STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235532	A. Building B. Wing	02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashley Healthcare Center	103 West Wallace Street Ashley, MI 48806

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 39056 Based on interview and record review, the facility failed to establish and maintain a system that assures a full and complete accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf, resulting in the potential for residents to not receive their personal funds and not meet their highest practicable level of wellbeing. Findings: During an interview on 01/24/22 at 03:26 P.M., Nursing Home Administrator (NHA) reported that the Resident Trust was handled by former Business Office Manager (FBOM) BB. Resident Trust information was not available for review at that time. During an interview on 01/25/22 at 10:36 A.M., FBOM BB reported that she received a call on 01/24/22 regarding the resident trust. FBOM BB reported that she set up a filing system and sent refunds to the residents that required it at that time and reported that corporate staff were responsible for maintaining the resident trust account. During an interview on 01/26/22 at 6:15 P.M., FBOM BB reported she worked at the facility as needed and was called in to address the resident trust fund process. FBOM BB reported that she identified the facility did not have resident funds in an interest bearing account and to remedy the fact, took the highest amount of interest a person would have earned and added that amount to each resident's account. In this case, the average was about $0.07, so she added $0.10 for each resident. FBOM BB reported that she was going to try and continue assisting with the trust account reconciliation but had a full time job at a different facility and would not be able to come to the facility until after hours. During an interview on 01/26/22 at 2:54 P.M., Activities Director (AD) R reported that she was told she would be responsible for Resident Trust beginning on 01/25/22, but that she was uncomfortable assuming the responsibility because the Resident Trust was not balanced and she could not account for the missing funds. AD R reported that there was $170 available but she could only balance $155.

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

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on observation, interview and record review, the facility failed to develop and implement comprehensive resident focused care plans based on a comprehensive assessment for 9 residents (Resident #2, #3, #6, #17, #19, #22, #42, #93 #148), resulting in unidentified care needs and hospitalization as the result of complications from inadequate provision of care according to standards of practice. Findings: Resident #2 (R2) Review of an Admission Record revealed R2 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: restlessness, agitation, altered mental status, and anxiety. Review of R2's Care Plan last revised 10/11/21 revealed, SKIN INTEGRITY: I am at risk for skin breakdown . Nurse will check skin weekly and document on skin assessment and treat per facility policy . Review of R2's Weekly Skin Assessments revealed R2's last assessment was completed on 12/5/21 Resident #3 (R3) Review of an Admission Record revealed R3 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: schizoaffective disorder and bipolar disorder. Review of a Minimum Data Set (MDS) assessment for R3, with a reference date of 9/2/21 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated R3 was cognitively impaired. Review of the Functional Status revealed that R3 required supervision with one person for personal hygiene/showering. Review of R3's Care Plan last revised on 8/27/21 revealed, Resident requires (assistance level) X (how many staff) for Bathing/Showering. Resident #6 (R6) Review of a facility Admission Record reflected R6 originally admitted to the facility on [DATE] with diagnoses that included a history of a stroke, bipolar disorder, major depressive disorder, high cholesterol, high blood pressure, conversion disorder with seizures or convulsions, drug induced Parkinsonism, osteoarthritis of the knee, Chronic Obstructive Pulmonary Disease (COPD), benign prostatic hyperplasia with lower urinary tract symptoms, hypothyroidism and gastro-esophageal reflux disease. Review of an admission Minimum Data Set (MDS) dated [DATE] reflected R6 was cognitively intact as evidenced by a Brief Interview for Mental Status assessment score of 13/15 and needed limited assistance from one person for transfers, dressing, toilet use, personal hygiene, and bathing. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of Census Data in the EMR reflected R6 admitted to the facility on [DATE], discharged to the hospital from 10/28/21-11/2/21, readmitted to the facility on [DATE], discharged to the hospital again from 11/12/21-11/18/21, readmitted to the facility on [DATE]. R6 had an unpaid hospital leave on 12/6/21, returned to the facility the same day and was hospitalized again from 12/18/21-12/31/21. Review of a COMS (R) Post Fall Evaluation note dated 9/15/21 at 3:49 p.m. reflected Called to resident (R6's) room. Resident found in wheelchair with grippy socks in place. He stated that he had fallen in the bathroom after trying to transfer unassisted. Denied pain. Skin assessment completed and no issues noted. Educated on call light use and waiting for assistance. (MD AA) and family member (name) notified of fall. No new orders obtained. According to the report the call light had been activated but R6 did not wait for assistance. No further details surrounding the fall were documented and additional interventions to prevent another fall were not added to the care plan. Review of the Care Plan Report, canceled in its entirety on 11/11/21 after R6 was hospitalized reflected that on 9/9/21 (date of admission), R6 was identified as needing assistance with Activities of Daily Living (ADLs), however the plan did not specify how many staff or what level of assistance was needed for bed mobility, transfers, personal hygiene, eating, bed mobility or toileting. The canceled care plan indicated that R6 was at risk for falls related to conversion disorder with seizures or convulsions and secondary Parkinsonism with the goal (R6) will have no serious injury related to