STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235444	A. Building B. Wing	06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Nursing Center	16588 Schaefer Detroit, MI 48235

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 39958 Based on observation, interview and record review the facility failed to maintain the dignity for 2 of 22 residents (Resident #22, #172) reviewed for dignity, resulting in the potential for feelings of decreased self-worth. Findings include: Resident #22 Review of an Admission Record revealed, Resident #22 originally admitted to the facility with pertinent diagnosis which included Dementia. Review of a Minimum Data Set (MDS) assessment, with a reference date of 4/3/21 revealed Resident #22 had cognitive impairment with a Brief interview for Mental Status (BIMS) score of 11, out of a total possible score of 15. In an observation on 6/6/21 at 12:21 p.m., Resident #22 ate from a lunch meal tray that sat on a walker in the dining room. In an interview on 6/6/21 at 12:22 p.m., Certified Nursing Assistant (CNA) T reported Resident #22 is eating on the walker because the tables are full in the dining room. CNA T then reported she should have used the bedside table but did not want to remove the radio off the bedside table. In an observation on 6/7/21 at 11:56 a.m., Resident #22 laid in bed with no sheets on the bed. In an interview on 6/7/21 at 11:58 a.m., CNA KK stated I haven't had time to make them yet (in regard to Resident #22's bed with no sheets). In an observation on 6/8/21 at 8:15 a.m., Resident #22 laid in bed with no sheets on the bed. 34901 Resident #172 Review of the Admission Record revealed Resident #172 (R172) was admitted on [DATE] with diagnoses that included osteomyelitis, diabetes mellitus, and epileptic seizures. (continued on next page)

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	On 6/6/2021 at 10:55 AM during the initial tour of the facility, Resident #172 (R172) was observed awake and sitting on the side of his bed. R172 appeared oriented and able to effectively express himself without difficulty. R172 stated he arrived at the facility on Friday (6/4/2021) and had asked for a urinal because he was unable to get to the bathroom. The facility never provided him a urinal so he was urinating in a wash basin. A wash basin half full of a liquid was observed on the floor next to R172's bed. On 6/6/2021 at 12:19 PM, Registered Nurse (RN) C was requested to observe the wash basin containing yellow liquid in R172's room. RN C said, I have to get a urinal for him. He is supposed to have a urinal. On 6/8/2021 at 8:46 AM, R172 was observed in his room, awake, and sitting on the side of his bed. R172 said, I still don't have a urinal. I'm using a trash can now. A trash can, containing a yellow liquid, was observed on the floor next to R172's bed. R172 said, Having to use a trash can makes me feel humiliated, less than a human, like an animal. I know for a fact that it's not sanitary. They haven't even given me a toothbrush or toothpaste. On 6/8/2021 at 8:56 AM, Director of Nursing (DON) BB was requested to observe the trash can containing a yellow liquid. DON BB said, I feel horrible. I expect my directives to be followed. We don't have urinals. I told them to go and get some. The CNA (Certified Nurse Assistant) assigned to a new admission should give the resident personal hygiene supplies. A review of the facility's policy titled, Promoting/Maintaining Resident Dignity, dated May 2021, revealed the following: -It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. -Compliance guidelines included: Respond to requests for assistance in a timely manner.

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F 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. 38208 Based on observation, interview, and record review the facility failed to post a list of names, mailing and email addresses, and telephone numbers of all pertinent State regulatory and informational agencies and advocacy groups in a highly visible area to residents, effecting all residents in facility, resulting in the potential for missed opportunities to make informed decisions. Findings include: On 6/14/21 at 1:00 PM, an observation was made on the first floor of facility that no posting of all pertinent State regulatory and information agency and advocacy groups were posted in a highly visible area for residents to see. Postings were found in the stairwell on the first floor. Observations on the second floor found only partial information postings available in hallway. During interview on 6/14/21 at 1:30 PM with Social Worker B it was confirmed that postings should be visible for all residents to see in a common area. Record review on 6/17/21 revealed the facility's admission packet did not provide this information. Further review of the policy Facility Required Postings (no implementation date) revealed: 1. Facility postings include the following: A. A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups to include but not limited to: i. State Survey Agency ii. State Licensure Office iii. Adult Protective Services (where state law provides jurisdiction) iv. Office of the State of Long-Term Care Ombudsman v. Protection and Advocacy Network vi. Home and Community Based Service Programs vii. Family and Medical Leave Act viii. Medicaid Fraud Control Unit ix. Applying for Medicare and Medicaid.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 34901 Based on observation, interview, and record review, the facility failed to ensure residents had access to previous survey results without having to ask the facility, resulting in residents being uninformed of deficiencies identified in the facility. This had the potential to affect all 67 residents who resided in the facility. Findings include: On 6/7/2021 at 10:30 AM, a confidential resident council meeting was held with four facility residents in attendance all of whom were alert, oriented, and able to express themselves without difficulty. Three residents remained in the meeting when the availability of State inspections was discussed. The residents in attendance stated they were interested in reviewing State inspection reports and that the reports were posted on the bulletin boards outside of the first-floor dining room. At the conclusion of the meeting, the two bulletin boards were observed in the presence of the three residents. State inspection reports were not there. On 6/9/2021 at 8:35 AM, the facility concierge (Staff Z) stated she was responsible for the location of the State inspection reports. Staff Z reported the survey book (the binder containing the State's inspection reports) was in her office. On 6/9/2021 at 9:00 AM, a sign in the first-floor stairwell was observed and indicated, Survey Results are located next to the 1st floor South Nursing Station. Please see any member of Management if you should have any questions. On 6/17/2021 at 10:03 AM, Nursing Home Administrator AA indicated that residents do not have access to the stairwell area and said, We need to move that (sign regarding availability of past survey results). The facility policy titled, Facility Required Postings, dated November 2017, was reviewed and revealed the following: -The facility will post required posting in an area that is accessible to all staff and residents. -The facility must also post the following: Most recent survey results of the facility.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on interview and record review the facility failed to inform a physician and family or resident representative of a change in condition in a timely manner, effecting 2 of 22 residents (Resident #61 and #27) reviewed for change in condition, resulting in the potential for missed opportunities to make decisions regarding a resident's health. Findings include: R#61 Record review of R#61's face sheet revealed the resident was admitted into the facility on [DATE] with diagnoses that included essential hypertension (high blood pressure) and Type 2 diabetes. According to the Minimum Data Set (MDS) dated [DATE], R#61 had impaired cognition and was extensive to total assist with Activities of Daily Living (ADLS). Record review of Dietary Progress Note dated 5/25/21 at 20:15 (8:15 PM) documented the following: Note Text: R#61 have experienced a unplanned weight loss, 15.6# (pounds), 10.1% x 6 months, resident weight is 138, remains within IBWR (Ideal Body Weight Range)124-150, resident is reported to be consuming meals without difficulty, add to weekly weight x 4 weeks, F.A.R (Food Acceptance Record) x 14 days, will request CBC w Diff (complete blood count) CMP (completed metabolic panel) Lipid Panel, TSH (thyroid stimulating hormone), UA (urinary analysis), Recommend Med Pass NSA (supplemental)1.7 BID (twice a day), speech evaluation to assure there is no difficulty with meal texture. F/U (Follow-Up). Record review of physician orders for the month of May 2021 revealed no recommendations had been implemented and no orders had been documented. During phone interview on 6/9/21 at 12:46 PM with Registered Dietician (RD) OO it was confirmed the physician was not informed of R#61's change in weight. RD OO confirmed that a note was put on a bulletin board in the electronic record. RD OO confirmed that there was no evidence that the physician received the note on bulletin board. RD OO confirmed that none of the recommendations were ordered or denied by physician. RD OO confirmed that recommendations were verbally given to nurses on the floor. During interview on 6/9/21 at 1:34 PM with Director of Nursing (DON) BB it was confirmed that there was no procedure or form to document recommendations. DON BB confirmed that after so many days the bulletin board will clear unless a specific date is entered. 34901 Resident #27 Review of the Admission Record revealed Resident #26 (R27) was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (stroke), end stage renal disease, hypertension, unspecified convulsions, and diabetes mellitus. A Minimum Data Set, dated dated dated [DATE] documented R27 had intact cognition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/2021 at 10:12 AM, during the initial tour of the facility, R27 was observed awake and sitting in his bed. R27 stated he just got back from the hospital on Friday (6/4/2021). R27 said he was in the hospital for several days because he had an infection in both feet. A review of the electronic health record for R27 was conducted with DON BB on 6/8/2021 at 11:10 AM and documented the following: -Nurse note on 5/21/2021 at 1:26 PM: Resident sent to hospital from dialysis. Doctor & responsible party notified. Further review of this note revealed that it was a late entry written on 5/22/2021 at 1:27 PM. On 6/08/2021 at 12:53 PM, DON BB, in the presence of the State Surveyor, called the medical transportation company responsible for taking R27 to and from the hemodialysis center and spoke with Dispatcher UU. Dispatcher UU reported R27 never made it to the hemodialysis center on 5/20/2021. Dispatcher UU said, (R27) was taken from (the nursing home) to (local hospital) on 5/20/2021 by us because he was in a lot of pain. On 6/17/2021 at 10:33 AM, DON BB stated there was an agency nurse on duty 5/20/2021 and he did not indicate that R27's concerned family member was notified. The DON acknowledged that the family was notified two days later on 5/22/2021. Record review of policy Notification of Changes revised 3/2/21 documented the following: The purpose of this policy is to ensure the facility promptly informs the resident, consults the residents' physician; and notifies, consistent with his or her authority, residents' representative when there is a change requiring notification.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 39958 Based on observation, interview and record review, the facility failed to accurately code the Minimum Data Set (MDS) Assessment for 1 of 22 residents (Resident #56) reviewed for MDS accuracy, resulting in inaccurate care planning for nutrition. Findings include: Review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.17.1, dated October 2019, revealed .The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being . an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT (Interdisciplinary Team) completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment . Resident #56 Review of an Admission Record revealed, Resident #56 admitted to the facility with pertinent diagnosis which included dysphagia (difficulty swallowing), aphasia (difficulty speaking), and adult failure to thrive. Review of a Minimum Data Set (MDS) assessment, with a reference date of 5/21/21, revealed Resident #56 had severe cognitive impairment and required a feeding tube. In an interview on 6/8/21 at 8:09 a.m., Unit Manager (UM) HH reported Resident #56 does not have a PEG tube (feeding tube inserted in stomach). In an observation on 6/8/21 at 8:10 a.m., Resident #56 laid in bed in their room. No feeding tube was noted in the abdomen (stomach). Review of a Physician Progress Note with a date of 5/4/21 revealed .ASSESSMENT/PLAN: Adult failure to thrive with dysphagia requiring peg tube- Nutrition consulted; Started on tube feeding . written by Physician Assistant (PA) NN. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/14/21 at 10:49 a.m., UM HH reported on 2/13/21 Resident #56's PEG tube came out and they could not get in back in. UM HH reported the physician was notified and decided to remove the feeding tube and give Resident #56 a pureed diet. In an interview on 6/14/21 at 10:53 a.m., MDS Coordinator LL reported she reviews the physician notes to identify what treatments and devices residents have, such as PEG tubes, to accurately code the MDS assessments. In an interview on 6/14/21 at 10:54 a.m., Director of Nursing (DON) BB reported Resident #56 did not have a PEG tube. DON BB then reported Resident #56 used to have a feeding tube, but it was removed. Review of an Incident Report, with a date of 2/13/21, revealed Resident #56 pulled out the feeding tube. Per the report .Nurse tried to put the tube back, but unsuccessful, DON and doctor were notified. In an interview on 6/14/21 at 12:36 p.m., Physician MM reported Resident #56's PEG tube was discontinued. Physician MM stated, I did D/C (discontinue) that PEG tube myself. Physician MM reported they decided not to put the PEG tube back in because Resident #56 was eating. Review of a Dietary Profile Assessment for Resident #56 with a date of 3/3/21 revealed .Res (resident) pulled out his PEG tube on 2/13/21 . In an interview on 6/14/21 at 4:26 p.m., PA NN reported he did not write Resident #56 had a PEG tube. PA NN then reported the progress note should say, Resident #56 had adult failure to thrive and should have been started on PEG tube. In an interview on 6/14/21 at 4:26 p.m., PA NN reported the Physician Progress Note for Resident #56, dated 5/4/21, was inaccurate. In an interview on 6/15/21 at 11:01 a.m., Registered Dietitian OO reported Resident #56 had a feeding tube in the past, but no longer had one in place.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on interview and record review the facility failed to develop and implement a care plan for antibiotic use, effecting 1 of 22 residents (Resident #32) reviewed for antibiotic stewardship, resulting in the potential for missed opportunities to monitor and assess a resident while receiving antibiotics. Findings include: R#32 Record review of Resident #32's (R#32) face sheet on 6/7/21 revealed original admission into facility on 4/6/20 with diagnoses that included peripheral vascular disease (poor circulation), hypertension (high blood pressure) and Type 2 diabetes. According to the Minimum Data Set (MDS) dated [DATE], R#32 had intact cognition and needed supervision with most Activities of Daily Living (ADLS). Record review on 6/7/21 of all R#32's care plans revealed no care plan implemented for antibiotic use related to a possible urinary tract infection (UTI). Review of physicians orders dated 6/5/21 at 13:40 (1:40 PM) revealed Ciprofloxacin HCL (antibiotic) 250 milligrams. Take 1 tablet by mouth two times a day for infection/uti? For 7 days. During interview on 6/9/21 at 12:26 PM with Director of Nursing (DONBB) it was confirmed that a care plan for antibiotic use should have been put in place when antibiotic was started.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 Based on observation, interview and record review the facility failed to update and implement interventions to care plans for 3 of 22 residents (Resident #44, #56, & #39) reviewed for nutritional and communication care plans, resulting in the potential for inadequate/inappropriate care and these residents not maintaining or achieving their highest practical physical well-being. Findings include: Review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.17.1, dated October 2019, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care . Review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.17.1, dated October 2019, revealed .the resident's care plan must be reviewed after each assessment, as required by S483.20 .and revised based on changing goals, preferences and needs of the resident and in response to current interventions . Review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.17.1, dated October 2019, revealed .Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care . Resident #44 Review of an Admission Record revealed Resident #44 originally admitted to the facility with pertinent diagnosis which included Vascular Dementia, Schizoaffective disorder, and Type 2 Diabetes. Review of a Minimum Data Set (MDS) assessment, with a reference date of 4/29/21 revealed Resident #44 had severe cognitive impairment with a Brief interview for Mental Status (BIMS) score of 3, out of a total possible score of 15. Further review of this MDS assessment, with a reference date of 4/29/21, revealed Resident #44 required setup help with eating. Review of a Progress Note for Resident #44, with a date of 5/16/21, revealed Significant wt (weight) loss 15. 4% (20#) in 180 days unplanned .Receives Mechanical soft diet texture, and set for weekly wts to start .No 30 or 90 wt available .Will monitor intake, weekly wts, and results from referrals prn (as needed). