I had notes in R7's medical record every month since 6/20/21 to 1/16/22, except for September 2021 no note was located. The note dated 6/20/21 (about 3 weeks after the Neurologist recommended a Gamma Knife consultation related to R7's trigeminal neuralgia pain) revealed no indication Physician I had reviewed the Neurologist recommendations or was aware that a referral was need for R7 to receive a Gamma Knife consultation. Under Plan revealed, 8. Trigeminal neuralgia. We will treat with her current medication's and follow symptomatically and follow with neurology as well as need. Physician I's notes date 7/17/21, 8/14/21, 10/10/21, documented the same thing as the note 6/20/21. Review of R7's. Physician I's note dated 11/8/21 item 8 was changed slightly to read, Trigeminal neuralgia, intermittently symptomatically and follow up with neurology for further suggestions, might have to increase her analgesics if need. Physician I's note 12/5/21 revealed, 8. Trigeminal neuralgia, still symptomatic, continue Tegretol, follow symptomatically and neurology follow up. Physician I's note dated 1/16/22 revealed, 8. Trigeminal neuralgia, still symptomatic, awaiting further recommendations from Neurology. We will treat with her current analgesics, including Tegretol, follow her level biochemically, and follow symptomatically and follow with further neurology recommendations as well. Review of R7's Psychiatric Evaluation dated 3/10/21 revealed under history of present illness, The patient is a [AGE] year old female with a past medical history of progressive multiple sclerosis diagnosed ,d+[DATE] years ago, currently wheelchair bound at baseline, having peripheral neuropathy with generalized severe pain, status post spinal cord simulator implant having history of severe mood disorder including major depressive disorder severe and recurrent with multiple suicide attempts in the past that included ingestion of antifreeze, having cardiac arrhythmias with a history of_____(unknown) tachycardia, history of psychosis with psychotic features, chronic anxiety, trigeminal neuralgia, chronic pain syndrome on low dose methadone, GERD, and chronic constipation as well as neurogenic bladder with implants and suprapubic catheter, migraine headaches, polyneuropathy, hypertension, chronic nicotine ingestion.

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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.

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F 0756 Level of Harm - Actual harm Residents Affected - Few	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** 28101 Based on interview and record review, the facility failed to monitor blood sugars for 1 Resident (R36) of 5 residents reviewed for medication regimen, resulting in R36 having an excessively high blood sugar when it was discovered and potential for serious harm or death related to prolonged high blood sugars. Findings include: Review of R36's face sheet, no date, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Acute myocardial infarction (heart attack), Morbid (severe) obesity, acute respiratory failure, sepsis due to streptococcus pneumoniae, neuromuscular dysfunction of bladder (neurological condition of the bladder), difficulty walking, anxiety disorder, sleep apnea and peripheral vascular disease. During record review on 2/9/22 at 4:00 PM, the Surveyor notified the Nursing Home administrator (NHA) that blood sugars and laboratory results were not located in R36 medical record. Review of R36's Medication Administration Record (MAR) for February 2022 revealed R36 had a blood sugar taken on 2/9/22 at 11:00 PM that read 430 (high, normal is 70-110) and a blood sugar was taken on 2/10/22 at 7:00 AM that read 317 (high, normal is 70-110). On 2/10/22 at 8:40 AM, the Director of Nursing (DON) verified R36 had not had any finger stick blood sugar readings since last November as the nurse writing orders only ordered blood sugars for 7 days and no one caught the error. The DON said R36 did not have an A1C (laboratory test for blood sugar monitoring) in the last year. The DON said she took R36 blood sugar when she became aware last night, notified the physician, ordered an A1C and verified all other residents that were diabetic were getting blood sugar readings. The DON was not aware R36's blood sugar was 430 at 11:00 PM on 2/9/22 and was not aware that there was no record of the nurse calling the physician at 11:00 PM when R36's blood sugar was 430. The DON was asked to provide the laboratory findings and any information on physician notification of the 430 blood sugar on 2/9/22 at 11:00 PM. Upon exit no laboratory findings or physician notification were provided. Review of R36's progress note dated 2/9/22 at 6:20 PM revealed a note electronically signed by the DON, Blood sugar check 347, New order recd. (received) Review of R36's Medication Regimen Review dated 2/1/22 at 12:00 PM revealed the note was signed by Pharmacist N that documented, The resident's medication regimen contained no new irregularities. Review of R36's Medication Regimen Review dated 1/4/22 at 10:03 AM that documented, The resident's medication regimen contained no new irregularities. Review of R36's Medication Regimen Review for December 2021 was not located in R36's medical record. (continued on next page)