falls AEB (as evidenced by) documentation thru next review. Interventions to meet the stated goal included Assistive Devices (non-specific); ensure call light or bathroom call light are answered promptly; ensure call light is within reach; monitor for signs and symptoms of fatigue; encourage rest periods as needed; nurse will assess resident for changes in physical or mental status and notify Dr. as needed and follow up with recommendations. Review of a Physical Therapy PT Discharge Summary for the dates of service 9/17/21-10/28/21 reflected that R6 had been discharged from physical therapy due to being discharged to the hospital. Review of the report reflected R6 had not met the majority of short or long-term goals, including reducing the risk for falls. According to the report a short-term goal was that R6 would Safely ambulate on level surfaces 150 feet using two wheeled walker with CGA (Contact Guard Assistance) with normalized gait pattern 90% of the time to facilitate increased participation in functional activity was not met. Review of an Order Recap Report for the date range 9/01/21-1/29/22 reflected R6 was prescribed Cyclobenzaprine HCl Tablet 5 MG (milligram) Give 5 mg by mouth three times a day for muscle pain for 5 days. Started on 12/13/21 and discontinued on 12/14/21. A second order for Cyclobenzaprine HCl Tablet 5 MG (milligram) Give 5 mg by mouth two times a day for muscle pain for 5 days started on 12/14/21 and ended on 12/19/2021. Cyclobenzaprine HCl is a muscle relaxer with side effects that include but are not limited to dry mouth or throat, headache, blurred vision, drowsiness, dizziness and fatigue. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of an Incident Note dated 12/18/21 at 3:05 A.M. reflected CNA (Certified Nurse Aide) doing rounds down hallway when coming back up hallway heard noise then yell. Found resident (R6) lying inside bathroom door facedown with feet just outside of door and lying up against the wall left side. When asked resident what happened he stated got dizzy and passed out but tried to catch himself on the wall with his left hand. Resident call light was not in use and he does have urinal at bedside that was empty. He also took off his oxygen and saturation was 90%, did have increased confusion A&Ox2 (alert and oriented to person and place). During assessment resident was assisted onto his right side where he yelled out in pain and unable to move his left leg at the hip, pain level 8/10 at this time. Other nurse notified doctor, the DON (Director of Nursing) and 911 was called. Resident also had hematoma to left side of forehead it is raised approximately measuring 5 cm x 3 cm, abrasion to left elbow and hematoma present. Resident was transported via (ambulance company) to (hospital). Attempted to contact family members one number no in service and left message with other contact. Review of a Hospital Discharge Summary dated 12/31/21 reflected [AGE] year old male with PMHx (previous medical history) of HTN (high blood pressure), COPD on 2L NC (2 liters via nasal canula), Afib (atrial fibrillation) (on eliquis), hypothyroidism, heart failure, s/p PPM (status-post permanent pacemaker), acute decompensated HF (heart failure) with preserved EF (ejection fraction) admitted following mechanical fall. Imaging showed left intertrochanteric fracture of the left femur, S/P Left hip ORIF (open reduction, internal fixation) with nail placement surgery. Following surgery, he was found to be hypotensive and in atrial fibrillation was started on Phenylphrine and received two liters of IVF (intravenous fluid) boluses and was transferred to ICU (intensive care unit) for close monitoring. Review of the Electronic Medical Record (EMR) for evidence of care planning reflected R6 did not have an active care plan in place for any focus areas. Attempts to open a current care plan or Kardex (an at a glance care guide) resulted in documents annotated No Data Found. Further review of the EMR revealed a historic care plan that had been canceled as of 11/11/21 due to R6 discharged from the facility for a hospitalization [DATE]-[DATE]. No evidence a new care plan had been developed or implemented upon readmission to the facility on [DATE] was found. On 1/24/22 the DON was asked to provide the fall incident report dated 12/18/21 and the accompanying investigation. According to the DON, only the incident report was available and no additional information could be found. Attached to the incident report was an Investigation Follow-Up form that was not filled out. Circumstances surrounding the fall were not reviewed and without a care plan in place, no interventions had been developed or implemented prior to the fall that may have prevented the serious injury. Resident #17 (R17) Review of a facility Admission Record reflected R17 admitted to the facility with pertinent diagnoses of Chronic Obstructive Pulmonary Disease (COPD), asthma, obstructive sleep apnea and allergic rhinitis. Review of an Admission Minimum Data Set (MDS) assessment dated [DATE] reflected R17 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 13/15 and needed extensive assistance from two people for bed mobility and transfers and required extensive assistance from one person for dressing, toilet use and personal hygiene. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the entire Care Plan Report initiated on 9/29/2021 did not reflect Focus areas, Goals or Interventions were developed or implemented that pertained to R17's need for oxygen therapy or the use of a BiPap machine related to pulmonary disease or sleep apnea. The care plan did not reflect specific requirements for Assistance with Daily Living (ADL) care such as the need for colostomy care, bed mobility, transfer status or bathing preferences. Review of a Care Plan initiated on 10/12/21 reflected (R17) is at nutritional risk related to obesity with a BMI (Body Mass Index) of 61.0 She has numerous food allergies. She has a diagnosis of crohns disease of small intestine with fistula, type II diabetes, hypokalemia and major depressive disorder recurrent that could affect nutritional status. (R17) chooses not to follow a diabetic diet or fluid restrictions. One goal of the Care Plan was that R17 would not consume any food that she is allergic to. An intervention on the Care Plan specified (R17) will not be served