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note for Resident #44, with a date of 5/25/21, revealed Resident has a (sic) unplanned weight loss, weight 110 .will recommend MED Pass NSA (supplemental drink) 1.7 TID (three times a day), Weekly weights x 4 weeks , CBC w Diff, CMP Lipid Panel. Review of the weight documentation for Resident #44 revealed there were no weights obtained in February, March, April, or June. Available weights included: 1/26/21 - 122.2 lbs (pounds) 5/10/21 - 110 lbs 5/14/21 - 110 lbs 5/27/21 - 112.2 lbs Review of the current Physician Orders for Resident #44 revealed no order for MED Pass NSA 1.7 TID, CBC w Diff or CMP Lipid Panel. Review of a Care Plan with an initiated date of 5/16/21 revealed the focus (Resident #44) is at nutritional risk AEB (as evidence by) and R/T (related to): significant wt loss 15.4%(20#) unplanned in 180 days . Interventions included Med Pass 1.7 TID 4oz, Weekly weights CBC w Diff CMP Lipid Panel .Meds/labs as ordered. Weigh weekly x 4 then monthly . In an interview on 6/9/21 at 9:10 a.m., Unit Manager HH reported Resident #44 did not have an order for Med Pass supplement. In an interview on 6/9/21 at 10:00 a.m., Dietary Supervisor Assistant H reported nutrition recommendations for residents are communicated verbally during the At-Risk meeting, and the nurse is responsible to follow through on the recommendations and obtain the physician orders. Resident #56 Review of an Admission Record revealed, Resident #56 admitted to the facility with pertinent diagnosis which included dysphagia (difficulty swallowing), aphasia (difficulty speaking), and adult failure to thrive. Review of a Minimum Data Set (MDS) assessment, with a reference date of 5/21/21, revealed Resident #56 had severe cognitive impairment and required a feeding tube. In an interview on 6/8/21 at 8:09 a.m., Unit Manager (UM) HH reported Resident #56 did not have a PEG tube (feeding tube inserted in stomach). In an observation on 6/8/21 at 8:10 a.m., Resident #56 laid in bed in their room. No feeding tube was noted in the abdomen (stomach). Review of a Care Plan with a revised date of 6/6/21 revealed the focus Alteration in nutrition AEB (as evidence by) tube feeding . Interventions included .Recommend Jevity (feeding tube formula) . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/14/21 at 10:49 a.m., UM HH reported on 2/13/21 Resident #56's PEG tube came out and they could not get in back in. UM HH reported the physician was notified and decided to remove the feeding tube and give Resident #56 a pureed diet. In an interview on 6/14/21 at 10:54 a.m., Director of Nursing (DON) BB reported Resident #56 did not have a PEG tube. DON BB then reported Resident #56 used to have a feeding tube, but it was removed. Review of an Incident Report, with a date of 2/13/21, revealed Resident #56 pulled out the feeding tube. Per the report .Nurse tried to put the tube back, but unsuccessful, DON and doctor were notified. Review of a Dietary Profile Assessment for Resident #56 with a date of 3/3/21 revealed .Res (resident) pulled out his PEG tube on 2/13/21 . In an interview on 6/15/21 at 11:01 a.m., Registered Dietitian OO reported Resident #56 did have a PEG tube and no longer had one. RD OO reported Resident #56's nutrition care plan should be updated when there is a change. RD OO reported herself and Certified Dietary Supervisor G are responsible for implementing and revising the dietary care plans. 15194 Resident 39 On 6/7/21 at 1:30 P.M., a record review of Resident #39 (R39) Minimum Data Set (MDS) dated [DATE] revealed that R39 had severely impaired cognitive (thought process) skills for decision making. Functional Status section G of the MDS noted the resident required extensive to total assist with all activities of daily living. Review of R39 Care Plan initiated on 8/7/2020, revealed, I am non verbal I will be offered social visits and a communication board an music during visits. I have little outer room activity. Interventions that were identified included: I currently am not interested in voting, offer me reading during visits, please offer me room visits and play music . On 6/8/21 at 11:30 A.M. during an observation of the R39, Certified Nurse Assistant (CNA) D was observed feeding the resident and attempting to communicate with the resident. There was no communication board present or at the resident's bedside. The CNA D continued to attempt to engage the resident in conversation. Nurse A entered the room an informed CNA D the resident was nonverbal and there was no communication board. On 6/8/21 at 11:35 A.M., Nurse A stated there had not been a revision or update in R39's care plan since 8/7/20. Nurse A verified that the care plan indicated the resident would utilize a communication board. Nurse A reported that R39 could not communicate and had not utilized a communication board since she worked on the unit. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Care Plans Comprehensive Guidelines policy (undated), revealed it is the facility's policy to have completed individualized comprehensive care plans that includes measurable objectives and timetables to meet the resident's medical, nursing, mental psychological needs .Each residents comprehensive care plan has been designed to: incorporate in the resident's condition dictates., identified problem areas, incorporate risk factors associated with identified problems .Care plans are revised as changes.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 This citation pertains to intake MI00119550 Based on interview and record review the facility failed to consistently document administration of medication and reorder medications that were not available, effecting 5 of 22 residents (R#16, R#32, R#42, R#51 and R#38) reviewed for medication administration, resulting in residents not receiving medications as ordered by the physician and the potential for medications not being therapeutic. Findings include: During interview 6/9/21 at 10:23 AM with Director of Nursing (DON BB) confirmed if not documented on Medication Administration Record (MAR) it was not given. DON BB confirmed that it was protocol to always sign for medication after administration. R#16 During interview on 6/6/21 at 9:30 AM, R#16 stated, There is never enough staff here and we don't get medications on time and sometimes not at all. Record review of R#16's face sheet on 6/7/21 revealed resident was admitted into the facility on [DATE] with diagnoses that included morbid obesity, mild persistent asthma (respiratory disease) and pain in right knee. According to the Minimum Data Set (MDS) dated [DATE], R#16 had intact cognition and was extensive to total dependence with Activities of Daily Living (ADLS). Record review of the Medication Administration Record (MAR) for May 2021 and June 2021 revealed the following medications were not signed out as administered for R#16: Melatonin (Sleep Aid)- 5/7, 5/8,5/12, 5/15,6/5 Protonix (Acid Reducer)- 5/9 Aripiprazole (Antipsychotic)-5/9 Dexifol (Supplement)-5/9 Docusate Sodium (Stool Softener)-5/9 Klor- con (Potassium supplement)-5/9 Lasix (diuretic)-5/9 Prozac (Antipsychotic)-5/9 Advair (Inhaler)- 5/9 Buspirone (Antianxiety)- 5/7, 5/8, 5/9, 5/15, 5/21, 6/4, 6/5. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Albuterol Sulfate (inhaler)- 5/9,6/4. Seroquel (Antipsychotic)- 5/9, 6/4. R#32 Record review of R#32's face sheet on 6/7/21 revealed original admission into facility on 4/6/20 with diagnoses that included peripheral vascular disease (poor circulation), hypertension (high blood pressure) and Type 2 diabetes. According to the Minimum Data Set (MDS) dated [DATE], R#32 had intact cognition and needed supervision with most Activities of Daily Living (ADLS). During an interview with R#32 on 6/6/21 at 8:42 AM, R#32 stated, They (facility) needs more help. Record review of Medication Administration Record (MAR) for May 2021 and June 2021 revealed the following medications were not signed out as administered for R#32: Aspirin (Antiplatelet)- 5/9 Atorvastatin (Cholesterol) -5/7, 5/8, 6/5. Ferrous Sulfate (Iron supplement)- 5/1 and 5/9. Lantus (long-acting insulin)- 5/7.5/8, 5/12 and 6/5. Plavix (Antiplatelet)- 5/9 Humalog (short acting insulin)- 5/7, 5/9, 5/12, and 5/21. Hydralazine (anti-hypertensive)- 5/7, 5/8, 5/9, 5/12, 5/21 and 6/5. R#42 Record review of R#42's face sheet revealed admission into the facility on [DATE] with diagnoses of Type 2 diabetes, congestive heart failure, hemiplegia (paralysis). According to the Minimum Data Set (MDS) dated [DATE], R#42 had intact cognition and was extensive assist with personal hygiene. During an interview on 6/6/21 at 8:50 AM, R#42 stated, Sometimes we don't get medications like we are supposed to, and they sure don't have enough staff. Record review of Medication Administration Record (MAR) for May 2021 and June 2021 revealed the following medications were not signed out as administered for R#42: Norvasc (antihypertensive)05/9 and 6/4. Atorvastatin (antiplatelet)- 5/7, 5/8, 5/9 and 5/12. Lasix (diuretic) - 5/1, 5/9, 5/23, 5/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Glipizide (anti hyperglycemic) -5/1, 5/9, 5/23 and 5/24 Juvia- (anti hyperglycemic)- 5/1, 5/9, 5/23, 5/24, 6/10 and 6/11 Keppra (anticonvulsant)- 5/7, 5/8, 5/12, 5/15,6/5, 6/9 and 6/10. Plavix (antiplatelet)- 5/9, 5/23, 5/24, 6/10 and 6/11. Sertraline (Antipsychotic) - 5/9 and 6/4. Metformin (antihyperglycemic) 5/9, 5/23 and 5/24. R#51 Record review of R#51's face sheet revealed admission into the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, malignant neoplasm (cancer) of tongue, major depression. According to the Minimum Data Set (MDS) dated [DATE], R#51 had intact cognition and was independent with most Activities of Daily Living (ADLS) During interview on 6/6/21 at 8:50 AM, R#51stated, I have to ask for medications they(facility) take forever to get them delivered. Record review of Medication Administration Record (MAR) for May 2021 and June 2021 revealed the following medications were not signed out as administered for R#51: Norvasc (anti-hypertensive)-5/9 Pepcid (antacid) 5/9 Symbicort- (inhaler) 5/9 During interview on 6/17/21 at 1:47PM, LPN A confirmed that all medications and treatments should be signed out to prove that they were given. LPN A confirmed the reason for signing out medications was to triple check that nurses have the right resident, right time, right dose, right route and right drug. Record review of the facility policy Medication Administration (no implementation date) revealed the following: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 15194 Resident 38 (R38) Review of the Admission Record for R38 stated the resident was admitted to the facility on [DATE] with diagnoses that included: Covid 19, rheumatoid arthritis, chronic obstructive pulmonary disease, severe protein calorie malnutrition and alcoholic hepatitis with ascites. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/7/21 at 10:30 A.M., during an interview R38 reported that his medications (Methadone and Percocet) were frequently not given to him in a timely manner and his Hepatitis C medication (Mavyret) was being discontinued. The resident explained that frequently this medication was not available because the nursing staff stored the medication in the Director of Nursing office and sometimes staff ignored his request or inquiries concerning his medications. On 6/8/2021 at 10:10 A.M. review of the Medication Administration Record (MAR) for Mavyret 100 milligrams revealed: missed/not documented as given on these dates: 4/4, 4/7, 4/13, 4/22, 5/9. The medication was not available and coded with the #10 for 5/6, 5/7, 5/8, 5/14 and 5/24. Mavyret was discontinued on 6/14/21, when the Director of Nursing (DON) informed physician H of a shortage of 4 tablets. On 6/15/21 at 9:00 A.M. Nurse A was asked where the facility stored R38's medication (Mavyret. Nurse A explained it was her understanding the medication was very expensive and to prevent loss of the medication it had been stored in the Director of Nursing office. Initially, staff including herself, were not aware where the drug was stored which contributed to confusion about the availability of the drug. Review of the Manufacturers Safety Information Sheet for Mavyret revealed, Frequent monitoring of relevant laboratory parameters. Before starting treatment with Mavyret Your doctor will do blood tests to check for hepatitis B infection. Your doctor will monitor you if you are at risk for Hepatitis B reaction during treatment and after you stop taking Mavyret. Review of the facility's lab book revealed that from January 2020 through November 2020 one entry was written which indicated labs had been refused in January. There were no other orders for labs for R38. On 6/15/21 at 3:10 P.M. Physician Assistant (P.A.) S stated: we probably should have ordered labs (for R38), but that medication was started by the GI (Gastrointestinal) staff, and we thought their service would follow R38. On 6/16 at 9:00 A.M. Physician N was contacted via the telephone and indicated labs for R38 would be ordered and P.A. S would follow up with the facility staff and Gastroenterology staff. Other medications reviewed but not documented as given included: Methadone HCL 10 milligram 2 Tablets 4/3, 4/9, 4/10, 4/11, 4/12, 4/13, 4/16, 4/17, 4/22, 4/23, 5/9, 5/21, 5/22, 5/23, 5/24. Percocet tablet 1 T. Q (every) 8 hour -4/3, 4/4 4/5, 4/7, 4/12, 4/13, 4/16, 4/17, 4/22, 4/25, 4/26, 4/28 On 6/17/21at 9:50 A.M. the Director of Nursing (DON) BB stated, Staff probably forgot to document the medications as given. DON BB was unable to provide evidence that the medication was administered.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview and record review the facility failed to provide Activities of Daily Living (ADL's) for 8 of 22 residents (R38, R16, R32, R42, R61, R19, R44, and R56) reviewed for personal hygiene, resulting in poor grooming and complaints of embarrassment and shame. Findings include: Resident 38 (R38) Review of the Admission Record for R38 stated: the resident was admitted to the facility on [DATE], with diagnoses that included: Covid 19, rheumatoid arthritis, chronic obstructive pulmonary disease, severe protein calorie malnutrition and alcoholic hepatitis with ascites. On 6/7/21 at 10:30 A.M. the Minimum Data Set, dated dated dated [DATE] documented R38 had a BIMS of 15/15 (intact thought process) and required one person physical assistance to perform activities of daily living. During an observation in R38's room on 6/6/21 at 8:24 A.M, 11:00 AM, and at 2:50 P.M. R38's hair was tangled. R38's hair had food crumbs and flakes of dandruff visible throughout the hair. The front of R38's shirt and pants were sained and soiled with a reddish substance and the resident's nails were long and dirty. During the interview at 2:50 P.M. R38 stated: I have been trying to get a shower, I need someone to braid my hair because I want to go on a leave, and I do not want to look like this. Staff came in my room a few days ago and took my clothes. I do not have anything to change into. Review of the Resident's Care Plan initiated 4/18/2020, entitled: Resident has impaired ability to complete ADL care and needs assistance related to impaired mobility, debility, and deconditioning. Interventions included (in part) .assist resident with bathing, dressing, assist with choosing appropriate clothes, provide nail care with showers . On 6/7/2021 at 10:30 A.M. Nurse A was queried concerning the R38's shower days. Nurse A reported that there was no shower book. Nurse A reported that facility had a Shower Team that provided showers to the residents. The nurse stated, Every resident is scheduled for a shower or bed bath and during the shower a skin assessment is performed including nail care. On 6/8/2021 at 10:05 a.m., Director of Nursing (DON) BB presented one form that documented R38 was offered a shower with hair care on 5/11, 5/13 and on 5/14 (offered) but the nurse had to confirm due to his leg wound. No evidence was provided that a shower was given on this date. DON BB reported additional documentation could be found in the clinical record if residents refused. No clinical notes were found in the resident's clinical records indicating R38 had refused showers. 38208 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R#16 Record review of R#16's face sheet on 6/7/21 revealed resident was admitted into facility on 2/9/21 with diagnoses that included morbid obesity, mild persistent asthma (respiratory disease) and pain in right knee. According to the Minimum Data Set (MDS) dated [DATE], R#16 had intact cognition and was extensive to total dependence with Activities of Daily Living (ADLS). During an observation of R#16 on 6/6/21 at 9:30 AM, R#16 was in their room and was observed to have body odor. During an interview on 6/6/21 at 9:30 AM, R#16 stated, I haven't had a shower since I got here. They (facility staff) do not have a Hoyer (lift) to get me up. On 6/7/21 R#16's shower sheets and skin assessments for the last 2 months were requested. The facility was unable to provide the documents prior to survey exit. On 6/7/21 at 1:23 PM an observation in the second floor dining room revealed an operational Hoyer lift that would have accommodated R#16's needs. R#32 Record review of R#32's face sheet on 6/7/21 revealed original admission into facility on 4/6/20 with diagnoses that included peripheral vascular disease (poor circulation), hypertension (high blood pressure) and Type 2 diabetes. According to the Minimum Data Set (MDS) dated [DATE], R#32 had intact cognition and needed supervision with most Activities of Daily Living (ADLS). During interview with R#32 on 6/6/21 at 8:42 AM, R#32 stated, No we don't get showers all the time. On 6/7/21 facility was asked to provide evidence of showers and skin assessments provided for the last two months. The facility staff were unable to provide consistent documentation of showers and skin assessments. R#32 received showers on 5/12/21,5/19/21, 5/28/21 and 5/31/21. R#42 Record review of R#42's face sheet revealed he was admitted into the facility on [DATE] with diagnoses of Type 2 diabetes, congestive heart failure, hemiplegia (paralysis). According to the Minimum Data Set (MDS) dated [DATE], R#42 had intact cognition and was extensive assist with personal hygiene. During an observation on 6/6/21 at 8:50 AM, R#42 was lying in bed with a scruffy beard and long nails with debris. During interview on 6/6/21 at 8:50 AM, R#42 stated, I like to be clean shaven except for my goatee. R#42 stated, I don't get showers like I am suppose too, it's been a long while. On 6/7/21 R#42's shower sheets and skin assessments for the last 2 months were requested. The facility was unable to provide the documents prior to survey exit. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R#61 Record review on 6/6/21 of R#61's of face sheet revealed resident was admitted into the facility on [DATE] with diagnoses that included essential hypertension (high blood pressure) and Type 2 diabetes. According to the Minimum Data Set (MDS) dated [DATE], R#61 had impaired cognition and was extensive to total assist with Activities of Daily Living (ADLS). On 6/6/21 at 9:15 AM, R#61 was observed in bed not dressed or groomed for the day. On 6/7/21 R#61's shower sheets and skin assessments for the last 2 months were requested. The facility was unable to provide the documents prior to survey exit. 39958 Resident #19 Review of an Admission Record revealed, Resident #19 originally admitted to the facility with pertinent diagnosis which included Frontotemporal Dementia (affects behavior and language). Review of a Minimum Data Set (MDS) assessment, with a reference date of 2/13/21 revealed Resident #19 had severe cognitive impairment. Resident #19 required extensive assistance of one staff with dressing, hygiene, and bathing. Review of a Nurse/CNA Skin Assessment (shower sheets) revealed, Resident #19 had a shower on 5/17/21, 5/20/21, and 5/27/21. Resident #19 did not have documented showers for April. Review of the Bathing task revealed Resident #19 scheduled shower days were Tuesday and Friday. Review of a Care Plan for Resident #19 revealed, focus Alteration in Activities of Daily Living . Interventions included .Provide total assistance with shower 2x weekly and prn. Encourage to participate as tolerated. Resident #44 Review of an Admission Record revealed, Resident #44 originally admitted to the facility with pertinent diagnosis which included Vascular Dementia, Schizoaffective disorder, and Type 2 Diabetes. Review of a Minimum Data Set (MDS) assessment, with a reference date of 4/29/21 revealed Resident #44 had severe cognitive impairment with a Brief interview for Mental Status (BIMS) score of 3, out of a total possible score of 15. Resident #44 required total dependence of one staff with dressing, personal hygiene, and extensive assistance of one staff with bathing. In an observation on 6/6/21 at 10:37 a.m., Resident #44 sat on the bed in the room. Resident #44 had on a stained shirt and hair was not combed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/7/21 at 1:45 p.m., Director of Nursing (DON) BB reported the shower team documents showers, not bed baths on the shower sheet. DON BB reported the shower team was created last month. DON BB then reported because there are no shower sheets, she cannot prove the showers or bed baths were completed. Resident #19 Review of an Admission Record revealed, Resident #19 originally admitted to the facility with pertinent diagnosis which included Frontotemporal Dementia (affects behavior and language). Review of a Minimum Data Set (MDS) assessment, with a reference date of 2/13/21 revealed Resident #19 had severe cognitive impairment. Resident #19 required extensive assistance of one staff with dressing, hygiene, and bathing. Review of a Nurse/CNA Skin Assessment (shower sheets) revealed, Resident #19 had a shower on 5/17/21, 5/20/21, and 5/27/21. Resident #19 did not have documented showers for April. Review of the Bathing task revealed Resident #19 scheduled shower days were Tuesday and Friday. Review of a Care Plan for Resident #19 revealed, focus Alteration in Activities of Daily Living . Interventions included .Provide total assistance with shower 2x weekly and prn. Encourage to participate as tolerated. Resident #44 Review of an Admission Record revealed, Resident #44 originally admitted to the facility with pertinent diagnosis which included Vascular Dementia, Schizoaffective disorder, and Type 2 Diabetes. Review of a Minimum Data Set (MDS) assessment, with a reference date of 4/29/21 revealed Resident #44 had severe cognitive impairment with a Brief interview for Mental Status (BIMS) score of 3, out of a total possible score of 15. Resident #44 required total dependence of one staff with dressing, personal hygiene, and extensive assistance of one staff with bathing. In an observation on 6/6/21 at 10:37 a.m., Resident #44 sat on the bed in the room. Resident #44 had on a stained shirt and hair was not combed. In an interview on 6/7/21 at 1:45 p.m., Director of Nursing (DON) BB reported the shower team documents showers, not bed baths on the shower sheet. DON BB reported the shower team was created last month. DON BB then reported because there are no shower sheets, she cannot prove the showers or bed baths were completed. Review of a Nurse/CNA Skin Assessment (shower sheets) revealed, Resident #44 had a shower on 5/11/21, 5/19/21, and 5/27/21. Resident #44 did not have documented showers for April. In an interview on 6/8/21 at 9:51 a.m., DON BB reported they just implemented the shower sheets because they recognized they were not doing them. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 6/8/21 at 10:18 a.m., Certified Nursing Assistant (CNA) KK prepared to give Resident #44 a shower. Resident # 44's nails were long with brown matter under them. Resident #44 did not receive nail care during the shower. In an interview on 6/8/21 at 10:23 a.m., CNA KK reported resident showers are given twice a week by the shower team. In an interview on 6/8/21 at 10:30 a.m., CNA KK reported the shower teams does nail care. CNA KK asked Resident #44 to cut and clean the nails, Resident #44 stated, Yeah I want my nails. CNA KK then stated, They are pretty clean, just need to be cut. In an observation on 6/8/21 at 10:31 a.m., Resident #44 had long nails with brown matter under them. In an interview on 6/8/21 at 2:39 p.m., CNA DD reported nail care is done with showers. They make sure they are clean and cute. They do not cut diabetic nails. In an observation on 6/8/21 at 2:42 p.m., Resident # 44's nails were long with brown matter under them. Review of Two South Shower Schedule revealed, Resident # 44 had showers on Tuesday and Friday Days. The schedule revealed ALL SHOWERS ARE TO BE COMPLETED AS SCHEDULED. ALL REFUSALS MUST BE REPORTED TO NURSE TIMELY. ALL SHOWER SHEETS MUST BE COMPLETED. In an interview on 6/9/21 at 1:20 p.m., Unit Manager HH reported nail care is done with showers. In an interview on 6/14/21 at 12:20 p.m., DON BB reported nail care ad shaving should be done with showers. Resident #56 Review of an Admission Record revealed, Resident #56 admitted to the facility with pertinent diagnosis which included Diffuse Traumatic Brain Injury (rapid shift of brain) and Adult Failure to Thrive. Review of a Minimum Data Set (MDS) assessment, with a reference date of 5/21/21 revealed Resident #56 had severe cognitive impairment. Resident #56 required total dependence of one staff with dressing, hygiene, and bathing. Review of a Nurse/CNA Skin Assessment (shower sheets) revealed, Resident #56 had a shower on 5/11/21. Resident #56 did not have documented showers for April. Record review of Activities of Daily Living (no implementation date) documented the following: The facility will ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 This citation pertains to MI00120492. This citation has three deficient practices. Deficient practice #1. Based on observation, interview, and record review, the facility failed to provide physician ordered wound care treatments, assess and monitor resident's skin condition, and follow the wound care team's recommendations for oral and topical antibiotics for one resident (#27) reviewed for quality of care, resulting in an immediate jeopardy when the resident was sent to the hospital on 5/21/21 and was found to be septic (life threatening blood infection), developed a left foot abscess, and experienced excisional debridement of his left foot down to the level of muscle. Findings include: On 6/6/2021 at 10:12 AM, during the initial tour of the facility, Resident #27 (R27) was awake and lying in his bed. R27 stated he just got back from the hospital on Friday (6/4/2021). R27 said I had poison in my blood. They cut my feet open and cleaned them. I had an infection in both feet. My pain level was 10 out of 10 when I went to the hospital. On 6/8/2021 at 9:50 AM, R27 stated he was sick the whole day prior to going to the hospital. R27 said, I slept the whole day. The next day I got up to go to dialysis and because I was in so much pain, I told the ambulance driver to take me straight to the hospital. The (nursing home) staff were not changing my dressing. Review of the Admission Record revealed R27 was originally admitted on [DATE]. R27 went to the hospital on 5/20/2021 and was readmitted to the facility on [DATE]. His diagnoses included end stage kidney disease, cerebral infarction, anemia, diabetes mellitus, and convulsions. A Minimum Data Set, dated dated dated [DATE] documented R27 had intact cognition. A review of R27's progress notes revealed the following: -5/21/2021 at 1:26 PM: Resident sent to hospital from dialysis. Doctor and responsible party notified. (This note was created on 5/22/2021 at 1:27 PM.) -6/4/2021 at 5:07 PM: Resident received from (local hospital) with diagnosis of foot infection .Skin is as follows: right foot amputation of 4th/5th toes. Open area to sacrum coccyx treatment intact .Right lateral foot has an open area treatment intact .Left plantar foot with multiple sutures treatment intact. Left (foot) has an open area to plantar foot. (Nurse Practitioner) aware of admission and current medication. Resident voices no pain at this time. On 6/8/2021 beginning at 11:10 AM, R27's clinical record was reviewed with Director of Nursing (DON BB) and the following was revealed: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R27's May 2021 Treatment Administration Record (TAR) review documented: Bilateral feet apply dry bulky protective dressing every two days and prn (as needed) every night shift every other day for protection. Ordered 2/27/2021. During May 2021, the dressing was not done on 5/2, 5/4, 5/6, 5/8, 5/10, 5/12, 5/14, and 5/20. According to DON BB, the implications of not receiving the proper wound care could result in non-healing of the wound, potentially it could have gotten worse, and potentially it could become infected. DON BB said, Septicemia is an infection. We know he had a foot infection. R27's Wound care team's note of 5/12/2021 documented in part the following: Wound #8 left MP (metatarsophalangeal) joint is a diabetic ulcer and has received a status of not healed. Subsequent wound encounter measurements are 2.4 cm (centimeter) length x 2.2 cm width x 0.4 cm depth, with an area of 5.28 square cm and a volume of 2.112 cubic cm. There is a moderate amount of sero-sanguineous drainage noted which has a mild odor. Wound bed has pink base epithelialization. Treatment recommendation: Metrogel (topical antibacterial) daily and prn to left foot wounds. Keflex (oral antibiotic) 500 mg 1 po (by mouth) twice a day x 10 days. Per review of R27's May 2021 TAR, the wound care team changed recommendations from Medihoney (topical wound dressing) to Metrogel daily to left foot wounds. DON BB said, It is not documented on the TAR so we can assume he didn't get it. This could cause the wound to become worse or get worse. A review of R27's Medication Administration Record (MAR) for May 2021 revealed that Keflex was not ordered. A request for skin assessments and shower sheets for March 2021, April 2021, May 2021, and June 2021 yielded one document dated June 8, 2021. On 6/8/2021 at 12:53 PM, DON BB, in the presence of the State Surveyor, called the medical transportation company that takes R27 to and from the hemodialysis center and spoke with Dispatcher UU. Dispatcher UU said, (R27) was taken from (the nursing home) to (local hospital) by us because he was in a lot of pain. On 6/9/2021 at 10:31 AM, Wound Care Team Nurse Practitioner (NP II) stated she recommended the Metrogel for left plantar foot because it had an odor and that's an indication that there may be an infection. I ordered a topical antibiotic. I want them to go ahead and follow my order. If they can't get the treatment, I want them to call me. They did not call about the Metrogel or they could have called (R27's) primary (care physician). A review of R27's consultation from Doctor of Podiatry Medicine (DPM) 3/5/2021 (created on 3/31/2021 at 9:02 PM) documented in part the following: .This patient is seen for a nursing home visit. Patient is seen for preventative foot care. Patient is unable to perform daily checkups to feet .Assessment .Pain in toes .Left foot more breakdown .Plan .Please continue off loading techniques to prevent any ulcerations or breakage of skin .Order wound care . A review of R27's consultation from Nurse Practitioner (NP ZZ) on 4/1/2021 documented in part the following: NP acute visit .follow up on acute and chronic medical problems .Assessment: Diabetic foot ulcer-local care as directed by Wound Care Team . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R27's consultation from NP ZZ on 5/6/2021 documented in part the following: NP acute visit . follow up on acute and chronic medical problems .Assessment: Diabetic foot ulcer - local care as directed by Wound Care Team . A review of R27's hospital records for the admission between 5/20/2021 and 6/4/2021 documented the following: Primary Diagnosis: foot infection. Surgical Procedure: I&D (incision and drainage) debridement left foot; excisional wound debridement right foot; repeated debridement of primary closure. -5/20/2021 at 4:02 PM: lab results: Staphylococcus aureus - Methicillin resistance detected. Interpretation: positive for methicillin resistant staphylococcus aureus (MRSA). -Blood Culture Collected 5/20/2021 at 4:02 PM. Critical value called to and read back by RN (Registered Nurse) 5/21/21 at 3:06 PM. Culture: staphylococcus aureus anaerobic bottle culture. Results: this result has been designated as a possible significant finding. -Radiology / Diagnostics of 5/20/2021 at 4:21 PM: Left foot. Impression: Skin ulcer and/or gas forming infection or abscess involving the plantar aspect of the fourth metatarsophalangeal joint. -Infectious Disease consult. Blood culture 5/20/2021 MRSA. Radiology: x-ray foot: possible abscess in the plantar aspect foot on admission. Assessment: Septicemia with MRSA. Most likely source: foot infection. admitted with right foot diabetic foot ulcer and a left foot diabetic foot ulcer associated with abscess. Status/post (s/p) left foot wound debridement with incision and drainage of abscess. S/P incision and debridement on 5/25/2021. Plan/Recommendation: vancomycin (antibiotic) and Unasyn (antibiotic). -Radiology report of 5/21/2021 at 11:02 PM: Complete left foot. Impression: skin ulcer and/or gas forming infection or abscess involving the plantar aspect of the fourth metatarsophalangeal joint. -Progress note 6/4/2021 at 10:30 AM: Impression: left foot abscess status post excisional debridement of left foot down to the level of muscle, 5/25/2021 secondary closure. -DPM: Left foot: lateral forefoot ulceration measure 2x1.5x1.5 cm opening to muscle layer, surgical closure site with sutures intact. On 6/08/2021 at 3:10 PM, observations of R27's feet were made in the presence of Certified Nursing Assistant (CNA) PP. Bottom of Right foot had small opening with red base. Left foot had open area where baby toe was removed. Multiple sutures were observed across the bottom of the left foot diagonally (baby toe to heel). Small opening noted midway of sutures. A facility policy titled, Wound Treatment Management, undated, was reviewed and revealed the following: -Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Treatments will be documented on the Treatment Administration Record Nursing Home Administrator (NHA) AA was notified of an Immediate Jeopardy on 6/9/2021 at 9:20 AM that began on 5/21/21, due to the facility's failure to provide the physician ordered treatment for a diabetic foot ulcer, implement the wound care team's recommendation for oral and topical antibiotics, and provide weekly skin assessments for March 2021, April 2021, or May 2021 for R27. A written plan for removal for the immediate jeopardy was received and verified on 6/14/2021. 1. Resident #27 will receive wound care treatment per the physician orders on 6/9/21, which reflects the order of using Metrogel daily and prn to his left foot wounds. Effective 6/9/21, it will be documented on the TAR in (electronic health record) as being done. 2. Effective 6/10/21, the days in which the resident has to go to dialysis, the contracted wound care team will evaluate and provide care upon his return back to the facility. In the event the contracted wound care specialist has left before he returns, a licensed nurse will provide his wound care treatment, which includes measurements. 3. The licensed nurses will conduct skin assessments on 6/9/21 for the residents within the facility to ensure there are no new skin issues. On 6/9/21, 66 of 67 skin assessments were completed. One resident was out to dialysis and their skin assessment will be completed upon their return. One of the skin assessments revealed that a resident had excoriation on both feet. The physician and resident's responsible party was notified, and a treatment was put in place. This resident will be evaluated by the contracted wound team on 6/16/21 and current treatment plan will remain in place. 4. On 6/9/21, the wound care policy was reviewed by the Administrator, Medical Director and Director on Nursing to ensure it's appropriate as written. it was deemed appropriate as evidenced by, meets the current standard of care. 5. On 6/9/21, the licensed nurses will be re-in-serviced on the wound care policy and their responsibility to ensure weekly skin assessments are being completed. Approximately 5 out of 15 licensed nurses have been in-serviced as of today. Only those who have been educated on the wound care policies and standards of care, will be allowed to provide those services. The education of the remaining nurses should be completed by 6/10/21. 6. On 6/2/21, a new wound care nurse was hired, and her official start date will be 6/14/21. Her sole responsibility will be wound care, skin care and preventative care, rounding with the contracted wound care team and carrying out any new recommendations from the contracted wound care team. The Unit Manager responsible for that floor, will complete wound care in the absence of the Wound Care Nurse and the Unit Manager is trained. 7. On 6/9/21, the contracted wound care notes will be scanned into the medical record when received from the wound care team. The licensed nurses will have access to the notes and/or recommendations given by the wound care company. The wound nurse or designee will be responsible for reviewing the information within 24 hours of receiving it from the wound care team and transcribing any new recommendations on to the TAR after verification from the primary care physician. The skin integrity care plan will be updated accordingly. If there are any new areas, the responsible party and physician will be notified. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. On 6/14/21, 7 residents who are seen by the contracted wound team for either pressure ulcers, diabetic ulcers and/or surgical ulcers, were reviewed. Residents care plans were reviewed and/or revised. 9. On 6/14/21, a new wound care nurse started her full-time position. Her sole responsibility will be wound care, skin care and preventative care, rounding with the contracted wound care team and carrying out any new recommendations from the contracted wound care team. The Unit Manager responsible for that floor, will complete wound care in the absence of the Wound Care Nurse and the Unit Manager is trained. Although the Immediate Jeopardy was removed on 6/14/21, the facility remained out of compliance at a scope isolated and severity of actual harm due to not all facility staff had received education and the State Agency could not verify sustained compliance. Deficient practice #2. Based on interview and record review, the facility failed to monitor and assess a potentially toxic medication (valproic acid) for one resident (#53), reviewed for management of drug levels, resulting in a missed opportunity for timely management of known physiological condition and potential for relapse in mood symptoms. Findings include: A review of the Admission Record revealed Resident #53 (R53) was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included injury of head, psychotic disorder with delusions, adjustment disorder with disturbance of conduct, mood disorder, and vascular dementia. Review of the Minimum Data Set, dated dated dated [DATE] documented severe cognitive impairment. A review of R53's clinical record documented the following: -Valproic acid solution 250 mg/5ml, give 750 mg by mouth two times a day related to mood disorder due to known physiological condition. Order date 5/27/2020. -Depakote (valproic acid) levels one time a day every 90 days for labs. Order date 3/3/2020. -Valproic acid level requested 2/21/2021. On 6/15/2021 at 12:29 PM, according to Director of Nursing (DON BB) valproic acid levels are to be obtained so you know if the resident is therapeutic or not. Review of R53's clinical record did not reveal the valproic acid level results requested on 2/21/2021. On 6/16/2021 at 10:42 AM, DON BB stated, Yesterday we requested the lab results (from 2/21/2021) and ordered another lab (to be drawn). DON BB acknowledged the valproic acid results were not obtained and reviewed and the subsequent lab obtained in a timely manner. A review of R53's lab test performed on 2/22/2021, obtained by the facility on 6/15/2021, documented valproic acid of 25L (low) ug/ml (micrograms per milliliter). Reference range: 50.0-100.0 ug/ml. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/17/2021 at 3:14 PM, a telephone interview was conducted with Psychiatric Nurse Practitioner (NP GG) who stated R53 had a bipolar diagnosis and was having mood swings of bipolar with violence, and valproic acid levels should be drawn every 90 days. NP GG stated she did not receive the lab results obtained February 2021. NP GG said, That's what I need, and I never get it. I don't have access to the results. In reference to R53's level of 25 ug/ml, NP GG stated, That's too low. I think that it could cause mood levels that would not be as stable as they could be. If the lab results come in, as a courtesy it would be nice to get a call if the levels are subtherapeutic. A review of the facility document used to train nursing staff titled, Laboratory, X-ray and EKG Orders, undated, revealed the following: -To ensure that diagnostic procedures are done based on medical necessity on a timely manner and abnormal results are referred to the physician. -Abnormal lab and X-ray results must be referred by the licensed nurse to the attending physician as needed and flagged for review. The attending physician will address any abnormal labs and will document interventions as needed and the reason why no intervention was required. A review of the facility policy titled, Laboratory Standing Order, undated, revealed the following: -It is the policy of this facility to obtain, maintain and monitor labs and admission orders resulting from medical conditions and/or medications. A lab draw will be ordered on admission and subsequently thereafter, based on diagnosis, symptoms, and/or medication ordered as follows: -Depakote level every 3 months. 39958 Deficiency Practice Statement #3 Based on interview and record review the facility failed to ensure follow-up appointments were scheduled for 1 of 22 residents (Resident #19) resulting in the potential for undetected decline in health. Findings include: Review of an Admission Record revealed, Resident #19 originally admitted to the facility with pertinent diagnosis which included Fracture to lateral orbital wall right side, Frontotemporal Dementia (affects behavior and language), Zygomatic Fracture (cheek and outer side of eye socket), and Nontraumatic Chronic Subdural Hemorrhage (bleeding in brain). Review of a Minimum Data Set (MDS) assessment, with a reference date of 2/13/21 revealed Resident #19 had severe cognitive impairment. Resident #19 required extensive assistance of one staff with dressing, hygiene, and bathing. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Progress Note with a date of 3/11/21 at 8:38 a.m. revealed, .Resident was transferred to (hospital name) instantly. Review of a Progress Note with a date of 3/13/21 at 10:50 p.m. revealed, pt alert and verbally responsive . arrived via ambulance-medications reviewed and transcribed as ordered . Review of Patient Discharge Instructions with a date of 3/3/21 revealed, Resident #19 had follow-up appointments which included: physician appointment in 1 to 2 weeks and Eye Institute 1 to 2 weeks. Review of a Transition of Care Form with a date of 3/12/21 revealed, follow-up appointment with physician in 2 weeks, please follow up with neurosurgery and request HEAD CT WITHOUT CONTRAST for subsequent primary care follow up. In an interview on 6/15/21 at 12:06 p.m., Unit Manager HH reported the Unit Manager does the follow up appointments when a resident is admitted . In an interview on 6/15/21 at 12:31 p.m., Director of Nursing (DON) BB reported Resident #19 did not go on follow-up appointments. DON BB then reported follow-up appointments are done by Staffing Coordinator PP or the nurse that does the admit.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on observation, interview, and record review the facility failed to implement the wound care program for 1 of 22 residents (Resident #52) reviewed for pressure ulcers, who was admitted on [DATE] with a stage 4 (deep wound reaching into muscle and bone with extensive damage) pressure ulcer on Sacro coccyx (upper buttock-back area) and stage 4 right ischium (upper thigh) pressure ulcer and facility staff did not transcribe and implement the hospital wound care orders until 5/13/2021. Wound care was missed on 5/15/2021, 5/16/2021, and 5/21/2021. This deficent practice resulted an immediate jeopardy for R#52, when wound care orders from hospital were not implemented on 5/10/21 and R#52 was readmitted on [DATE] to the hospital emergency room with a septic (harmful infection) pressure ulcer. This deficient practice effects an additional 66 residents at risk for serious injury, harm, and/or death. Findings include: Review of R#52's face sheet revealed original admission into facility on 5/10/21 included diagnoses of pressure ulcers, end stage renal disease (kidney disease), paraplegia (paralysis of lower body). Review of R#52's Minimum Data Set (MDS) dated [DATE] documented R#52 had intact cognition and was total dependence with most Activities of Daily Living (ADLS). Review of R#52's Treatment Administration Record (TAR) for May 2021 documented the following: Cleanse/irrigate with wound cleanser loosely pack sacrum and right ischium with kerlix(gauze) the is moistened with med honey (wound medication). Cover with ABD (large absorbent pad) pads and secure with fabric tape daily and prn (as needed) when soiled. Order date:5/12/21 (two days after admission). Review of TAR revealed missing treatment opportunities on 5/15/2021, 5/16/2021, and 5/21/2021. Review of R#52's hospital records dated 5/22/21 at 14:00 (2:00 PM) documented Reason for admission: Sepsis (harmful infection) decubitus ulcer (pressure ulcer). During an interview with R#52 on 6/09/21 at 10:10 AM, R#52 confirmed she was unable to reposition herself and felt that her wounds were getting better. R#52 confirmed that she had not seen the wound care team yet but hoped to see them that day. During an interview with R#52 on 6/16/21 at 10:30AM, R#52 confirmed that in May the staff did not perform her wound care as ordered from hospital. R#52 confirmed wound care was not done for a couple days after arrival. R#52 confirmed that bandages would be saturated and left on all day. R#52 stated, My wounds were changed twice a day when I was in the hospital, I think the reason I got an infection was because they (facility) didn't do my wound care correctly. During an interview with Wound Consultant (DNP II) on 6/16/21 at 11:34 AM it was confirmed that wound consultants were not informed they needed to see resident until 6/9/21. During an observation of wound care on 6/16/21 at 11:45 AM it was confirmed R#52 had a stage 4 pressure ulcer to Sacro coccyx area and a Stage 4 to right ischium and both remained unhealed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/17/21 at 2:10 PM, with Director of Nursing (DON) BB it was confirmed the admitting nurse documented on a progress note on 5/10/21 and acknowledged R#52 had pressure ulcers. DON BB confirmed all wound care should be done as ordered for new admissions as well as resident identified to have new pressure ulcers. DON BB confirmed that resident was admitted on [DATE] and wound care was not started until 5/13/21. DON BB confirmed that wound care for R#52 was not consistently administered. On 6/17/21 at 3:05 pm, Administrator AA was notified of the Immediate Jeopardy (IJ) that began on 5/1021 due to the facilities failure to implement wound care program for R#52. A written plan of removal for the immediate jeopardy was received and verified on 6/17/21. 1. Resident #52 received wound care treatment per the physician orders on 6/9/21. Resident was seen by the wound care team initially on 6/9/21 and recommendations were put in place. 2. Resident #52 was seen by the wound team on 6/16/21 and an order for Maxorb ag every other day and as needed was added to right ankle. Resident was placed on a low air loss mattress, will be frequently repositioned, will evaluate bilateral lower extremities and we will float heels. Resident will continue to be seen by wound care team weekly and the facility wound nurse/designee will complete the treatments, as recommended. Treatment progress will be documented every other day and as needed. Physician will be notified immediately of any changes in the status of the wounds. 3. The licensed nurses will conduct skin assessments on 6-9-21 for the residents within the facility to ensure there are no new skin issues. On 6/9/21, 66 of 67 skin assessments were completed. One resident was out to dialysis and their skin assessment will be completed upon their return. One of the skin assessments revealed that a resident had excoriation on both feet. 4. On 6/14/21, 7 residents who are seen by the contracted wound team for either pressure ulcers, diabetic ulcers and/or surgical ulcers, were reviewed. Residents care plans were reviewed and/or revised. 5. On 6/9/21, the wound care policy was reviewed by the Administrator, Medical Director and Director of Nursing to ensure it is appropriate as written. It was deemed appropriate as evidenced by, meets the current standard of care. 6. On 6/9/21, the licensed nurses were re-in serviced on the wound care policy and their responsibility to ensure weekly skin assessments are being completed. Approximately 9 out of 15 licensed nurses have been in serviced as of 6/14/21. Only those who have been educated on the wound care policies and standards of care, will be allowed to provide those services. The education of the remaining nurses should be completed by 6/14/21. 7. On 6/14/21, a new wound care nurse started her full-time position. Her sole responsibility will be wound care, skin care and preventative care, rounding with the contracted wound care team and carrying out any new recommendations from the contracted wound care team. The Unit Manager responsible for that floor, will complete wound care in the absence of the Wound Care Nurse and the Unit Manager is trained. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. On 6/9/21, The contracted wound care notes will be scanned into the medical record when received from the wound care team. The licensed nurses will have access to the notes and/or recommendations given by the wound care company. The wound nurse or designee will be responsible for reviewing the information within 24 hours of receiving it from the wound care team and transcribing any new recommendations on to the TAR after verification from the primary care physician. The skin integrity care plan will be updated accordingly. If there are any new areas, the responsible party and physician will be notified. Although the immediate jeopardy was removed on 6/14/21, the facility remained out of compliance at a scope of isolated and severity of actual harm due to sustained compliance had not yet been verified by the State Agency.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on interview and record review, the facility failed to provide proper supervision and implement appropriate safety interventions for 1 of 22 residents (Resident #53) reviewed for accidents, resulting in a fall, three-inch wound to forehead, and an emergency hospital encounter with admission. Findings include: A review of the Admission Record revealed Resident #53 (R53) was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included injury of head, muscle wasting and atrophy, psychotic disorder with delusions, adjustment disorder with disturbance of conduct, mood disorder, and vascular dementia. Review of the Minimum Data Set (MDS) dated [DATE] documented severe cognitive impairment, one person limited physical assistance for bed mobility and transfers, supervision for locomotion about the unit, unsteady and only able to stabilize himself with staff assistance while walking, moving from seated to standing position and surface-to-surface transfers, and one-person extensive physical assistance for walking in his room. The MDS indicated R53 was to use a wheelchair for a mobility device. A review of R53's clinical record documented in part the following: -5/4/2021 nurse note: Writer called to resident's room by the Housekeeping supervisor. Upon arrival writer noticed three cenas (Certified Nurse Aides) surrounding resident who was face down on the floor in the room in front of the bed. Writer noted pooled blood on the floor coming from the face of the resident. Writer and other staff were calling the resident by name and he was responsive. Writer rolled the resident into a supine position and cleansed the blood with a clean towel. It was then noted a large gash to the middle of the forehead. The resident remained responsive. 911 was called and in route. (Physician) was also notified and wanted the resident transferred to the hospital . -5/12/2021 nurse note: Resident returned to facility at approx (approximately) 1130 am via stretcher accompanied by 2 EMTs (emergency medical technician) from (local hospital). Resident is a readmit from (unit) who suffered a fall about 1 week ago. (R53) is incontinent to (bowel and bladder) .and is a fall risk. Three inch wound noted to center of resident's forehead in late stages of healing with no signs of infection noted. (Physician) aware of resident's return and medications entered into (electronic health record). Review of R53's care plans documented the following: Actual Fall related to Confusion was reviewed/updated on 1/18/2019, 7/23/2019, and 5/14/2021. Interventions included: Remind resident to use call light and ask for assistance when needed. Alteration in Communication related to diagnosis of dementia with confusion . was reviewed and updated on 2/17/2015/8/7/2019. Interventions included .Anticipate needs and accommodate accordingly each shift and prn (as needed) . Staff will anticipate needs which resident cannot communicate clearly, will provide care as needed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Potential for Fall and Injury related to psychotropic medication use, dementia diagnosis with poor decision making skills, generalized weakness, poor safety technique, as evidenced by: impulsive attempts to transfer self and to stand without staff assistance. (R53) can be uncooperative with care. This care plan was reviewed/updated on 2/17/2015, 9/20/2016, 12/3/2018, and 8/7/2019. Interventions included: Check wheelchair for functionality and safety prior to resident using it, daily and prn (as needed) .Encourage and remind resident to use call light, to ask for assistance with transfers and ambulation, prior to attempts to transfer or ambulate alone. Answer call light in an appropriate amount of time, respond to resident's needs promptly .Ensure a safe environment; make sure call light is within reach for the resident. Maintain clutter free environment .Frequent visual checks throughout each shift .Monitor frequently if resident wanders, provide activities and refocus/reorient to a supervised area as often as possible .One person assist with all transfers. On 6/09/2021 at 3:19 PM, Director of Nursing (DON) BB stated she authored R53's nurse note of 5/4/2021. DON BB reported that there were no written witness statements because the witnesses did not have much to say. On 6/14/2021 at 11:58 AM, Certified Nurse Aide (CNA) Y stated, I was standing outside of (R53's) room talking with another CNA. I had my back to his doorway, so I don't know how he got back into his room. (R53) can walk but his gait is not great. He's unstable (while walking) and it's getting worse. On 6/14/2021 at 12:10 PM, CNA EE stated, (R53) was in the dining room (prior to his fall). I saw (R53) walking back to his room. He usually walks from the dining room to his room. He's not supposed to be walking independently. CNA EE denied assisting R53 or seeking assistance for R53 when the Resident was observed walking back to his room. On 6/16/2021 at 10:26 AM, when DON BB was interviewed regarding R53's fall and stated, (Prior to R53's fall) there was a CNA standing outside of his room. R53 is able to move about freely. He's not on a one-to-one. We believe he was trying to get back in bed. DON BB reported that if a resident is observed walking and appears to be unstable, staff should stabilize them and assist them. When DON BB was informed that staff reportedly saw R53 walking by himself but did not provide assistance, she stated, That's not what they told me. The facility document titled, Fall Prevention Program, undated, was reviewed and revealed the following, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on observation interview and record review the facility failed to consistently monitor and implement interventions for weight loss, effecting 1 of 22 resident (Resident #61), reviewed for unplanned weight loss, resulting in the potential for additional or continued weight fluctuations and compromised nutritional status. Findings Include: Record review of Resident #61's (R#61) face sheet revealed resident was admitted into the facility on [DATE] with diagnoses that included essential hypertension (high blood pressure) and Type 2 diabetes. According to the Minimum Data Set (MDS) dated [DATE], R#61 had impaired cognition and was extensive to total assist with Activities of Daily Living (ADLS). Record review of Weights and Vitals for R#61 documented the following: 12/16/2021 12:44 (12:44 PM) - 152 lbs. (pounds) 03/24/2021 11:50 (11.50 AM)- 144.6 lbs. 05/15/2021 14:51 (2:51 PM)- 138.4 lbs. 05/27/2021 21:41 (9:41 PM)- 132.6 lbs. Record review of Dietary Progress Note dated 5/25/21 at 20:15 (8:15 PM) documented the following: Note Text: (R#61) have experienced an unplanned weight loss, 15.6# (pounds), 10.1% x 6 months, resident weight is 138, remains within IBWR (Ideal Body Weight Range)124-150, resident is report to be consuming meals without difficulty, add to weekly weight x 4 weeks, F.A.R (Food Acceptance Record) x 14 days, will request CBC w Diff (complete blood count) CMP (completed metabolic panel) Lipid Panel, TSH (thyroid stimulating hormone), UA (urinary analysis), Recommend Med Pass NSA (supplemental)1.7 BID (twice a day), speech evaluation to assure there is no difficulty with meal texture. F/U (Follow-Up). Record review of physician orders for the month of May 2021 revealed no recommendations had been implemented and no orders had been documented. During phone interview on 6/9/21 at 12:46 PM with Registered Dietician RD OO it was confirmed the physician was not informed of R#61's change in weight. RD OO confirmed that a note was put on a bulletin board in the electronic record. RD OO confirmed there was no evidence that the physician received the note on bulletin board. RD OO confirmed none of the recommendations were ordered or denied by physician. RD OO confirmed that recommendations were verbally given to nurses on the floor. RD OO confirmed that weights were not consistently monitored or increased to assess for continued weigh loss for R#61. Record review of policy Nutrition: Weight Changes revised on 3/26/21 documented the following: .It is the policy of this facility to provide adequate nutrition and hydration, therefore, a comprehensive assessment will be done to all residents on a timely basis to maintain an acceptable nutritional status and to provide a therapeutic diet when there is nutritional problem. - 7. Dietary Manager/Dietitian will do a comprehensive nutritional assessment on admission, quarterly thereafter or as necessary to identify risk factors .