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F 0756 Level of Harm - Actual harm Residents Affected - Few	Review of R36's Medication Regimen Review dated 11/02/21 at 1:50 PM that documented, The resident's medication regimen contained no new irregularities. During a telephone interview with Pharmacist N on 2/10/22 at 9:30 AM, he confirmed that he did R36's pharmacy review on 2/1/22 and he should have verified nursing was monitoring R36's blood sugar, the readings and the Resident's A1C. The Pharmacist also verified nursing and the physician should have been monitoring R36's blood sugars and A1C. Pharmacist N did not offer any reason for this error.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observation, interview, and record review, the facility failed to assist 1 Resident (R7) obtain dental services of 1 Resident reviewed for dental services, resulting in R7 having difficulty chewing food. Findings include: 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 an interview with R7 on 2/7/22 at 11:03 AM, R7 said her dentures were lost during her transition from her last nursing home to this one. R7 opened her mouth to show she had multiple missing teeth. R7 said it is hard to chew food. R7 denied the facility has not assisted her with any dental appointments or assisted her with getting a denture replacement. On 2/7/22 at 11:19 AM the surveyor asked the NHA for the facility process to ensure resident received dental care and where R7's record would be for a referral for dental care and dentures. The NHA was not aware of R7's dentures had been lost or her need for dental care. The NHA said he did not know the facility process, but he would get the information. Upon exit the facility did not provide a policy or process to meet residents dental care needs and did not provide any record of a dental referral or acknowledgement that R7 needed assistance getting new dentures.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on observation, interview, and record review, the facility failed to maintain food safety in the kitchen and the Nutrition Room refrigerator as evidenced by the dish machine was not cleaning the dishes, dirty appliances, dirty surfaces, and expired food, resulting in the potential for food borne illnesses. Findings: On [DATE] at 10:14 AM, an initial review of the facility kitchen was conducted. Review of the walk-in cooler revealed: a half gallon container of 2% lactose free milk dated as arrived at the facility [DATE], opened on [DATE], and labeled with a use by date of [DATE]. A second half gallon container of 2% lactose free milk revealed date labeling of received by the facility on ,d+[DATE] (no year), opened on ,d+[DATE], with a discard date of [DATE]. An opened and undated container of Med-Pass was observed. Three undated hams were observed. DA O reported the hams were not for the facility residents but were employee hams left over from the holidays. Review of the spice shelf revealed a container of honey dated as opened on ,d+[DATE] and a discard date of [DATE], an opened 32 ounce (oz) container of imitation vanilla opened 2/`0 with a discard date of ,d+[DATE]. An opened bottle of Kitchen [NAME] Brewing and Seasoning Sauce revealed the only date of [DATE]. A container of ginger revealed dated of [DATE] and [DATE]. A container of nutmeg revealed one date on the container of [DATE]. Nutrition room On [DATE] at 4:32 PM, a review was conducted of the refrigerator in the Nutrition Room with Certified Dietary Manager (CDM) Q. The Refrigerator/Freezer Temperature Log reflected inconsistent monitoring with many blank spaces on the log. The refrigerator/freezer review revealed seven packages of frozen shrimp and frozen vegetables labeled for Resident #4 (R4). The packages were not dated when they were placed in the freezer. An opened package of cheese tortellini labeled for Resident #31 (R31) was dated [DATE]. Review of the refrigerator including