pineapple, nuts, kiwi, honey, fish, aspartame, chestnuts, chocolate, cinnamon, shellfish, strawberries, sucrolose or tomato products. Review of a Nursing Note dated 1/13/22 at 6:49 A.M. reflected Patient took medications with pop and resident stated that she didn't realize that she had bought sugar free pop which contains aspartame. Patient stated that 'her throat was swelling up', patient's eyes and lips swelled up. An EpiPen was given patient was still unresponsive and started responding again after 911 was contacted and she was sent to the ER (emergency room). Doctor and mother notified. Review of a Nursing Note dated 1/17/22 at 2:35 P.M. reflected Patient was found at 1400 (2:00 P.M.) having difficulty breathing after having fish at lunchtime. Patient reported that she did not eat much fish. Patient had difficulty breathing and speaking and reported tightness in her chest. Patient was given an EpiPen, patient stated little effect. Patient offered Benadryl, but unable to swallow. Ambulance called, patient was sent to (name of hospital), leaving by ambulance at 1435 (2:35 P.M.). Physician (MD Z) and family notified. During an interview on 1/31/22 at 8:01 A.M., R17 recalled the allergic reactions from earlier that month and stated Oh yeah, that's the week they tried to kill me! R17 said she purchased a diet soda by mistake, believing the beverage was a regular cream soda because of the labeling. R17 said she set it aside to give to one of the CNA's and didn't realize what she was drinking when the nurse handed it to her to swallow her medications with on 1/13/22. R17 reported that she never would have chosen to eat fish and that her allergies are supposed to be listed on her meal card, but on 1/17/22 she was served fish. R17 explained that she thought the fish was chicken but was concerned about how pale and white it was. R17 said that when she went to take a forkfull of the meat, it flaked off near her mouth causing a second serious allergic reaction. Resident #19 (R19) Review of an Admission Record revealed R19 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke, dementia, and depression. Review of R19's Care Plan last revised 8/26/21 revealed, SKIN INTEGRITY: I am at risk for skin breakdown . Nurse will check skin weekly and document on skin assessment and treat per facility policy . Review of R19's Weekly Skin Assessments revealed they were not completed as ordered. R19's Weekly Skin Assessments were completed on 11/4/21, 11/18/21, 12/2/21, 12/30/21, and 1/20/22. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Resident #22 Review of an Admission Record revealed R22 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia with behavioral disturbances. Review of R22's Care Plan last revised 4/20/21 revealed, SKIN INTEGRITY: I am at risk for skin breakdown r/t (related to): decrease in mobility .Nurse will check skin weekly and document on skin assessment and treat per facility policy. Review of R22's Weekly Skin Assessments revealed R22's last assessment was completed on 12/3/21. Resident #42 (R42) Review of an Admission Record revealed R42 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: muscle weakness and difficulty in walking. Review of R42's Care Plan last revised 12/5/21 revealed, SKIN INTEGRITY: I am at risk for skin breakdown r/t: impaired mobility and I have bilateral casts to my lower extremities. Nurse will check skin weekly and document on skin assessment and treat per facility policy . Staff will check resident routinely and PRN, if soiled cleanse and apply a skin barrier . Wash and dry skin thoroughly following each incontinence. Review of R42's Nursing Note dated 12/29/21 revealed, Resident had a f/u (follow up) appointment with (Orthopedic Provider) today At her appointment her BLE (bilateral lower extremity) cast were removed . During an observation on 01/23/22 at 10:27 AM, R42 was in her room sitting up in a wheelchair. She was able to self-propel in her wheelchair and did not have orthopedic casting on her bilateral lower extremities. Review of an Admission Record revealed R42 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: muscle weakness and difficulty in walking. Review of R42's Care Plan last revised 12/5/21 revealed, SKIN INTEGRITY: I am at risk for skin breakdown r/t: impaired mobility .Nurse will check skin weekly and document on skin assessment and treat per facility policy . Review of R42's Weekly Skin Assessments revealed R42's last assessment was completed on 12/1/21 and not again until 12/1/22. Resident #93 (R93) (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of a facility Admission Record reflected R93 admitted to the facility on [DATE] with diagnosis that included Multiple Sclerosis (MS), a stage 3 pressure ulcer, weakness, diabetes, bipolar disorder, morbid obesity, a history of urinary tract infections, anxiety, depression, lymphedema, hypertension, anxiety, depression, generalized muscle weakness and oropharyngeal dysphagia. Review of an Admission MDS dated [DATE] reflected R93 was assessed by staff as having intact short- and long-term memory and needed extensive assistance from two people for bed mobility, transfers and toilet use and was totally dependent on two staff for dressing and bathing. Review of a Care Plan Report including Revision history initiated on 12/9/21 reflected no care plan focus areas had been developed for R93 that pertained to her diabetes or congestive heart failure. R93 was identified as having limited physical mobility related to weakness but no interventions pertaining to transfers or locomotion were specified. A care plan was not developed for R93 pertaining to ADL care despite the MDS assessment reflecting R93's need for extensive assistance. Resident #148 (R148) Review of an Admission Record revealed R148 was a [AGE] year-old male, originally admitted to the facility on [DATE], following a 63-day hospitalization for aspiration pneumonia, urinary tract infection and altered mental status. R148 had a gastrostomy tube (tube feed) for hydration and nutrition and an order for NPO (nothing by mouth). Review of a Care Plan for R148 revealed it was void of all safety interventions related to the tube feed. (No interventions for aspiration precautions, height of head of bed, checking for residual, type and rate of tube feed ordered, when to contact the physician, etc.).