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 This citation has two deficient practices. Deficient practice #1. Based on interview and record review, the facility failed to ensure consistent coordination of care between the facility and the contracted dialysis center for 1 of 22 residents (Resident #52) reviewed for dialysis services, resulting in the potential for miscommunication, inadequate documentation of resident's clinical conditions, and unmet care needs. Findings include: Review of the Admission Record revealed Resident #52 (R52) was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included epilepsy, sepsis, paraplegia, anemia, cerebrovascular disease, pressure ulcer, and end stage renal disease. Review of the Minimum Data Set (MDS) dated [DATE] revealed R52 had intact cognition. On 6/08/2021 at 9:31 AM, Licensed Practical Nurse (LPN QQ) reported that before a resident leaves for a hemodialysis treatment, their vitals are taken and the hemodialysis communication sheet is completed and sent with the resident. On 6/16/2021 at 11:09 AM, LPN HH was interviewed and stated, When a resident returns from the hemodialysis facility, the hemodialysis sheets are reviewed for vitals, weights and recommendations if any. The sheets are then scanned into the resident's medical record. Hemodialysis communication sheets for R52 were not available in her clinical record or at the nurse's station. On 6/16/2021 at 12:30 PM, Medical Records (Staff CCC) provided hemodialysis communication sheets for R52 dated: 5/11/2021, 5/13/2021, 5/15/2021, and 6/15/2021. Staff CCC stated, No other hemodialysis communication sheets were available. Review of the Medical Record revealed R52 was discharged from the facility between 5/21/2021 and 6/3/2021. Review of the Medical Record revealed Hemodialysis communication sheets were not available for 5/18/2021, 5/20/2021, 6/5/2021, 6/8/2021, 6/10/2021, and 6/12/2021 for R52. On 6/17/2021 at 10:33 AM, Director of Nursing (DON) BB was interviewed and stated she was aware that some of R52's hemodialysis sheets were not available. According to DON BB, Staff are told to call the hemodialysis center if communication sheets are not returned. DON BB reported that the purpose of the hemodialysis communication sheets are to coordinate care between the dialysis facilities and ourselves. Deficient practice #2. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to secure transportation services to an offsite dialysis center for 1 of 22 residents (Resident #27) reviewed for hemodialysis treatments, resulting in the potential for build-up of waste products in the blood causing health compromise and lack of knowledge regarding the renal status and care needs of the resident. Findings include: Resident #27 Review of the Admission Record revealed Resident #27 (R27) was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction, end stage renal disease, hypertension, unspecified convulsions, and diabetes mellitus. A Minimum Data Set, dated dated dated [DATE] documented R27 had intact cognition. On 6/6/2021 at 10:12 AM, during the initial tour of the facility, R27 was awake and lying in his bed. R27 reported that he just returned from the hospital on Friday (6/4/2021). During an interview on 6/8/2021 at 9:50 AM, R27 reported he was sick the whole day prior to going to the hospital, I slept the whole day. The next day I got up to go to dialysis and because I was in so much pain, I told the ambulance driver to take me straight to the hospital. R27 stated he usually went to the dialysis center on Tuesday, Thursday, and Saturday. On 6/8/2021 at 12:53 PM, DON BB, in the presence of the State Surveyor, called the medical transportation company that takes R27 to and from the hemodialysis center and spoke with Dispatcher UU. Dispatcher UU said, Is (R27) still in the hospital or is he back in the nursing home? DON BB stated R27 was back in the nursing home. Dispatcher UU said, We did not know he was out of the hospital. No one called us. He needs to be reinstated. (R27) was supposed to dialyze today. Per review of R27's hospital records for the admission between 5/20/2021 and 6/4/2021, R27 received dialysis in the hospital on 6/4/2021 at 9:00 AM. Once off the telephone, DON BB reported that when R27 returned to the facility, admissions or nursing should have notified the transportation company. DON BB stated, We don't want anyone to miss their (dialysis) treatment. His physician should have been notified that he missed his appointment. DON BB stated, I don't see a note that the physician was notified.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 This citation pertains to intakes MI00111127, MI00112478, MI00117985, MI00118858, MI00119550, and MI00120492. This citation has 2 Deficiency Practice Statements. Based on observation, interview, and record review, the facility failed to ensure sufficient staffing was available to render care, pass meal trays, and meet resident needs for all 67 residents in the facility. An Immediate Jeopardy was determined on 6/15/2021 when on the following dates and times, there was only one licensed or registered nurse in the building: 5/4/2021 (census of 69) between 7:00 AM and 7:00 PM; 5/9/2021 (census of 65) between 7:00 AM and 2:30 PM; 6/4/2021 (census of 67) between 9:00 PM and 12:15 PM on 6/5/2021; and 6/5/2021 (census of 66) between 12:16 PM and 7:00 PM. The facility staff did not administer prescribed insulin, IV antibiotics, anti-psychotics, anti-coagulants, anti-hypertensives, and/or anti-convulsants for Residents #1, #16, #19, #20, #22, #27, #32, #36, #38, #39, #42, #44, #51, #52, #56, #172, and #173. This deficient practice resulted in the likelihood for actual harm for Residents #1, #16, #19, #20, #22, #27, #32, #36, #38, #39, #42, #44, #51, #52, #56, #172, and #173, and placed all residents residing in the facility at risk for serious harm, injury, and/or death. Based on observation, interview, and record review, the facility also failed to ensure meals were delivered and served in a timely manner for three residents (#8, #36, and #38) due to insufficient staffing resulting in resident dissatisfaction. Findings include: On 6/6/2021 at 8:10 AM, Licensed Practical Nurse (LPN) U was observed on the first floor. LPN U stated her shift began at 7:00 PM on 6/5/2021 and she was waiting for her relief to arrive. LPN U stated LPN V's, who was working on the second floor, shift began at 7:00 PM and there were two Certified Nurse Aides (CNA) working the midnight shift as well. LPN U said, Having only two CNAs on the midnight shift has been a habit lately. On 6/6/2021 at 8:25 AM, CNA T, who worked on the locked dementia unit, said, I actually have help today. CNA T said, Sometimes I work by myself. On 6/6/2021 at 10:00 AM, during the initial tour of the facility, no nursing staff was observed on the 2 North unit. There were eleven residents residing on the unit. At 10:12 AM, Resident #27 (R27) was observed awake and lying in his bed. On R27's overbed table was a plastic bag containing a disposable carryout container. Gnats were observed swarming around the bag. During an interview at this time, R27 stated the contents of the bag contained uneaten Chinese carryout from the evening before and no one had been in his room to dispose of the bag. On 6/6/2021 at 10:25 AM, Certified Nurse Aide (CNA) EE was observed on 2 North. When interviewed, CNA EE said, I was supposed to arrive at 7 AM but I arrived at 9:30 AM today. CNA EE stated he did not know the nurse that was working on 2 North, I haven't seen her. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 6/6/2021 at 10:37 AM, an unidentified resident stated he was in pain. When interviewed, he said, I went from evening to morning without pain meds. I have to wait forever for pain meds. Usually there is no one here. On 6/6/2021 at 10:55 AM, Resident #172 (R172) was observed awake and in his room. When interviewed, R172 stated he had a bone infection in his foot after a toe amputation and was to receive intravenous (IV) antibiotics. R172 stated that yesterday he had to go downstairs to the first floor to get some nursing help regarding his scheduled IV antibiotic treatment. R172 stated he finally received a treatment at 1:15 AM but had not received any treatments since. On 6/6/2021 at 11:03 AM, Resident #173 (R173) was heard calling for a nurse. When interviewed, R173 stated his urinary catheter bag needed to be changed, he needed some water, and he had pain in his foot. R173 pulled his call light. The call light system at the nurse's station was observed lit signifying that R173 needed assistance but there was no staff observed around the nurse's station. On 6/6/2021 at 11:10 AM, the telephone located at the 2 North nurse's station was ringing. An unidentified resident answered the phone and said, No one is here. You'll have to call back. When queried about the phone call the unidentified resident said, They wanted a nurse. On 6/6/2021 at 11:18 AM, Resident #52 (R52) was observed awake and lying in her bed. When interviewed R52 said, There might not be a nurse to work this side of the floor (2 North) on afternoon and midnights. I take a lot of meds and have gone without. On 6/6/2021 at 11:23 AM, when interviewed CNA EE stated he still had not seen a nurse on 2 North. On 6/6/2021 at 11:37 AM, when interviewed LPN HH stated she arrived at 11:00 AM today to work on 2 South and that the facility called her in to relieve the midnight nurse. On 6/6/2021 at 11:51 AM, Registered Nurse (RN) C was observed on 2 North. When interviewed she stated she arrived around 10 AM and had been watching over the 1 South med cart. Director of Nursing (DON) BB had just instructed her to come to the 2 North unit. A review of the Medication Administration Records (MAR) for R27, R52, R172, and R173 was conducted with RN C and the following medications were not administered on 6/6/2021 at the designated times: R27: 9:00 AM antibiotic, anticonvulsant, anti-hypertensive, insulin per sliding scale. R52: 6:00 AM anticoagulant, 8:00 AM anticonvulsant, antibiotic, topical wound solution, anticonvulsant, and 9:00 AM antibiotic. R172: 6:00 AM IV antibiotic, 9:00 AM anticonvulsant and long-acting insulin. R173: 9:00 AM anti-coagulant, anti-hypertensive, mood-stabilizer, anti-convulsant, fast-acting insulin, and long-acting insulin. On 6/6/2021 at 12:43 PM during an interview, R173 said, Ain't no nurses usually on shift. When you push the (call) light don't no one come. Today, I ain't had no meds yet. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 6/7/2021 at 10:30 AM, a confidential resident council meeting was held with four facility residents in attendance all of whom were alert and oriented and able to express themselves without difficulty. The following statements were made regarding facility staffing: -There is not enough staff. -The facility is cheap, and they won't hire people. -I was getting ready to go to bed and no one was there to give me a night gown or brief. I slept in my underwear without a gown. -I'm smelling urine and feces on residents. The residents in the building aren't being cleaned. On 6/9/2021 at 3:19 PM, the clinical record for Resident #53 (R53) was reviewed with DON BB in terms of a fall with major injury that occurred on 5/4/2021. DON BB authored the following progress note: Writer called to resident's room by the Housekeeping supervisor. Upon arrival writer noticed three cenas surrounding resident who was face down on the floor in the room in front of the bed. Writer noted pooled blood on the floor coming from the face of the resident. Writer and other staff were calling the resident by name and he was responsive. Writer rolled the resident into a supine position and cleansed the blood with a clean towel. It was then noted a large gash to the middle of the forehead. The resident remained responsive. 911 was called and in route. Dr. (name) was also notified and wanted the resident transferred to the hospital . DON BB stated she responded to the fall because the only nurse on duty on 5/4/2021 was at lunch. A review of staffing schedules and individual staff punch sheets revealed that the facility had only one nurse working on the following dates and times: 5/4/2021 (census of 69) between 7:00 AM and 7:00 PM 5/9/2021 (census of 65) between 7:00 AM and 2:30 PM 6/4/2021 (census of 67) between 9:00 PM and 12:15 PM on 6/5/2021 6/5/2021 (census of 66) between 12:16 PM and 7:00 PM When interviewed Confidential Staff Informant #1 said, A lot of the residents don't get meds right because there is no one to give it to them. Sometimes I won't see a nurse (on the unit) my entire shift. When interviewed Confidential Staff Informant #2 said, Residents will ask for meds. I have to go to another unit to ask the nurse for the residents' meds and the residents have to wait a long time. When interviewed Confidential Staff Informant #3 said, Wound dressings haven't been done. I will come on shift and will be the only nurse and because of that wound care is further delayed because of med pass. Resident #1 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of an Admission Record revealed, Resident #1 admitted to the facility with pertinent diagnosis which included Schizophrenia (mental disorder), Adjustment Disorder, and Central Cord Syndrome (loss of movement and sensations in arms and hands). Review of a Minimum Data Set (MDS) assessment, with a reference date of 3/12/21 revealed Resident #1 had severe cognitive impairment, with a Brief interview for Mental Status (BIMS) score of 2, out of a total possible score of 15. Review of a Medication Administration Record (MAR) for Resident #1 revealed: Medications that were not passed on 6/5/2021 included an anticonvulsant, antibiotic, antianxiety, and antipsychotic. Resident 8 (R8) On 6/6/21 at 11:44 A.M, R8 complained frequently his food was served cold and on last night (Saturday 6/5/2021) meals were served very late because the food cart had been left on the elevator. R8 reported the food cart was left on the elevator for over an hour and there was no nursing staff to pass the trays on the 1 North Hall. R8 continued stating, his grits at breakfast were sometimes so cold they jelled because there may be only one nurse aide or nurse to pass their trays. R8 stated: There is not enough staff and on 6/5/21 for dinner the nurse was not available for residents on this hall. Review of the Admission Record for R8 documented the resident was admitted to the facility on [DATE] with diagnoses which included: Tear of Lateral Meniscus injury, osteoarthritis of the knee, hypertension, and age-related physical debility. The MDS dated [DATE], documented R8 had a BIMS of 15/15 (intact thought process). The resident was identified as being independent for eating and required set up only. Resident #16 (R#16) During interview on 6/6/21 at 9:30 AM, R#16 stated, There is never enough staff here and we don't get medications on time and sometimes not at all. Record review of R#16's Admission Record on 6/7/21 revealed resident was admitted into facility on 2/9/21 with diagnoses that included morbid obesity, mild persistent asthma (respiratory disease) and pain in right knee. According to the MDS dated [DATE], R#16 had intact cognition and was extensive to total dependence with Activities of Daily Living (ADLS). Record review of R#16's MAR for 5/9/21 at 9:00 AM revealed medications that were not signed out as administered included an antipsychotic, diuretic for hypertension, and two antipsychotics. Resident #19 Review of an Admission Record revealed, Resident #19 originally admitted to the facility with pertinent diagnosis which included Frontotemporal Dementia (affects behavior and language), Mood Disorder, Adjustment Disorder, and Chronic Subdural Hemorrhage (bleeding in brain). (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of a MDS assessment, with a reference date of 2/13/21, revealed Resident #19 had severe cognitive impairment. Review of a MAR for Resident #19 revealed medication not passed on 6/5/2021 included an anticonvulsant and antipsychotic. Resident 20 (R20) Review of the Admission Record revealed R20 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease, epilepsy, diabetes mellitus, hypertension, and peripheral vascular disease. According to R20's May 2021 MAR, medications not passed on 5/4/2021 included an anti-hypertensive, anti-coagulant, anti-convulsant, fast-acting insulin per sliding scale, long-acting insulin, and pancreatic enzymes. Medications not passed on 5/9/2021 included an anti-coagulant, anti-convulsant, fast-acting insulin per sliding scale, anti-hypertensive, and pancreatic enzymes. According to R20's June 2021 MAR, medications not passed on 6/5/2021 included an anti-hypertensive, anticoagulant, anticonvulsant, fast-acting insulin per sliding scale, long-acting insulin, and pancreatic enzymes. Resident #22 Review of an Admission Record revealed, Resident #22 originally admitted to the facility with pertinent diagnosis which included Dementia and Hypertension. Review of a MDS assessment, with a reference date of 4/3/21 revealed Resident #22 had cognitive impairment, with a BIMS score of 11, out of a total possible score of 15. Review of a MAR for Resident #22 revealed medications not passed on 6/5/2021 included an antihypertensive, anticoagulant, and antipsychotic. R27 Review of the Admission Record revealed R27 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction, end stage renal disease, hypertension, unspecified convulsions, and diabetes mellitus. According to R27's May 2021 MAR, medications not passed on 5/4/2021 included an anticoagulant, anticonvulsant, anti-hypertensive, and fast-acting insulin per sliding scale. Medications not passed on 5/9/2021 included an anticoagulant, anticonvulsant, anti-hypertensive, and fast-acting insulin per sliding scale. According to R27's June 2021 MAR, medication not passed on 6/5/2021 included an antibiotic, fast-acting insulin per sliding scale. Resident #32 R(#32) During interview with R#32 on 6/6/21 at 8:42 AM, R#32 stated, They (facility) needs more help. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of R#32's Admission Record, revealed an original admission into facility on 4/6/20 with diagnoses that included peripheral vascular disease (poor circulation), hypertension (high blood pressure) and Type 2 diabetes. According to the MDS dated [DATE], R#32 had intact cognition and needed supervision with most ADLs. Record review of R#32's MAR for 5/9/21 revealed the following 9:00 AM medications were not signed out as administered an antiplatelet and antihypertensive. Resident #36 (R36) On 6/6/21 at 11:44 A.M. during the initial tour and on 6/7/21 at 2:00 P.M., R36 complained on Saturday, 6/5/2021, the dinner trays were left on the elevator for over an hour because there was no nursing staff to pass trays. R36 stated: It's not enough staff to take care of the residents. Food is served cold, and we end up waiting for our medications because the nurse is on the other side passing those residents their medications. R36 commented: Sometimes (R8 in the room across the hall) responded to his call light because nursing staff was on another floor. Review of the Admission Record for R36 indicated the resident was admitted to the facility on [DATE] with diagnoses that included: chronic obstructive pulmonary Disease, convulsions, chronic pain, Bipolar Disorder, cerebral infarction affecting left non-dominant side and malignant neuroleptic syndrome. Review of the MDS dated [DATE] documented R36 had a BIMS of 15/15 (intact thought process), was independent for eating and required set up only. Review of the May 2021 MAR For R36 revealed medication not passed on 5/4/2021 included an inhaler. Medications not passed on 5/9/2021 included a pain medication, inhaler, antihistamine, antihypertensive agent, antipsychotic and antianxiety. Resident 38 (R38) Review of the Admission Record for R38 indicated the resident was admitted to the facility on [DATE], with diagnoses that included: Covid-19, rheumatoid arthritis, chronic obstructive pulmonary disease, severe protein calorie malnutrition and alcoholic hepatitis with ascites. On 6/7/21 at 10:30 A.M., review of the MDS dated [DATE], documented R#38 had a BIMS of 15/15 (intact thought process) required limited assistance with eating. Review of R38's May 2021 MAR indicated medications not passed or administered as ordered on 5/4/21 included a duragesic patch, inhaler, antihistamines, pain medication, controlled pain medication. On 6/6/21 at 11:44 A.M., R38 approached the surveyor and stated: There is not enough staff. The resident continued to follow the surveyor and commented: On 6/5/21 at the dinner meal he was the last resident to receive his tray because there was not enough nursing staff, and the nurse could not be located to inquire about his food. R38 asked to be interviewed later (6/7/21) after smoking time. R38 stated he had requested for the carton containers on his tray to be opened because of his arthritis but on 6/5/21 he could not open the carton. Pointing to the unopened milk cartons on the bedside table, the resident stated: No one could help me there was no staff downstairs. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 6/7/21 at 1:17 P.M. during an interview with Dietary Cook O concerning the delivery of the resident's meals tray on 6/5/21. Cook O stated: Around 6:30 P.M. She went to the first floor to return the food cart to the kitchen. The Cook discovered the one North Food Cart still on the elevator with approximately 10-12 resident's trays that had not been served. Cook O was instructed by her supervisor and the Administrator (who were contacted by phone) to pass the trays to the residents. Cook O stated: there was no nurse or Aide on the floor. I passed the trays as I was instructed by the Union Steward. In a subsequent Interview Dietary Manager H confirmed Cook O had been directed to pass the resident's their trays on the one North hall on 6/5/21. On 6/17/21 at 2:20 P.M. during an interview, DON BB stated on 6/5/2021 there was a staff shortage but provided no other reasons why the nurse aides assigned to the floor did not pass trays to the residents on the 1 North hall. Resident 39 (R39) Review of the Admission Record for R39 indicated the resident was admitted to the facility on [DATE] with diagnoses of Covid-19, hypoxemia, schizophrenia, dementia, behavior disturbance, seizures, essential hypertension, and acute respiratory failure with hypoxia. Review of R39's June 2021 MAR indicated medications not passed on 6/4/2021 included an inhaler, antihypertensive agent, anti-seizure medication, and neuropathic (nerve) pain agent. Medications not passed on 6/5/2021 included a mood stabilizer, antihypertensive agent, anti- seizure, and neuropathic (nerve) pain agent. Resident #42 (R#42) During interview on 6/6/21 at 8:50 AM, R#42 stated, Sometimes we don't get medications like we are supposed to, and they sure don't have enough staff. Record review of R#42's Admission Record revealed admission into the facility on [DATE] with diagnoses of Type 2 diabetes, congestive heart failure, hemiplegia (paralysis). According to the MDS dated [DATE], R#42 had intact cognition and was extensive assist with personal hygiene. Record review of R42's May 2021 MAR for 5/9/21 at 9:00 AM revealed the following medications were not signed out as administered two antihypertensives, anti hyperglycemic, antiplatelet, and antipsychotic. Resident #44 (R#44) Review of an Admission Record revealed, Resident #44 originally admitted to the facility with pertinent diagnosis which included Vascular Dementia, Schizoaffective disorder, Anxiety, Epilepsy (causes seizures) and Type 2 Diabetes. Review of a MDS assessment, with a reference date of 4/29/21 revealed Resident #44 had severe cognitive impairment with a BIMS score of three, out of a total possible score of 15. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of R#44's May 2021 and June 2021 MARs revealed the following medication were not passed. May 4, 2021 included a fast acting insulin and June 4 2021 included an anticonvulsant, antianxiety, fast acting insulin, long acting insulin, antidepressant, and anti-tremor. Resident #51 (R#51) During interview on 6/6/21 at 8:50 AM, R#51 stated, I have to ask for medications they(facility) take forever to get them delivered. Record review of R#51's Admission Record revealed admission into the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, malignant neoplasm (cancer) of tongue, major depression. According to the MDS dated [DATE], R#51 had intact cognition and was independent with most ADLs. Record review of R51's MAR for 5/9/21 at 9:00 AM revealed R51's anti-hypertensive medication was not signed out as administered Resident 52 (R52) Review of the Admission Record revealed R52 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included epilepsy, sepsis, end stage renal disease, cerebrovascular disease, and pressure ulcer. Record review of R51's MAR for 6/5/2021 revealed medications not passed included an antibiotic, anticonvulsant, and anticoagulant. Resident #56 Review of an Admission Record revealed, Resident #56 admitted to the facility with pertinent diagnosis which included Diffuse Traumatic Brain Injury (rapid shift of brain) and Mood Disorder. Review of a MDS assessment, with a reference date of 5/21/21 revealed Resident #56 had severe cognitive impairment. Record review of MARs for Resident #56 revealed: Medication not passed on 5/4/2021 included an anticoagulant. Medication not passed on 6/4/2021 included an anticoagulant and antipsychotic. R172 Review of the Admission Record revealed R172 was admitted on [DATE] with diagnoses that included osteomyelitis, diabetes mellitus, and epileptic seizures. Record review of R172's MAR for 6/5/2021 revealed medications not passed included an IV antibiotic, muscle relaxant, and insulin per sliding scale. R173 (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Admission Record revealed R173 was admitted on [DATE] with diagnoses that included diabetes mellitus, intracardiac thrombosis, cerebral infarction, major depressive disorder, anxiety disorder, hypertension, and schizoaffective disorder bipolar type. Record review of R173's MAR for 6/5/2021 revealed medications not passed included an anticoagulant, anticonvulsant, antihypertensive, long-acting insulin, and fast-acting insulin per sliding scale. During an interview 6/15/21 at 10:23 AM, DON BB confirmed being the only nurse on duty on 5/9/21 from 7:00 AM to 2:30 PM. On 6/15/2021 at 4:05 PM, during an interview, Nursing Home Administrator (NHA) AA stated they did not have an emergency staffing plan. She said, We're still working on trying to get it where it meets the needs of the facility. When asked if she had a plan to show me, NHA AA said, No. A telephone interview was conducted with the facility's Consultant Pharmacist (CP) JJ on 6/15/2021 at 3:17 PM. CP JJ provided the following information regarding the clinical implications of missed or untimely medication administration for the following medications: -anticonvulsants: if being used for seizures it should be given on a timely basis. If it is used as a mood stabilizer, it is less critical but should not be delayed more than two hours. -anticoagulant: if being used as a prophylactic, it is a good practice to stay within plus or minus one hour of the designated administration time. -antipsychotics should be given as prescribed because it is being used for psychosis. -pancreatic enzymes: for the sake of the patient, they should be given regularly, or the patient may experience diarrhea. -insulin: timing is very important. Long-acting insulin should be administered within plus or minus one hour of the designated administration time. Fast-acting insulin should be administered 15 minutes before mealtime or with a meal. On 6/17/2021 at 10:33 AM, when the Director of Nursing was interviewed regarding staffing concerns identified during the survey, she said, I anticipated it, because we have a staffing crisis. I've been in the building as the only nurse, and I know how difficult it is. This is a direct result of not having enough staff. A review of the facility policy titled, Nursing Services and Sufficient Staff, undated, documented the following: It is the policy of the facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident . Providing care includes, but is not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 6/15/2021 at 4:35 PM, NHA AA was verbally notified and received written notification of the immediate jeopardy that began on 5/4/2021 and was identified on 6/15/2021 due to the facility's failure to provide sufficient staffing to meet resident needs. The following written plan for removal for the immediate jeopardy was received and verified on 6/16/2021. 1. The facility staffing levels were adequate on 6/15/21 and the resident clinical needs were met as evidenced by the MAR's/TAR's (Medication Administration Record and Treatment Administration Record) completed. 2. The Social Worker interviewed 39 residents with BIMS (Brief Interview for Mental Status) score of 9 or higher for potential neglect on 6/15/21. There were no negative outcomes. 3. Nursing initiated a physical assessments for 28 residents with BIMS score of 8 or below for potential neglect on 6/15/21. There (were) no negative outcomes. 4. Facility staffing policies and procedures were reviewed/revised on 6/15/21. 5. The Emergency Staffing policy was reviewed and revised to include the procedure to address resident clinical needs in the event there are call offs which only leaves (1) nurse in the facility. 6. The policy, (item 4 (e) which now states, The Director of Nursing, Unit Managers, Staffing Coordinator and Administrator will be expected to report to work in the event there are call-offs or no shows of licensed nurses resulting in only one nurse in the building. The Director of Nurses and Unit Managers will facilitate and assist with resident needs based on diagnosis and overall quality of care/acuity of current resident population. 7. The Emergency Contingency Plan was reviewed and revised on 6/16/21. 8. A staff Town Hall meeting was initiated by the Administrator on 6/15/21 to provide education and facility staffing policies and procedures. Town hall meetings will be held monthly to provide updates to staff, as well to receive staff feedback and input. 9. A corporate consultant began providing oversight on 6/15/21 of staffing and provides weekly facility visits. Visits will continue weekly for at least 3 months. 10. The Administrator reviewed and revised the Facility Assessment on 6/15/21 and the staffing patterns were adjusted accordingly. Nursing Managers rotate weekends for nursing staffing/scheduling. 11. The facility is actively .recruiting nurses and nurse aides. There were (2) LPN's in orientation on 6/15/21 and (1) LPN interviewed on 6/15/21. 12. The facility is initiating additional staffing resources/agencies, as needed to keep staffing numbers in acceptable parameters. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Although the Immediate Jeopardy was removed on 6/15/21, the facility remained out of compliance at a scope widespread and severity of no actual harm with the potential for more than minimal harm that is not an immediate jeopardy due to sustained compliance could not be verified by the state agency. 15194 38208 39958

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 This Citation Pertains to Intake MI00111786 Based on observation, interview and record review the facility failed to follow the procedure for reconciling controlled substances (drugs that have high potential for abuse) in the medication storage room and medication carts, resulting in a drug diversion and the potential for drug diversion to go undetected. Findings include: It was reported to the State Agency on 4/8/20 that the Director of Nursing (DON) became aware of a drug diversion from the facility backup narcotic (controlled substance) box on 4/7/20. In an observation and interview on 6/7/21 at 11:11 a.m., a box that contained controlled substances had a green tag. Licensed Practical Nurse (LPN) A reported when a controlled substance is taken from the backup box the nurse must call the physician and the pharmacy. LPN A then reported two nurses should be present to remove control substances and complete the Emergency Drug Kit Slip. LPN A reported the controlled substance backup box is delivered with a green tag and when it is opened replaced with a red tag. The backup box tags are not observed daily, only when something is removed per LPN A. In an interview on 6/7/21 at 8:39 a.m., Administrator AA reported being unaware of the drug diversion which occurred in April 2020. Administrator AA reported they did not have the FRI (Facility Reported Incident) related to the incident. In an interview on 6/8/21 at 5:06 p.m., Director of Nursing (DON) BB reported they could not find the QAPI (Quality Assurance & Performance Improvement) report on the drug diversion. Review of a Police report with a date of 4/9/20 at 3:20 p.m. revealed, the facility representative states the listed items were last counted on 4/6/20 at 6:00 a.m. Items were discovered missing on 4/7/20 at 8:30 a.m. The facility representative stated there are cameras in the facility but not in the medication room . Property Description: 15- Hydrocodone/APAP 5/325 mg (miligram) (pain medication) 10-Xanax 0.25 mg (for anxiety) 10-Tylenol 3 (pain medication) 4-Fentanyl 12 MCG (microgram) (pain patch) 5-Fentanyl 25 MCG (pain patch) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5-Fentanyl 50 MCG (pain patch) 5-Fentanyl 75 MCG (pain patch) 5-Fentanyl 100 MCG (pain patch) 10-Morphine Sulfate Quick Release 30mg (pain medication) 15-Hydrocodone/APAP 10/325 mg (pain medication) 4-Hydrocodone/APAP 7.5/325mg (pain medication) 2-Morphine 20 mg Bottles (pain medication) Review of Narcotic Reconciliation forms for April 2020 revealed, on 4/3/20 all controlled substances were accounted for. On 4/7/20 the following medication were not accounted for: 15- Hydrocodone/APAP5/325 mg 10-Xanax 0.25 mg 9 -Tylenol 3 4-Fentanyl 12 MCG 5-Fentanyl 25 MCG 5-Fentanyl 50 MCG 5-Fentanyl 75 MCG 5-Fentanyl 100 MCG 10-Morphine Sulfate Quick Release 30mg 15-Hydrocodone/APAP10/325 mg 4-Hydrocodone/APAP 7.5/325mg 2-Morphine 20 mg Liquid Review of a Controlled Medications Shift Change form for 1 North medication cart revealed, the number of partial or full control substances were no documented for 6/14/21 - 6/16/21. LPN A reported controlled substances should be signed out when removed. Review of a Controlled Medications Shift Change form for 1 South medication cart revealed, the number of partial or full control substances were no documented for 6/14/21. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a Controlled Medications Shift Change form for 2 North medication cart revealed, the number of partial or full control substances were no documented for 6/10/21 and 6/15/21. In an observation on 6/16/21 at 11:49 a.m., the controlled substance backup box sat on top of a cart in the medication storage room and was not under double lock. LPN A reported she told the two nurses to lock it (backup box) up when they were finished. In an interview on 6/17/21 at 8:47 a.m., LPN AAA reported controlled substances are counted by two nurses at the beginning and end of the shift and must be documented. In an interview on 6/17/21 at 8:49 a.m. DON BB reported at the beginning and end of the shift nurses are expected to count and document all controlled substances. DON BB then reported the controlled substance backup box should be under double lock. In an interview on 6/17/21 at 11:47 a.m., Administrator AA reported she has no additional information on the drug diversion from last year. Reported the only additional information she had was provided in the police report. The consultant reported they contacted the previous Admin and tore the office apart looking for the info. The Admin reported there has not been any other incidents related to drug diversion. Stated [NAME] would have let me known. In an interview on 6/17/21 at 1:23 p.m., Pharmacist BBB reported she recalled the incident for the drug diversion. Pharmacist BBB then reported the incident was fully investigated by the facility and the pharmacy. Review of a Report of Theft or Loss Controlled Substances form with a date of 4/7/20 revealed, Employee Pilferage (stealing) checked for type of loss. Review of an STAT (immediate) Box Delivery Log with a date of 4/2/20 revealed, one narcotic box was delivered to the facility. Review of a Controlled Substance Administration & Accountability Policy with no date revealed, Policy: It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion, or accidental exposure . Policy Explanation and Compliance Guidelines . f. All controlled substances (Schedule II, III, IV, V) are account for in one of the following ways . ii. All control substances obtained from a non-automated medication cart or cabinet recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided . j. The charge nurse or designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify i. Controlled substances that are destroyed are appropriately documented; and ii. Medications removed from either the automated dispensing system or medication cart/cabinet have a documented physician order .