the findings of: a carton of thickened dairy drink dated as opened , d+[DATE], CDM Q reported the container should be discarded three days after it was opened. A sealed package of chopped ham slices labeled for R31 reflected a manufacturers expiration date of [DATE], an opened bag of frozen cooked rice dated [DATE]. CDM Q reported this bag should have been discarded within three days. CDM Q reported that the 32 ounce (oz) carton of Med Plus dated as opened on ,d+[DATE] should have been discarded within three days. 39083 On [DATE] at 1:14 PM, during an observation of the dish machine cycle, multiple dishes coming out of the dish machine clean cycle wash, were observed to still have food caked on them. Immediately, during the next dish machine cycle, the detergent pump was observed to not be providing dish machine detergent to properly clean the dishes. On [DATE] at 3:10 PM, Dietary Manager Q stated, I don't see it coming out, referring to the detergent feed line, while the dish machine was running a cycle. Dietary Manager Q proceeded to change out the detergent cartridge, which did not resolve the issue during the next dish machine cycle. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2013 FDA Food Code Section ,d+[DATE].17 Warewashing Equipment, Cleaning Agents. When used for WAREWASHING, the wash compartment of a sink, mechanical warewasher, or wash receptacle of alternative manual WAREWASHING EQUIPMENT as specified in ,d+[DATE].12(C), shall contain a wash solution of soap, detergent, acid cleaner, alkaline cleaner, degreaser, abrasive cleaner, or other cleaning agent according to the cleaning agent manufacturer's label instructions. Pf

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F 0835 Level of Harm - Actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 28101 Based on observation, interview, and record review, the facility failed to administer resources effectively and efficiently to maintain the residents highest practicable physical, mental, and psychosocial well-being, resulting in a repeat immediate jeopardy for water temperatures, and immediate jeopardy for infection control, most deficiencies that were on the last annual survey were repeated and no active quality assurance program in place to resolve facility issues. Findings include: During the quality assurance review on 2/7/22 at 2:36 PM, the Nursing Home Administrator (NHA) said he has been the administrator since September 2021. The NHA said the former Director of Nursing (DON) ran the Quality Assurance (QA) meetings. The NHA found the QA book but could not locate records that showed all key personnel (NHA, DON and Medical Director) had attended the meetings since he was the administrator. The NHA could not speak to the process or what the facility had put in place after the immediate Jeopardy for hot water temperatures after the last annual survey. The NHA could not speak to a process improvement plan of any of the concerns that had been identified during this survey. See the 2567 dated 2/10/22 for the immediate jeopardy at 689 for water temperature too high and the immediate jeopardy at 880 for infection control related to COVID-19 concerns. The survey team identified 7 regulatory concerns at the harm level and two immediate jeopardy concerns. The team identified multiple concern that were systematic and led to care concerns for multiple residents. See the 2567 dated 2/10/22 for the details of all concerns. The NHA did not have any quality assurance program in place to identify or fix facility concerns.

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F 0841 Level of Harm - Actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 28101 Based on interview and record review, the facility failed to implement resident care policies related to diabetic care, wound care, activities of daily living, physician services, medical consultation, dental care, pharmacy reviews and medial coordination of care, resulting in multiple harm level deficiencies. Findings include: During the quality assurance (QA) review on 2/7/22 at 2:36 PM, the Nursing Home Administrator could not locate a QA plan that indicated the medical director was involved in coordination of care for the residents. QA meeting minutes did not indicate the Medical Director attended all quarterly QA meetings. See the 2567 dated 2/10/22 for care deficiencies related to lack of blood sugar/laboratory monitoring of diabetic patients. Lack of complete and accurate pharmacy reviews, lack of dental care, lack of wound care, and lack of activities of daily living all resulting in harm or the potential for serious harm.