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F 0657 Level of Harm - 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** 29073 Based on observation, interview and record review, the facility failed to review and revise the comprehensive plan of care for 9 residents (R2, R23, R10, R11, R19, R30, R41, R40, and R3), resulting in harm from resident to resident abuse and the potential for ongoing resident to resident abuse and complications from unmet care needs. Findings: Resident #2 (R2) Review of an Admission Record revealed R2 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: restlessness, agitation, altered mental status, and anxiety. Review of R2's Physician Note dated 2/1/22 revealed, (R2) was seen today in regards to a recent resident to resident in which she grabbed another residents arm. (R2) is noted to have severe dementia and paranoia. There is a history of her with increased anxiety each day near noon. It is apparent that there was no ill intent. I would suggest she be in her own room so that she does not feel the need to protect her belongings. Psych will continue to follow . During an interview on 2/1/22 at 11:41 A.M., Physician Z reported that he completed an assessment on R2 following the allegation of abuse. Physician Z reported that she exhibited behaviors of having a difficult past with keeping her items packed and becoming protective of her items. Physician Z reported that because of her possessive behaviors with her items and her space she would have benefited from having a private room. Physician Z reported that R2 may have become overwhelmed to the point she felt she had to protect her items which resulted in the physical altercation between R2 and R5. Review of R2's Care Plans revealed no care plans or revisions for known behaviors of protective behaviors for belongings, increased behaviors around noon, and paranoia. Review of R2's Care Plan revealed, Behavior (no further documentation for the focus) Created on: 8/30/2021. I will not have any behaviors throughout the next review . I may become overstimulated. please take me to a calm environment if this happens . Offer activities of choice . Review of R2's Care Plan revealed, Psychosocial well being (sic) (no further documentation for the focus) Created on: 8/30/2021 .I will be up and dressed daily. and remain in a calm and happy appearance. throughout the next review date . During an observation on 01/23/22 at 01:09 P.M., R2 was visibly agitated, aggressive, and destructive of facility property. R2 was wielding a butter knife and used it to remove the key pad off of the wall and was using the knife to attempt to break through the lock on the double doors. LPN M was blocking her path and was not communicating (verbal or non-verbal) with her in an attempt to deescalate the situation. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of R2's Behavior Note dated 1/23/22 at 4:28 P.M. revealed, Resident became agitated during lunch time. She went to her room and packed her clothes up in a bag and box. She went to the electronic/keypad box attached to the wall and took out a butter knife she had kept from her meal tray and began trying to pry the box off the wall using the butter knife. Staff notice what she was doing and began walking towards her to intervene, but she managed to pull the box completely off the wall. One Staff member stayed with resident as she was repeatedly shoving at the door handles in an attempt to open them, and the other staff member went to get assistance from maintenance to repair the torn off electronic box. Resident refused to give staff the butter knife. Maintenance repaired the box on the wall. Resident took her things back to her room, unpacked, and butter knife was removed from room. Resident redirected with ice cream and apple juice. Refused to participate in activities. Will continue to monitor and follow up as needed. (Indicating an increase in aggressive behaviors.) During an interview on 01/24/22 at 12:30 P.M., R5 reported to this surveyor that her roommate (R2) had assaulted her the previous day (1/23/22). R5 was tearful and anxious when reporting the allegation of resident to resident abuse. Resident #23 (R23) Review of an Admission Record revealed R23 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: delusional disorder, dementia, and anxiety. Review of R4's Nursing Note dated 9/4/21 at 11:00 A.M. revealed, This writer was notified by (Licensed Practical Nurse LPN EEE) that (R4) had stated that he had gotten into a fight. This writer questioned resident who stated (R23), the guy who walks around and goes through people's stuff. He wanted my blue blanket. Per (LPN EEE), resident stated that (R23) had punched him repeatedly and that resident had blocked these punches . Review of R23's Nursing Note dated 12/19/21 revealed, Please have resident evaluated by (physician) for progression of dementia symptoms. He continues to decline in the evening and consistently attempts to self-ambulate, creating a safety situation for him. Review of R23's Nursing Note dated 12/25/21 revealed, Resident exhibiting signs of delusions, primarily in the overnight, causing potential risk to his safety. He is becoming increasingly anxious, restless, and agitated . Review of R23's Care Plan revealed no entry or revision for aggressive behavior resulting in a resident to resident altercation, increased paranoia, restlessness, or agitation. Resident #10 (R10) Review of an Admission Record reflected R10 admitted to the facility with pertinent diagnosis including diabetes, chronic pain, high blood pressure and cirrhosis of the liver. Review of a Nursing Note dated 12/25/21 at 6:55 a.m. reflected Resident (R10) has a rash that started under his breast and on bilateral 4 AM it has now spread to his back neck head and belly (sic). Call on call doctor new orders to start permethrin (a cream used to treat scabies) use as directed 1 dose today then again in a week. Resident is on ISO (isolation) for 48 hours. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of a Care Plan including revision history originally initiated 9/16/21 did not reflect the transmission based precautions and related treatments needed to manage his scabies diagnosis. Resident #11 (R11) Review of an Admission Record revealed R11 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes and hypertension. Review of R11's Health Status Note dated 1/27/22 revealed, Resident has been having diarrhea resulting in accidents this shift. He has also had a urinary accident this HS (night). He has been calling out for help all evening instead of using his call light. He is requiring two people for transferring and is showing increased weakness. Contacted (physician) who ordered CBC (blood test), CMP (blood test) and C.Diff (stool sample) labs. Labs entered into (Hospital) for collection . During observations from 1/23/22-2/3/22, R11 was not in Isolation/Contact Precautions. During an interview on 02/03/22 at 12:24 P.M., Infection Control Nurse (ICN) G reported that R11 should have been placed in Contact Precautions immediately after the possibility of C. Diff was discussed. ICN G reported that there were no results for the C. Diff test, and she was unable to determine if the stool sample was obtained and sent for testing. Review of the Fundamentals of Nursing revealed, .C. difficile (which is transmitted by the fecal-oral route) is harder to eliminate from the environment. It is a spore-forming microorganism, meaning it can remain on surfaces (e.g., bedside table, stethoscope) in a dormant state for long periods. To reduce the risk of cross-contamination among patients, use Contact Precautions in addition to Standard Precautions . [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 441). Elsevier Health Sciences. Kindle Edition. Review of Review of a Care Plan including revision history originally initiated 10/10/21 did not reflect the transmission based precautions and related treatments needed to manage his gastro-intestinal illness and potential c.diff infection. Resident #19 (R19) Review of an Admission Record revealed R19 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke, dementia, and depression. Review of R19's Nursing Note dated 10/24/21 revealed, Resident is being combative with cares . Review of R19's Nursing Note dated 12/8/21 revealed, Resident was very combative towards staff as we were trying to change her and get her up and dressed for the day, her behavior improved during the afternoon and became worse at dinner again . Review of R19's Nursing Note dated 12/20/21 revealed, (R19) was found in another residents room last night licking empty dinner dishes last night. Review of R19's Nursing Note dated 12/23/21 revealed, While staff were completing HS (nighttime) cares resident was combative. She was trying to bite, hit, and scratch . (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of R19's Nursing Note dated 12/24/21 revealed, (R19) was found in another residents bathroom tonight flushing objects down the toilet. Review of R19's Care Plan revealed no entry or revision for combative behaviors or entering other residents rooms. Resident #30 (R30) Review of an Admission Record revealed R30 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia, psychotic disorder, and adjustment disorder. Review of R30's Behavior Note dated 12/24/21 revealed, (R30) is showing signs of agitation and aggression. He attempted to hit a CNA tonight during cares. He is slowly becoming more restless and paranoid. Review of R30's Care Plans revealed no entry or revision for combative behavior, aggression, or paranoia. Resident #41 (R41) Review of an Admission Record revealed R41 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia with behavioral disturbances and psychosis. During an interview and observation 01/23/22 at 01:30 P.M., CNA PP reported that R41 had increased behaviors and frequently required 1:1 attention which included walking the hall with R41. Review of R41's Physician Note dated 1/24/21 revealed, .intermittent aggressive behavior and prior elopement risk . Review of R41's Care Plans revealed no entry or revision for aggressive behavior, pacing, or 1:1 care. Resident #40 (R40) Review of an Admission Record revealed R40 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: altered mental status and alcoholism. Review of R40's Physician Order dated 11/23/21 revealed, Temazepam Capsule 15 MG Give 1 capsule by mouth at bedtime for sleep. (Temazepam is a Benzodiazepines Sedative-Hypnotic) Review of R40's Care Plans revealed no entry or revision regarding monitoring for a Benzodiazepines/Sedative-Hypnotic, behavior management, or her mental health diagnosis. Resident #3 (R3) (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of an Admission Record revealed R3 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: schizoaffective disorder and bipolar disorder. Review of R3's Behavior Note dated 12/24/21 revealed, Resident has been observed ambulating through the hallways she also has been going into other residents rooms this evening and urinating in their toilets when staff tries to redirect she will come out and just sit on the floor in the hallway . Review of R3's Care Plans revealed no entry or revision regarding R3's wandering into other residents rooms.