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F 0756 Level of Harm - Minimal harm or potential for 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. 39958 Based on observation, interview, and record review the facility failed to ensure that a physician responded to pharmacist Medication Regimen Review (MRR) recommendations consistently for one residents (Resident #22) of five residents reviewed for a medication regimen review, resulting in the potential for the continuance of unnecessary medications and lack of communication of recommended medication changes. Findings include: Review of an Admission Record revealed, Resident #22 originally admitted to the facility with pertinent diagnosis which included Dementia. Review of a Minimum Data Set (MDS) assessment, with a reference date of 4/3/21 revealed Resident #22 had cognitive impairment, with a Brief interview for Mental Status (BIMS) score of 11, out of a total possible score of 15. Review of Pharmacy Medication Regimen Review recommendations for Resident #22 revealed: - February 2021- Thiamine stores should be replete by now, suggest we stop. The document had no signature or Physician/Prescriber Response. - March 2021- Thiamine stores should be replete by now, suggest we stop .Request #2. Please change famotidine 20 mg qam (every morning) to 20 mg qhs (at bedtime) to optimize efficacy. The document had no signature or Physician/Prescriber Response. - April 2021- Thiamine stores should be replete by now, suggest we stop .Request #3. Please change famotidine 20 mg qam to 20 mg qhs to optimize efficacy .Request #2. The document had no signature or Physician/Prescriber Response. - May 2021- Thiamine stores should be replete by now, suggest we stop .Request #4. Please change famotidine 20 mg qam to 20 mg qhs to optimize efficacy .Request #3 The document had no signature or Physician/Prescriber Response. - June 2021- Please change famotidine 20 mg qam (every morning) to 20 mg qhs (at bedtime) to optimize efficacy . Request #4. Review of a Physician Order revealed, Famotidine 20 mg Give 1 tablet by mouth one time a day with a administer time of 0900 (9:00 a.m.) with a discontinued date of 6/14/21.Thiamine 100 mg Give 1 tablet by mouth one time a day with a discontinued date of 6/14/21. In an interview on 6/14/21 at 12:15 p.m., Director of Nursing (DON) BB reported the MRR were not completed because she is the only one to handle them.

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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** 41741 Based on observation, interview, and record review the facility failed to maintain sanitary food contact and non-food contact surfaces resulting in potential cross contamination. This deficient practice has the potential to affect all 67 residents in the facility. Findings include: During the initial kitchen tour on 06/06/21 at 08:41 AM, the following was observed: 1. Black sticky residue and trash debris on the floor of the dry storage room. When queried Certified Dietary Manager (CDM) G advised the porter called off today, but we just hired a new relief porter who is completing training and once he is done it will be cleaned weekly like it is scheduled. CDM G also advised the last porter left on 05/15/21, but the storage room has been cleaned since then. According to the 2013 FDA Food Code, 6-501.12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing. 2. Four burnt out light bulbs in the dry storage room. When queried CDM G advised maintenance knows about the lights being out. CDM G advised maintenance request are put in the maintenance request book or we walk down the hall and tell the maintenance director. 3. Heavy grease deposits on the stove hood filters. When queried CDM G advised the filters are cleaned quarterly by the company that comes out. During an interview on 06/08/21 at 12:55PM Maintenance Director (MD) RR advised do not have any documentation regarding when the stove hood filters were serviced. MD RR stated, me and the food service manager dropped the ball on this, because the company has not been out since 2019, apparently the ladies have been taking the filters down and cleaning them. 4. Grease deposits and food debris in the microwave. According to the 2013 FDA Food Code, 4-602.12 Cooking and Baking Equipment. (B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. 5. Food debris at the bottom of refrigerators 6 and 7. When queried CDM G advised the refrigerators were cleaned at the end of May 2021. 6. Black specks inside the roof of the ice machine. When queried CDM G advised the company came out and cleaned it but would have to talk more with maintenance because they would have the log. During an interview on 06/08/21 at 10:55 AM Maintenance Director RR stated, ice machines are on a monthly cleaning schedule and I clean them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During review of the facility's [NAME] Nursing Center Ice Machine Cleaning Checklist it stated Task: Clean & Sanitize Ice Machine, By: [Employee name], When: 5/15/21. According to the 2013 FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: . (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cleaned: . (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. 7. Two burnt out lightbulbs above the tray line and two burnt out light bulbs above the tray line reach in refrigerator. During an interview on 06/06/21 at 12:00 PM CDM G advised there is no cleaning schedule or policy, the porter gets a list of things to do every Wednesday, the task differs depending on what needs to be cleaned. On 06/06/21 at 02:27 PM observed food debris and dry yellow liquid in the refrigerator designated for food brought in for residents. When queried Unit Manager A advised the refrigerator is cleaned out by the midnight nurse on Fridays.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 41741 Based on observation, interview, and record review the facility failed to properly maintain the exterior garbage disposal area in a clean and sanitary manner, resulting in the potential for the attraction of pests and rodents. This deficient practice has the potential to affect all 67 residents in the facility. Findings include: On 06/16/21 at 08:20 AM observed twelve wooden pallets, three black manual wheelchairs, one motorized wheelchair, one Geri-chair, two white bins, one blue bin, two white bed frames, two brown bed frames, a 3-drawer wooden nightstand, a gray two shelf cart, a green broom, and a small black garbage can surrounding the exterior garbage dumpster. During an interview on 06/16/21 at 08:55 AM Maintenance Director (MD) RR advised currently looking for a scrap company to pick up the items but have not been able to find one yet. MD RR advised maintenance is responsible for cleaning around the exterior of the dumpster but no written policy. MD RR stated, I try to place as many items as I can in the dumpster every week to clear out some of the area.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 15194 Based on interview and record review the facility Nursing Home Administration (NHA) AA failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable, physical,mental and psychosocial well-being of each resident, resulting in medications and wound treatments not being provided appropriately, worsening of pressure sores, unsafe unsanitary environment, inadequate supervision and insufficient staffing. This deficient practice had the potential to affect all 67 residents within the facility. Findings include: In an interview on 6/17/21 at 2:15 P.M. Administrator AA reported the facility had been utilizing agency staff to provide care to the residents of the facility. Administrator AA stated: Staffing had been a challenge since the first of 2021. The administrator was queried whether operating budget cuts had affect nurse staffing? NHA AAresponded, There had not been in budget decreases for direct care staff but other auxiliary departments and services may have been reduced. The Administrator denied knowing the extent of insufficient nurse staffing on 5/4, 5/9, 6/4 and 6/6 when the facility had only one nurse in the facility (per staffing Posting). The insufficient staffing contributed to inadequate supervision which potentially created and unsafe, unsanitary environment for the residents. When asked if the communication to the governing body was done in a written notice the Administrator responded NO we communicate verbally. According to the Administrator the governing body was aware of the insufficient staffing issues in the facility but was unaware of medications missed or not being given as ordered, concerns with wounds and pressure ulcers, and insufficient supplies such as urinals and toothbrushes.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 15194 Based on observation, interview and record review the facility's governing body failed to engage in operational oversight of the facility, resulting in three immediate Jeopardizes (IJ) due to systemic, widespread non-compliance in Quality of Care, Insufficient Staffing and worsening of pressure ulcers. This deficient practice resulted in the likelihood of serious harm and/or death for all 67 residents in the facility. Findings include: In an interview on 6/17/2021 at 2:50 P.M. during an interview with the Financial Controller (FC) L (speaking on behalf of the governing body) stated,The Administrator (NHA AA) had been directed not to reduce direct care staff but there had been reduction of staff in Nutrition Services and some vacant positions in Nursing which had not been filled. FC Lwas unable to identify how frequently the Administrator had communicated with the governing body concerning inadequate staffing in the facility. In addition, there was no evidence presented demonstrating collaboration between the facility administration and governing body concerning the implementation of an emegency staffing plan due to inadequate staffing. FC Lwas queried concerning the governing body's involvement in the development and implementation of the Facility's Assessment revised on 6/16/21, after the first IJ and if there would be any reduction of residents in the facility due to insufficient staffing and the emergency staffing plan be implemented? The controller responded there maybe some changes but that has not been decided.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 15194 Based on interview and record review the facility failed to ensure the Medical Director (MD K) fulfilled his responsibility of implementing resident care policies and ensure current professional standards of practice were utilized. This deficient practice affected all 67 vulnerable residents. Findings include: In an interview on 6/17/21 at 2:30 P.M. with the Medical Director (MD) K (via telephone) he stated,he had signed a contract with the facility sometime in August/September of 2020. The Medical Director indicated he never received a job description but he thought he could make a difference for this vulnerable population. The Medical Director (MD) K explained his job duties only included attending the Quality Assurance Meetings (held Monthly) and review of the plan of correction after a survey by the State Agency. The Medical Director (MD) K stated, On occasions he responded to telephone calls from the facility staff when the Attending doctor wasn't available but never implemented, signed or participated in the development of any resident care policies. Through his involvement in The Quality Assurance (QA) meetings the Medical Director identified that the facility required lots of commitment and time due to frequent managerial changes and the concerns presented in the QA meetings. A copy of the Medical Director's responsibilities was requested and provided. The undated, unsigned document stated: The facility retains a physician designated as Medical Director, to coordinate the medical care provided by attending physicians, and to assist with development and implementation of resident care policies. The Medical Director's responsibilities include participation in: a). Administrative decisions including recommending, developing, and approving facility policies related to resident care of physical, mental and psychosocial well-being. b). Issues related to the coordination of medical care identified through the facility's QA committee and other activities related to the coordination of care c). Organizing and coordinating physician services and services provided by other professionals as they relate to resident care. d). Participate in QA Committee.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 Based on observation, interview and record review the facility failed to maintain complete and accurate medical records (feeding tube status) for one resident (Resident #56) of 22 sampled residents reviewed for medical records, resulting in the potential for providers lacking pertinent information to care for residents. Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing.High-quality documentation is necessary to enhance efficient, individualized patient care. Quality documentation has five important characteristics: it is factual, accurate, complete, current, and organized . Accessed from: Kindle Locations 24106-24108). Elsevier Health Sciences. Kindle Edition. Resident #56 Review of an Admission Record revealed, Resident #56 admitted to the facility with pertinent diagnosis which included Dysphagia (difficulty swallowing), Aphasia (difficulty speaking), and Adult Failure to Thrive. Review of a Minimum Data Set (MDS) assessment, with a reference date of 5/21/21, revealed Resident #56 had severe cognitive impairment and a feeding tube. In an interview on 6/8/21 at 8:09 a.m., Unit Manager (UM) HH reported Resident #56 does not have a PEG tube (feeding tube inserted in stomach). In an observation on 6/8/21 at 8:10 a.m., Resident #56 laid in bed in their room. No feeding tube was noted in the abdomen (stomach). Review of a Progress Note for Resident #56 with a date of 5/14/21 revealed Significant wt (weight) loss . Receives: TF (tube feeding) and p.o. (by mouth) diet of Pureed . Review of a Physician Progress Note with a date of 5/4/21 revealed .ASSESSMENT/PLAN: Adult failure to thrive with dysphagia requiring peg tube- Nutrition consulted; Started on tube feeding . written by Physician Assistant (PA) NN. In an interview on 6/14/21 at 10:49 a.m., UM HH reported on 2/13/21 Resident #56's PEG tube came out and they could not get in back in. In an interview on 6/14/21 at 10:54 a.m., Director of Nursing (DON) BB reported Resident #56 does not have a PEG tube. DON BB then reported Resident #56 used to have a feeding tube, but it was removed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Incident Report, with a date of 2/13/21, revealed Resident #56 pulled out the feeding tube. Per the report .Nurse tried to put the tube back, but unsuccessful, DON and doctor were notified. In an interview on 6/14/21 at 12:36 p.m., Physician MM reported Resident #56's PEG tube was discontinued. Physician MM reported they physically look at the residents when they complete the visit. Physician MM stated, I did D/C (discontinue) that PEG tube myself. Physician MM reported they decided not to put the PEG tube back in because Resident #56 was eating. Review of a Dietary Profile Assessment for Resident #56 with a date of 3/3/21 revealed .Res (resident) pulled out his PEG tube on 2/13/21 . In an interview on 6/14/21 at 4:26 p.m., PA NN reported the Physician Progress Note for Resident #56, dated 5/4/21, was inaccurate. In an interview on 6/15/21 at 11:01 a.m., Registered Dietitian OO reported Resident #56 had a feeding tube in the past, but no longer has one in place.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview and record review, the facility failed to ensure communication/documentation of Hospice services provided to one (#36) of one reviewed for hospice services of a total of 22 sampled residents, resulting in a lack of coordination of comprehensive services and care provided to the resident. Findings include: On 6/6/21 at 4:00 P.M. review of the Admission Record for R36 revealed the resident was admitted to the facility on [DATE] with diagnosis that included chronic obstructive pulmonary disease, (a lung disease resulting in constriction of the airway) shortness of breath, convulsions, chronic pain, bipolar disorder, cerebral infarction (stroke), hemiplegia, hemiparesis and anxiety disorder. A review of the Minimum Data Set assessment dated [DATE], revealed R#36 had a BIMS 15/15 (intact thought process) and required the assistance of one person to perform activities of Daily living. A Social Service Note dated 5/20/21 revealed R#36 had requested to meet with the Hospice nurse in person and the Social Worker was in the process of facilitating the resident's request. Further review of the clinical records indicated hospice consult was initiated on 1/20/21 and a Hospice agreement was signed by Resident#36 on 1/22/2021. On 6/6/at 5:00 P.M. Licensed Practical Nurse A was asked if the hospice communication binder could be reviewed. Licensed Practical Nurse A searched the cupboards and presented a white binder identifying the company and the contact number for the hospice company. The binder was opened and there was no content inside of the binder. Licensed Practical Nurse A who was observing, was queried concerning the contents of the empty binder. Licensed Practical Nurse A explained visits and all pertinent documentation from the hospice company should have been filed in the binder after every visit however, that information was only accessible to the Director of Nursing. The Hospice nurse was contacted by phone utilizing the information on the front of the binder .Hospice Nurse J identified herself as the nurse responsible for Hospice visits for R#36. Hospice Nurse J was asked how was care and services communicated between the facility and the hospice company? Hospice Nurse Jstated: My last visit with R#36 was on 6/1/21 and during each visit she communicated her concerns to the Director of Nursing (DON). When asked if there was any documentation related to the visits and care of R#36 Hospice Nurse Areported there were lots of notes/visits, which the Director of Nursing (DON BB) had access, but no documentation had been provided to the facility or placed in the hospice binder. In an interview on 6/14/21 at 10:46 A.M. DON BB was queried concerning the hospice binder and the communication between the facility staff and the hospice company. DON BB stated: The hospice nurse did communicate with her during visits with (R#36) but the written visits, contact information, pertinent documents had only been accessible to her. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility' hospice service agreement (Hospice Services), dated September 1, 2020 under subtitle, Communication Protocol The shall work together to develop a written communication protocol governing how they will communicate all information needed for residents care . (such as physician orders and medical information) including how such communication will be documented to ensure that the needs of residents are addressed and met 24 hours a day.