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F 0846 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies and procedures ensuring the administrator's responsibilities for facility closure are completed successfully. 28101 Based on interview and record review, the facility failed to develop a policy and procedure to ensure the administrators duties and responsibilities involved with providing the appropriate notices in the event of a facility closure, resulting in the potential of resident rights being violated and care not being delivered adequately in the event of a facility closure. Findings include: The Nursing Home Administrator (NHA) was asked for a copy of the facility policy for the administrators' duties in the event of a facility closure on 2/7/22 at 3:26 PM. The NHA said he did not have one, but he would call his supervisor and get it. The NHA returned saying the facility did not have a policy. Upon exit no policy was provided that indicated what the NHA duties were in the event of a facility closure.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 28101 Based interview and record review, the facility failed to hold quarterly quality assurance meeting with key personnel and develop a system to identify and address facility concerns, resulting in multiple harm level deficiencies and harm level care of residents. Findings include: During the quality assurance review on 2/7/22 at 2:36 PM, the Nursing Home Administrator (NHA) said he has been the administrator since September 2021. The NHA said the former Director of Nursing (DON) ran the Quality Assurance (QA) meetings. The NHA found the QA book but could not locate records that showed all key personnel (NHA, DON and Medical Director) had attended the meetings since he was the administrator. The NHA could not speak to the process or what the facility had put in place after the immediate Jeopardy for hot water temperatures after the last annual survey. The NHA could not speak to a process improvement plan of any of the concerns that had been identified during this survey. See the 2567 dated 2/10/22 for the immediate jeopardy at 689 for water temperature to high and the immediate jeopardy at 880 for infection control related to COVID-19 concerns. The survey team identified 7 regulatory concerns at the harm level and two immediate jeopardy concerns. The team identified multiple concern that were systematic and led to care concerns for multiple residents. See the 2567 dated 2/10/22 for the details of all concern. The NHA did not have any quality assurance program in place to identify or fix or address the facility concerns.

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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. 28101 Based on interview and record review, the facility failed to develop and implement plans of action to correct quality deficiencies, resulting in repeated citations and ongoing care concerns. Findings include: During the quality assurance review on 2/7/22 at 2:36 PM, the Nursing Home Administrator (NHA) said he has been the administrator since September 2021. The NHA said the former Director of Nursing (DON) ran the Quality Assurance (QA) meetings. The NHA found the QA book but could not locate records that showed all key personnel (NHA, DON and Medical Director) had attended the meetings since he was the administrator. The NHA could not speak to the process or what the facility had put in place after the immediate Jeopardy for hot water temperatures after the last annual survey. The NHA could not speak to a process improvement plan of any of the concerns that had been identified during this survey. See the 2567 dated 2/10/22 for the immediate jeopardy at 689 for water temperature to high and the immediate jeopardy at 880 for infection control related to COVID-19 concerns. The survey team identified 7 regulatory concerns at the harm level and two immediate jeopardy concerns. The team identified multiple concern that were systematic and led to care concerns for multiple residents. See the 2567 dated 2/10/22 for the details of all concern. The NHA did not have any quality assurance program in place to identify or fix or address the facility concerns.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 28101 Based on interview and record review, the facility failed to maintain a quality assurance committee with the minimum staff required, resulting in systemic facility concerns. Findings include: During the quality assurance review on 2/7/22 at 2:36 PM, the Nursing Home Administrator (NHA) said he has been the administrator since September 2021. The NHA said the former Director of Nursing (DON) ran the Quality Assurance (QA) meetings. The NHA found the QA book but could not locate records that showed all key personnel (NHA, DON and Medical Director) had attended the meetings since he was the administrator. The NHA could not speak to the process or what the facility had put in place after the immediate Jeopardy for hot water temperatures after the last annual survey. The NHA could not speak to a process improvement plan of any of the concerns that had been identified during this survey. See the 2567 dated 2/10/22 for the immediate jeopardy at 689 for water temperature to high and the immediate jeopardy at 880 for infection control related to COVID-19 concerns. The survey team identified 7 regulatory concerns at the harm level and two immediate jeopardy concerns. The team identified multiple concern that were systematic and led to care concerns for multiple residents. See the 2567 dated 2/10/22 for the details of all concern. The NHA did not have any quality assurance program in place to identify or fix facility concerns.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observation, interview, and record review, the facility failed to follow CDC (Center Disease Control) and CMS (Centers for Medicare and Medicaid Services) guidelines and recommendations to contain and prevent the spread of COVID-19, resulting in an Immediate Jeopardy (IJ) when the facility staff did not appropriately utilize PPE (personal protective equipment) and follow basic infection control practices, resulting in 1 resident (R12) contracting COVID-19 and the continued risk for infectious disease spread in the facility. This deficient practice placed all residents and staff at risk for serious harm, injury, and or death from COVID-19 and other infections. On 1/31/22 at 8:49 AM, the Director of Nursing (DON) was passing medications. The DON reported she was passing medication because the Licensed Practical Nurse (LPN) E that was scheduled tested positive for COVID-19 at the end of her shift on 1/26/22. The DON was asked for the records of all staff that have tested positive for COVID-19 in the last month, family and notification of positive COVID-19 staff and COVID-19 test results for all residents. The DON found an employee binder for COVID-19 testing. LPN E's name was not on the employee's list, and she was not able to find any documentation that she tested positive. The DON said they did not have an infection preventionist on staff at this time but the former infection preventionist had set up the binder and managed all the COVID-19 testing and notification. The DON said she assigned LPN K to test the residents for COVID-19 on 1/26/22. LPN K was also assigned to resident care that night. The DON could not find any records that indicted the residents were tested for COVID-19 and when she checks with LPN K, LPN K did not test the residents for COVID-19. As of 1/31/22 at 9:00 AM, none of the residents were tested for COVID-19 that were exposed to COVID-19 on 1/26/22 when the facility was aware that LPN E tested positive for COVID-19 at the end of her shift. Review of the facility COVID-19 binder revealed it only had 31 of 36 staff currently employed staff listed. The staff person that tested positive for COVID-19 on 1/26/22 was not listed anywhere in the binder. 11 staff were highlighted in yellow, and the DON said they were the staff that had recently tested positive for COVID-19. The DON was not able to locate an accurate record of staff testing. The DON was not able to locate the dates that the 11 staff had tested positive. The DON said the former infection control nurse had managed all of the COVID testing information and she was not aware the process and paperwork. On 1/31/22 at 9:30 AM, the DON and NHA were asked how the residents and families were notified of positive COVID-19 staff and residents in the building. They both indicated that the residents were verbally notified, and families were called. They were asked for the documentation of this notification, and they reported it was not documented anywhere and they did not have anyway of verifying that notification was done on 1/26/22 when a staff member tested positive for COVID-19. Resident medical records were reviewed, and notes were located for other dates of COVID-19 notification, however none of the records documented notification of staff testing positive on 1/26/22. Resident #12 (R12) (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R12's face sheet, no date, revealed he was a [AGE] year old male that was admitted to the facility on [DATE] and had diagnoses that included: weakness, acute respiratory disease, difficulty walking, unsteady on feet and adult failure to thrive. Review of R12's progress noted dated 1/31/22 at 6:09 PM revealed, Resident tested positive of Covid, DON (Director of Nursing) sent resident to ER via Ambulance cart to (name of hospital). On 2/1/22 at 3:35 PM, the State Agency served to the facility NHA a notice of Immediate Jeopardy (IJ) that was identified on 1/31/22 and began on 1/26/22 for failing to develop and utilize and infection control program and practice infection control standards of practice to prevent a COVID-19 outbreak. The facility provided the following IJ Removal Plan: Issue Cited: Riverside Manor Nursing center the facility failed to develop and utilize an infection control program and practice infection control standard of practice to prevent a covid-19 outbreak. 