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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. 15194 Based on interview and record review the facility failed to implement an effective Quality Assurance Program that developed, identified, and implemented appropriate plan of actions to correct systemic deficiencies related to the Quality of Care and Quality of Life for residents, resulting in residents' complaints of unmet care needs due to a shortage of staff and preventative measures for wound care not being implemented. Findings include: On 6/17/2021 at 3:00 P.M. during an interview with the Administrator, the Quality Assurance Coordinator stated: deficiencies related to insufficient staffing were addressed and identified. There was no corrective plan of action available for review. There was no collaborative effort demonstrated by the Governing body to assist or provide ongoing monitoring in assuring corrective measures were consistently available and executed related to insufficient staffing, providing Activities of Daily Living and repeated quality of care Indicators. The Administrator indicated the facility had an ongoing Quality Assurance Committee which met monthly. The Committee included all Department Managers and the Medical director. There was no evidence of involvement of the Medical Director in ensuring the infection control practices were monitored and implemented. The facility's Quality Assurance Program did not demonstrate or address mechanisms or systems in place to address infection related adverse events for residents, requiring wound care and treatment. This deficiency and lack of follow through resulted in residents being transferred to the hospital for additional care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 38208 This citation pertains to Intake MI00119500 Deficiency Practice Statement A Based on observation, interview and record review the facility failed to: 1.) adhere to their infection control protocols to prevent the spread of COVID-19 and 2.) ensure adequate hand hygiene during resident care in 1 of 22 residents (REsident #44) reviewed for infection control, resulting in the potential of the spread of infections effecting all residents and staff. Findings include: On 6/6/21 at 8:05 AM, five surveyors were allowed entry to the building without being questioned for Covid-19 exposure and temperatures were not requested to monitor for possible infection. On 6/14/21 at 10:20 AM, an observation of Nurse A wearing mask below nose and mouth while providing care was observed. On 6/17/21 at 1:20 PM, an observation of Nurse A wearing mask below nose and mouth while providing care was observed. Nurse A was interviewed, and confirmed mask should be worn over mouth and nose when providing care to residents. On 6/17/21 at 1:20 PM, an observation of Nurse A wearing mask below nose and mouth while providing care was observed. Nurse A was interviewed, and confirmed mask should be worn over mouth and nose when providing care to residents. On 6/17/21 at 11:15 AM, during record review of facility's infection control surveillance had revealed no documentation for the month of June related to Resident #32 who had been started on antibiotic on 6/5/21 or any other residents that were being monitored for infection control issues. It was revealed that the antibiotic stewardship was not being followed related to Mcgreers Criteria (A guideline used by facilities to monitor antibiotic use). During interview on 6/17/21 at 11:20 AM, Director of Nursing (DON BB) confirms that Infection control protocols have not been followed consistently. DON BB confirms that all visitors and staff should be questioned for Covid 19 exposure and temperatures should have been obtained to monitor for infection. DON BB confirms that all staff providing care to residents should properly wear a mask. DON BB confirms that the mask worn by staff did not meet the recommendations of CDC (Center of Disease Control) guidelines. DON BB confirms that the education for infection control preventionist has not been completed. Record review of Infection Prevention and Control Program (no implemented date) documents the following: This facility has established and maintains an infection and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the Centers for Disease Control, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19. Although screening for symptoms will not identify asymptomatic or pre-symptomatic individuals with SARS-CoV-2 infection, symptom screening remains an important strategy to identify those who could have COVID-19 so appropriate precautions can be implemented. 39958 Resident #44 Review of an Admission Record revealed, Resident #44 originally admitted to the facility with pertinent diagnosis which included Vascular Dementia, Schizoaffective disorder, and Type 2 Diabetes. Review of a Minimum Data Set (MDS) assessment, with a reference date of 4/29/21 revealed Resident #44 had severe cognitive impairment with a Brief interview for Mental Status (BIMS) score of 3, out of a total possible score of 15. Resident #44 required total dependence of one staff with dressing, personal hygiene, and extensive assistance of one staff with bathing. In an observation on 6/8/21 at 10:18 a.m., Certified Nursing Assistant (CNA) KK prepared to give Resident #44 a shower. CNA KK applied gloves with no hand hygiene. CNA KK then removed Resident #44's clothes and sat Resident #44 on the shower chair. CNA KK washed, rinsed and dried Resident #44's face, upper body and back. CNA KK washed Resident #44's peri area from front to back. CNA KK placed the washcloths used to wash Resident #44 on the shower table and not in a bag. CNA KK rinsed and patted dry Resident #44's peri area. In an observation on 6/8/21 at10:42 a.m., CNA KK put Resident # 44 on brief, pull up and clothes. CNA KK did no change gloves or perform hand hygiene during Resident #44's shower. In an observation on 6/8/21 at 10:46 a.m., CNA KK removed gloves with no hand hygiene and walked Resident #44 back to the unit. The dirty linen used for Resident #44's shower remained on shower bed. In an interview on 6/9/21 at 11:07 a.m., CNA KK reported gloves are removed when the shower is complete. CNA KK then reported the linen is picked up and bagged when the shower is done. In an interview on 6/14/21 at 12:21 p.m., Director of Nursing (DON) BB reported staff should change gloves during the shower. DON BB then reported gloves should not be worn for the entire shower. Review of a Hand Hygiene policy with no date revealed, Policy: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice . 6. Additional considerations: a. The use of gloves does not replace hand hygiene . In an observation on 6/16/21 at 10:00 a.m., Licensed Pratical Nurse (LPN) A sat at the 1st floor nurses station with a mask under the chin and not around mouth or nose. 41741 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Deficiency Practice Statement B Based on interview and record review, the facility failed to develop and implement a water management plan to reduce the risk of legionella in the domestic water supply, resulting in the potential growth of legionella and other opportunistic pathogens in premise plumbing. The deficiency affects all 67 residents and staff in the facility. Findings include: During an interview on 06/08/21 at 10:53 AM regarding the facilities water management plan, with the Maintenance Director RR, it was found the facility has no active water management plan being carried out within the facility. MD RR advised there is no water management plan and we do not do any testing; we just check the water temperatures daily. At this time there was not a viable document to review that contained procedures being followed by the facility to reduce the instance of Legionella.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on observation, interview and record review the facility failed to implement its protocol for antibiotic use, effecting one resident (R 32) out of 26 residents reviewed for antibiotic stewardship, resulting in the facility not following protocols for antibiotic use and monitoring resident consistently during antibiotic use for adverse reactions. Findings include: Observation of urine specimen on 6/7/21 at 8:15 AM in R32's room on bedside table. R 32 said the specimen was because of using an antibiotic. During record review of R32's face sheet on 6/7/21 revealed original admission into facility on 4/6/20 with diagnoses that included peripheral vascular disease (poor circulation), hypertension (high blood pressure) and Type 2 diabetes. According to the Minimum Data Set (MDS) dated [DATE], R32 had intact cognition and needed supervision with most Activities of Daily Living (ADLS). Record review on 6/7/21 of R32's physician orders revealed order dated 6/5/21 at 1340 (1:40 PM), Ciprofloxacin HCL (Antibiotic) 250 mg (milligrams) - Give 1 tablet my mouth two times a day for infection/UTI (urinary tract infection)? For 7 days. Record review on 6/7/21 of R32's care plans revealed no care plan for antibiotic use. Record review on 6/11/21 of R32's Weights and Vitals Summary indicated R32's temperature was only assessed on 6/6/21 and 6/9/21. Record review on 6/11/21 of R32's medical chart revealed no evidence of laboratory test being accomplished before administering antibiotics of infection on 6/5/21. On 6/14/21 no evidence of results from urine sample were received by facility. During interview on 6/14/21 at 1:15 PM with Director of Nursing (DON)BB confirms that antibiotic stewardship protocols were not implemented but should have been before R32 was started on antibiotic for urinary tract infection. DON confirms that R32's temperatures were not consistently monitored or documented to assess for adverse reactions. DON confirms that an antibiotic care plan was not implemented until 6/9/21. DON BB confirms that no results have been obtained as of today to reveal if resident had a urinary tract infection and that ordered antibiotic was necessary or correct for treating R32's possible urinary tract infection. During interview on 6/17/21 at 2:15 PM, Medical Director K confirms all physicians should follow the Antibiotic Stewardship program. Record review on 6/14/21 of Antibiotic Stewardship Program no implementation date indicated. It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.

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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. 38208 Based on interview and record review the facility failed to have the designated Infection Control Preventionist complete the specialized training in infection prevention and control (discipline concerned with preventing healthcare associated infections.), effecting all residents of facility, resulting in the potential for missed opportunities to maintain a sufficient infection control program. Findings include: During record review on 6/16/21 at 1:15 PM of Infection Control Program revealed no evidence of specialized training in infection prevention and control was completed by the designated Infection Control Preventionist. During interview on 6/16/21 at 1:20 PM with Director of Nursing/ Infection Control Preventionist confirmed that specialized training in infection prevention and control was not completed and confirms the facility should follow CMS (Centers of Medicare and Medicaid Services) guidelines.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41741 Based on observation, interview and record review the facility failed to ensure adequate space was available for residents dining in the 2 North dining room, maintain the physical facility and equipment in a sanitary manner and good repair, resulting in an unpleasant, non-homelike environment. This deficient practice affects all 67 residents in the facility. Findings include: On 06/06/21 at 08:23 AM observed gloves, medicine cups, sugar packs, tartar sauce packs, straw wrappers, cup tops, trash debris, and black residue on the floor of Unit 2 South. On 06/06/21 at 08:30 AM observed black residue and stickyness on the floor of Unit 2 North. On 06/06/21 at 08:31 AM observed 14 residents eating breakfast in 2 North Dining Room. On 06/06/21 at 08:32 AM observed resident trying to leave out of 2 North dining room but unable to leave because there was not enough room. CNA Y stated What's wrong, you're trying to get out? How did this table get like this? CNA Y proceeded to move two residents and one table for the resident to get out of the dining room. On 06/06/21 at 10:12 AM observed gnats flying around a bag of food in room [ROOM NUMBER]. On 06/06/21 at 10:55 AM observed no waste basket in the bathroom in room [ROOM NUMBER]. On 06/06/21 at 01:28 PM observed nightstand top drawer missing with an old cupcake in it, a hole near the bathroom, and brownish food debris on the floor in room [ROOM NUMBER]. On 06/06/21 at 01:53 PM observed no call light notification light outside the room, yellow stain underneath the resident bed, brown fecal matter specks on the toilet seat and no trash can in the bathroom in room [ROOM NUMBER]. On 06/06/21 at 02:20 PM observed yellow stain near the resident bed in room [ROOM NUMBER]. On 06/06/21 at 02:22 PM observed peeling paint along the wall near the window, gaps between four file tiles, radiator cover hanging, hole in the door and a hole in the wall near the window in the 2 North Dining room. On 06/08/21 at 10:24 AM observed no paper towel in paper towel dispenser of the 2 South bathroom. On 06/08/21 at 10:25 AM observed a tennis ball size hole in the wall in room [ROOM NUMBER]. On 06/08/21 at 10:26 AM observed white gloves and white garbage bag on the floor of the 2 South clean linen closet. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/08/21 at 10:35 AM the Environmental Services Supervisor (ESS) SS advised the residents rooms are cleaned daily, stated we do three sweeps of the rooms a day. ESS SS advised deep cleaning of the residents' rooms is done once a week, stated we do about a couple of them a day. On 06/08/21 at 10:50 AM observed fecal matter in the corner under the shower chair with bugs crawling on it in 1 North Shower room. When queried, ESS SS stated that looks like BM [bowel movement]. Cigarette smell in the 1 North Shower room. When queried, ESS SS acknowledged that it did smell like cigarette smoke and we do have a few suspected residents, but no one should be smoking in the bathroom. Also observed layer of gray dust on the Heating, Ventilation, and Air Conditioning vents in the 1 North bathroom. When queried, MD RR advised maintenance cleans the vents once a month. During review of the facility's Cleanliness Surveillance Checklist, retyped 1/26/12, it states Routine Cleaning: 1. All horizontal surfaces cleaned daily? (tables/window ledges/bedside stands/counters/sinks/tubs/floors) .7. Are handwashing facilities inspected daily for adequate supplies? Residents Bathrooms: 1. Lavatory clean? 2. Commode clean? Floor clean & dry?

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41741 This citation pertains to Intake MI00112478. Based on observation, interview, and record review the facility failed to maintain an effective pest management program, resulting in the presence of mice in the facility. This deficient practice has the potential to affect all 67 residents in the facility. Findings include: On 06/06/21 at 08:18 AM Observed a dead mouse on the glue trap in front of the resident bed in room [ROOM NUMBER]. During an interview on 06/08/21 at 10:35 AM the Maintenance Director (MD) RR advised nursing units have a pest log to report any sightings of pest. MD RR advised the facility has a contact with [pest control company] and they come out every Tuesday. MD RR also advised that he sometimes sets out mouse traps in the facility, so whoever sets out the traps, between him and the pest control company, will check them. On 06/08/21 at 10:45 PM Observed the dead mouse still on the glue trap in front of the resident bed in room [ROOM NUMBER]. When queried MD RR advised will get rid of this right away. MD RR was asked who put out the glue trap, MD RR stated I put this trap out. During review of the 1 North Pest Sighting log, no mention of mice in room [ROOM NUMBER] was noted.