1. Identification of Residents Affected or Likely to be Affected: While all residents have the potential to be affected, the affected area is throughout the facility. Beginning 2/2/22 - Emar will be updated daily for s/s of Covid BID and any COVID-19 test results. The staff member that tested positive was immediately sent home. 2. Actions to Prevent Occurrence/Recurrence: Upon receiving notice of F 880 The facility needs to immediately get assistance from a qualified infection preventionist to institute an infection control program who policies and procedures, education for staff and enough staff to ensure assessing, screening, and testing of all residents and staff for Covid-19, per CDC recommendation and infection control standard of practice. Beginning 2/2/22 - Registered Nurse (RN) G is a certified infection control prevention was hired back at Riverside Healthcare center. Beginning 2/2/22 - All residents and staff were tested for covid on 2/1/22 by the Don and Charge Nurse and none tested positive. Staff with a positive covid-19 will be immediately sent home and instructed not to report to work to avoid additional exposure to others. Staff will be directed on when to return to work based on asymptomatic and symptomatic status per facility policy and CDC Guidelines. Contact tracing will be initiated. Residents that test positive will be immediately place in isolation and transferred out to the hospital and/or a covid hub for medical care and readmitted after clearance with initiation of notification and documentation. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning 2/2/22- All staff, residents and legal guardians were notified of the past positive cases and will be documented in the medical records of each patient chart by the DON. Contact tracing and monitoring with documentation in the medical record of testing notification. Testing of residents and staff will be performed weekly and/or more according to the positivity rate. Covid-19 screening Results will documented in the resident's electronic medical record. Beginning 2/2/22- The Infection Control nurse has made tracking logs to track all residents and staff covid testing with results. Beginning 2/2/22- The Gratiot County health department was notified of the positive covid case and any positive case of covid 19 test and contact tracing, monitoring and documentation. Beginning 2/2/22 - An audit was done by DON to see if any residents/staff were showing s/s of covid, and none noted on 2/2/22. Beginning 2/2/22- All residents who are not fully vaccinated was offered the vaccine by the DON. All staff are fully vaccinated except the ones who have an approved exemption. Beginning 2/2/22- Physicians was notified of the positive covid case on 2/2/22. Beginning 2/2/22- The policy on infection control/covid testing was reviewed and deemed appropriate. The Administrator and DON have been re-educated by the Regional Nurse on Covid 19 prevention, screening/testing, monitoring and education for staff and enough staff to ensure testing for both residents and staff. The policy addresses the implementation of COVID -19 screening, testing and/or PPE use? Beginning 2/2/22- The entire facility will be placed in observation for 5 days per CDC/CMS guidelines. All staff will be required to wear N-95 mask. Beginning 2/2/22- The facility added another screening tool for residents that includes monitoring s/s of covid BID and the facility added another screening tool for staff which will be done for s/s of covid 19 at the start of the shift and the end of the shift. Beginning 2/2/22- All residents covid results will be documented in the Electronic Medical Record (EMR) whenever the test is done immediately. Date the Facility Asserts Likelihood for Serious Harm No Longer Exists: 2/4/2022 On 2/6/22 the State Agency verified the facility had initiated there IJ removal plan. Although the Immediate Jeopardy was removed on 2/2/22, 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. 31771 On 1/31/22 at 8:59 AM, Medical Records (MR) L was observed performing housekeeping duties and wearing a surgical mask rather than the N95 mask. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/31/22 at 9:24 AM, Activity Aide (AA) M was observed wearing a surgical mask as she was pushing a resident in her w/c that did not have foot pedals in place. AA M reported she started working at the facility 1/11/22 and that she had not been tested for COVID 19 since she started at the facility. On 2/7/22 at 8:53 AM, a large sharps container was observed sitting unsupported on the top of the East medication cart. Also noted was the sharps container that was affixed to the side of the cart remained over-filled with needles and syringes extending above the fill line. Review of the Employee and Visitor COVID 19 screening log did not reveal that the Medical Director had been in the building. On 2/9/22 at 11:43 AM, a telephone interview was conducted with Medical Director (MD) I. MD I reported a review of the facility Employee and Visitor COVID 19 screening log would not reveal his name. MD I reported that he screens himself before he enters the building.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 28101 Based on interview and record review, the facility failed to implement a policy and procedure for antibiotic stewardship, resulting in the potential for residents on antibiotics to develop antibiotic resistance infections. Findings include: During the infection control review on 2/8/22 at 1:29 PM, the Director of Nursing (DON) said the former infection control nurse managed the antibiotic stewardship program. The DON was not familiar with the antibiotic stewardship program. The DON provide an infection control binder that the former infection control nurse used but she was not able to locate monthly reviews of residents that had been on antibiotics and could not speak to what the facility protocol was for antibiotic review. Prior to exit the facility did not provide any information on the system they were using for antibiotic stewardship.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 28101 Based on interview and record review, the facility failed to employ an infection preventionist, resulting in the facility not being able to maintain infection control standards related to COVID-19, immunizations and antibiotic stewardship that has the potential to cause serious harm or death to residents. Findings include: Upon entering the facility on 1/23/22 the facility did not have an infection preventionist in current employment. On 2/1/22 at 3:35 PM, the State Agency served an Immediate Jeopardy (IJ) notice to the facility for failing to develop and utilize and infection control program and practice infection control standards of practice to prevent a COVID-19 outbreak. During the infection control review on 2/8/22 at 1:29 PM, the facility could not locate or demonstrate they had been following standard infection control protocols related to antibiotic stewardship or immunizations.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Report COVID19 data to residents and families. 28101 Based on interview and record review, the facility failed to inform residents, their representatives, and families of a confirmed COVID-19 infection of staff on 1/26/22, resulting in residents, representatives, and family members being uniformed of residents potentially being exposed to COVID-19 and unaware of residents needs for monitoring or care. Findings include: During an interview with the Director of Nursing (DON) on 1/31/22 at 8:49 AM, the DON said Licensed Practical Nurse (LPN) E tested positive for COVID-19 on 1/26/22 after her shift was over. The DON was asked for verification of resident, representative and family and notification of positive COVID-19 staff. The DON was not able to locate any information on notification of the COVID-19 positive staff member on 1/26/22. Review of multiple resident records notes were found for notification in the progress notes for previous outbreaks. None of the records reviewed indicated residents, representatives or families were notified of the COVID-19 positive staff member that worked on 1/26/22.

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

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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 0886 Level of Harm - Actual harm Residents Affected - Few	Perform COVID19 testing on residents and staff. 28101 Based on interview and record review, the facility failed to test residents that were exposed to COVID-19 when they became aware an employee tested positive for at the end of there shift on 1/26/22, resulting in delayed testing results for one resident R12 and the potential for other residents to have a delay in identification of the onset of COVID-19 which can lead to serious health problems and/or death. Findings include: During an interview with the Director of Nursing (DON) on 1/31/22 at 8:49 AM the DON said Licensed Practical Nurse (LPN) E tested positive for COVID-19 on 1/26/22 after her shift was over. The DON was asked for verification resident COVID-19 testing. The DON had assigned Licensed Practical Nurse (LPN) K to test residents for COVID-19 when LPN K was working on 1/26/22 along with her normal nursing duties. The morning of 1/31/22 the DON contacted LPN K and discovered resident COVID-19 testing was not done on 1/31/22. The facility began testing residents for COVID-19 on 1/31/22 when it was discovered testing was not done as required on 1/26/22. On 1/31/22 R12 tested positive for COVID-19 (5 days after standard testing was to begin) and was admitted to the hospital. R12 did not return to the facility prior to survey exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 28101 Based on interview and record review the facility did not implement a policy and procedure to ensure all staff were offered a COVID-19 vaccination, resulting in the potential that staff did not get a vaccination and potentially resulting in the residents getting exposed to COVID-19. Findings include: On 2/8/22 at 11:22 AM, the Human Resources Director (HRD) D was asked for verification that all staff were offered the COVID-19 vaccination. HRD D said the former infection control nurse handled that information and she would contact her to get records of when staff were offered the COVID-19 vaccination. HRD D returned saying she could not locate the records, but she only had 5 staff that have not been vaccinated. HRD D said she did not have any record that the 5 staff that were not vaccinated had been offered the COVID-19 vaccination. Upon exit the facility did not provide any verification that all staff were offered a COVID-19 vaccination.