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 37577 Based on observation, interview, and record review, the facility failed to provide timely and consistent ADL (activities of daily living) care to 9 residents (Resident #42, Resident #148, Resident #145, Resident #20, Resident #143, Resident #146, Resident #151, Resident #17, and Resident #93, R#28), resulting in an immediate jeopardy, when beginning on 01/23/22, the facility failed to provide staffing to meet the ADL needs of the residents and allowed residents to (a) lay in their urine and feces for extended periods of time, (b) not receive meals timely or eating assistance if required, (c) go un-bathed, unkempt, and to be malodorous, (d) remain in bed for over 24 hours, and (e) unnecessarily utilize a bed pan for toileting. This deficient practice also resulted in feelings of embarrassment, humiliation, and diminished self esteem. Findings: Resident #42 (R42) Review of an Admission Record revealed R42 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: muscle weakness and difficulty in walking. Review of a Minimum Data Set (MDS) assessment for R42, with a reference date of 11/30/21 revealed a Brief Interview for Mental Status (BIMS) score of 6, out of a total possible score of 15, which indicated R42 was cognitively impaired. Review of the Functional Status revealed that R42 required extensive 2-person assistance for bed mobility, transferring, and toileting. During an observation on 01/23/22 at 10:27 A.M., R42 was in her room sitting up in a wheelchair. The left side from her armpit to her ankle was saturated with urine and the bed linen was saturated with urine. R42's room smelled strongly of urine. R42 cried and voiced frustration and humiliation at the lack of assistance to the bathroom and lack of staff to assist with incontinence care. During an interview on 02/01/22 at 12:15 P.M., Certified Nurse Aide (CNA) BBB reported that facility CNA's were ordered to give all resident in the facility a shower beginning 01/31/22 but were not educated on the reason why all residents needed a shower. CNA BBB reported that they were given a skin assessment sheet on 01/31/22 to begin using to track and assess residents skin. CNA BB reported being directed by the corporate staff to give residents showers even if they refused and if residents refused showers they should be sent to the hospital for a psychiatric evaluation. Resident #148 (R148) Review of an Admission Record revealed R148 was a [AGE] year-old male, originally admitted to the facility on [DATE], following a 63-day hospitalization for aspiration pneumonia, urinary tract infection and altered mental status. R148 had a gastrostomy tube for hydration and nutrition and an order for NPO. During an observation on 01/24/22 at 9:50 A.M., R148's brief, gray sweatpants, bed sheet, and blue pad were saturated with urine. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 01/24/22 at 10:33 A.M. and 10:51 A.M., R148's brief, gray sweatpants, bed sheets, and blue pad were saturated with urine and the room had a strong urine smell. During an observation on 01/24/22 at 11:48 A.M., R148's brief, gray sweatpants, bed sheets, blanket, and blue pad were saturated with urine and the room had a very strong odor of urine. During an observation on 01/24/22 at 12:43 P.M., R148's brief, gray sweatpants, bed sheets, blanket, and blue pad were saturated with urine and the room had a very strong odor of urine. During an observation on 01/24/22 at 2:08 P.M., R148's brief, gray sweatpants, bed sheets, blanket, and blue pad were saturated with urine and the room had a very strong odor of urine. During an observation on 01/24/22 at 2:50 P.M., R148's brief, gray sweatpants, bed sheets, blanket, and blue pad were saturated with urine and the room had a very strong odor of urine. During an interview on 01/26/2022 at 4:59 P.M., CNA D reported that many residents were left wet for extended periods of time due to the lack of staffing. CNA D also indicated that R148's scrotum was bright red with possible MASD (moisture associated skin damage) because R148 was often found in a urine saturated brief. During an observation on 01/31/22 at 08:06 A.M., R148's sheets and gown were soaked in urine. At 8:12 A.M., CNA DDD entered the room and provided peri care. With R148 laid flat, naked, and fully exposed, CNA DDD left the room to retrieve a clean gown and sheets. Resident #145 (R145) Review of an Admission Record revealed R145 was a [AGE] year old female, admitted to the facility on [DATE], with pertinent diagnoses of rheumatoid arthritis, high blood pressure, chronic kidney disease, anxiety disorder, and diabetes mellitus. During an observation on 01/24/22 at 1:37 P.M., the call light was activated for R145. During an observation on 01/24/22 at 2:08 P.M., the call light for R145 remained activated. During an observation on 01/24/22 at 02:29 P.M., the call light for R145's room remained activated. When asked about the residents' needs, the R145 responded I'm really wet, please help me. During an observation on 01/24/22 at 02:50 P.M., the call light remained on for R145. During an observation on 01/26/22 at 05:43 P.M., the call light activated for R145. Corporate Nurse (CN) JJ asked R145 what the need was and the R145 responded I'm wet. CN JJ responded, ok, I will get an aide to help you. At 6:00 P.M., the surveyor asked CN JJ if an aide had been alerted to the needs of R145 and CN JJ responded, No, I was just gonna tell someone. Resident #20 (R20) (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of an Admission Record revealed R20 was a [AGE] year old male, originally admitted to the facility on [DATE], with pertinent diagnoses of anoxic brain damage (caused by lack of oxygen to the brain for an extended period of time), congestive heart failure, major depressive disorder, muscle weakness, cognitive communication deficit, diabetes mellitus type 2, and placement of a colostomy in December 2021. R20 was dependent on staff for all ADL care. During observations on 01/23/22 from 10:00 A.M. to 4:30 P.M., R20 remained in bed. During an observation on 01/24/22 at 8:09 A.M., R20 laid in bed, was unkempt, hair was greasy, and the resident was malodorous. During observations on 01/24/22 from 7:30 A.M. to 5:00 P.M., R20 remained in bed. During an observation on 01/25/22 at 10:20 A.M., R20 laid in bed, was unkempt, hair was greasy, resident was malodorous and wearing the same shirt as 1/24/22. During an observation on 01/25/22 from 7:50 A.M. to 11:49 A.M., R20 remained in bed. Resident #143 (R143) Review of an Admission Record revealed R143 was a [AGE] year old female, admitted to the facility on [DATE], with pertinent diagnoses of metabolic encephalopathy (a chemical imbalance in the brain that causes personality changes), restlessness and agitation, dysphagia (difficulty swallowing food or liquids), and constipation. During an observation on 01/26/22 at 9:57 A.M., R143 loudly cried and screamed I need to poop. At 10:07 A. M., CNA O obtained a bed pan and assisted R143 onto the bed pan. CNA O stated that R143 does not normally use a bed pan but there wasn't enough staff to get the resident to the bathroom safely. R143 required 2 staff persons to transfer to the bathroom. During an observation on 02/01/22 at 11:00 A.M., R143 yelled help several times. R143's call light laid on the floor out of reach and out of sight of the resident. No staff were visible on the unit and the alarm at the nurse desk sounded loudly, making R143's screams for help inaudible at the nurses desk. Out of concern for R143's safety, the surveyor alerted staff. Staff entered R143's room and stated, oh (R143) needs to get off the bed pan. Resident #146 (R146) Review of an Admission Record revealed R146 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses of Cerebral Palsy, mild intellectual disabilities, history of falls, and diabetes mellitus. R146 was dependent on staff for hygiene, eating, transfers, and going to the bathroom. During an observation on 01/23/22 at 11:52 A.M., R146 tried to communicate a need, reached down to the brief and slid a hand down into the brief. R146 stated yeah the brief needed to be changed. During an observation on 01/23/22 at 12:01 P.M., R146 tugged at the brief, stated bath and held her nose and pointed toward the groin. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 01/23/22 at 1:19 P.M., R146 had not yet received a lunch tray. At 1:29 P.M., after all other residents on the west hall had completed lunch, staff entered the residents room and assisted R146 with lunch. During an observation on 01/25/22 at 10:20 A.M., R146 wore the same shirt as 01/24/22, still soiled with food stains. During an observation on 01/31/22 at 09:13 A.M., staff provided R146 with assistance to eat breakfast. Staff indicated that R146 eats last on the hall because staff are required to provide assistance and due to lack of staff, R146 had to wait until everyone else had breakfast. Resident #151 (R151) Review of an Admission Record revealed R151 was a [AGE] year old male, admitted to the facility for long term care on 01/11/22, with pertinent diagnoses of muscle weakness, type 1 diabetes mellitus, major depressive disorder, and vascular dementia. R151 was contracted and the elbows and wrists, required 2 staff person assistance with a mechanical lift for transfers, and required assistance from 1 staff person to eat and drink. During an observation on 01/23/22 at 1:16 P.M., R151 had not yet received lunch, while the other residents on the hall had completed lunch. At 1:31 P.M., CNA O assisted R151 with lunch and stated that there was not enough staff to assist everyone with lunch in a timely manner. During multiple observations on 01/24/22, R151 laid in bed continuous for 8.5 hours. During multiple observations on 01/25/22, R151 laid in bed continuous for 9 hours. When asked R151 acknowledged being in bed for over 24 hours and could not remember the last time being out of bed. During an interview on 01/25/22 at 10:02 A.M., CNA PP reported they could not shower, reposition, and change residents as required because of the lack of staff. 29073 Resident #17 (R17) Review of a facility Admission Record reflected R17 admitted to the facility with pertinent diagnoses of Chronic Obstructive Pulmonary Disease (COPD), asthma, obstructive sleep apnea and allergic rhinitis. Review of an Admission Minimum Data Set (MDS) assessment dated [DATE] reflected R17 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 13/15 and needed extensive assistance from two people for bed mobility and transfers and required extensive assistance from one person for dressing, toilet use and personal hygiene and bathing. During an interview on 1/23/22 at 4:10 P.M., R17 reported she has not been getting showers. According to R17, she finally got a bed bath last week Friday (1/21/22) after not getting a shower in three weeks. In addition to not getting regular showers, R17 reported she was not washed up daily. During a follow-up interview on 1/31/22 at 8:01 A.M., R17 said she should be getting showers on Tuesdays and Fridays but that they are not done and that makes her feel dirty. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #93 (R93) Review of a facility Admission Record reflected R93 admitted to the facility on [DATE] with diagnosis that included Multiple Sclerosis (MS), a stage 3 pressure ulcer, weakness, diabetes, bipolar disorder, morbid obesity, a history of urinary tract infections, anxiety, depression, lymphedema, hypertension, anxiety, depression, generalized muscle weakness and oropharyngeal dysphagia. Review of an Admission MDS dated [DATE] reflected R93 was assessed by staff as having intact short- and long-term memory and needed extensive assistance from two people for bed mobility, transfers and toilet use and was totally dependent on two staff for dressing and bathing. During an interview and observation on 1/23/22 at 4:41 P.M., R93 was lying in bed wearing a hospital gown, her hair was matted and clumped with residue. R93 reported she had not been showered or had her hair washed since admitting to the facility on [DATE] (45 days). During an interview on 1/25/22 at 1:58 P.M., Psychologist QQ reported he had just met with R93 and noticed her matted hair. According to Psychologist QQ, the impact on a resident left sitting wet or soiled or not being showered regularly would be self-evident, It would be horrible. Review of the Fundamentals of Nursing revealed, Personal hygiene affects patients' comfort, safety, and well-being. Hygiene care includes cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities such as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation, foster a positive self-image, promote healthy skin, and help prevent infection and disease. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition. Resident #28 (R28) Review of an Admission Record revealed R28 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: overactive bladder and muscle weakness. Review of a Minimum Data Set (MDS) assessment for R28, with a reference date of 10/20/21 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated R28 was cognitively impaired. Review of the Functional Status revealed that R28 required extensive 2 person assist with transferring and toileting. Review of R28's Care Plan last revised on 5/3/21 revealed, URINARY/BOWELS: I am incontinent of bladder d/t (due to) my inability to feel the urge to void. I will let staff know if I need to have a bowel movement, however this is not consistent. I do receive a diuretic which increases my frequency, I rely on staff for my toileting needs throughout the day. I use incontinence products, but my incontinence puts me at risk for skin breakdown . Staff will assist me with toileting regularly and PRN (as needed) .Toileting: extensive assist x2 staff . Review of R28's Braden Scale for Predicting Pressure Ulcer Risk revealed that R28 was at risk for skin breakdown. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation and interview on 2/1/22 at 1:03 P.M., CNA ZZ was the only CNA working on the Memory Care Unit. CNA ZZ attempted to call the East/West Units for assistance and no staff would answer. CNA ZZ reported that there were 4 residents that required 2-person assist on the Memory Care Unit including R28. CNA ZZ reported that R28 had been requesting to use the bathroom prior to lunch and was incontinent of urine, but because she required 2-person assistance she would have to wait in her urine until another staff member arrived in the unit. The facility Administrative team was notified, on 01/31/22 at 10:53 A.M., of the Immediate Jeopardy (IJ) that was identified on 1/27/22 and began on 01/23/22, when the facility failed to provide timely and consistent ADL care. This deficient practice placed all residents, who required staff assistance for the maintenance of ADL's, residing in the facility at risk for serious harm, injury, and/or death. As of date of exit, 2/3/22 at 4:00 P.M., the facility had not developed an approved plan to remove the Immediate Jeopardy and the State Agency was not able to verify the residents living at the facility were free from the potential for serious injury, serious harm and or death.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 37577 Based on observation, interview and record review, the facility failed to prevent accidents and hazardous situations for 17 residents (Resident #148, Resident #144, Resident #42, Resident # 8, Resident #153, all 11 residents on the locked memory care unit, Resident #6, and Resident #3) resulting in an Immediate Jeopardy, when beginning on 01/23/22, the facility failed to (a) follow a strict ordered diet of NPO (nothing by mouth) and provide a functioning call light system for Resident #148, (b) implement standard safety protocols to prevent a fall and correctly assess for neurological changes after an unwitnessed fall for Resident #144, (c) safely transport Resident #8 and Resident #42 in a wheelchair, and assess Resident #42's level of staff assistance needed to safely complete activities of daily living, (d) follow the physician order to check wanderguard placement twice daily for Resident #153 and provide a system for staff to quickly identify which residents were at risk for elopement, (e) provide a system for staff in the locked memory care unit to, (1) access health records, (2) locate the crash cart, and (3) contact other staff in case of an emergency, and maintain and audit for properly stocked crash carts, (f) develop a plan of care to prevent a fall with fracture for Resident #6, and (g) secure a shower room on the locked memory unit, to prevent Resident #3 from accessing the shower room independently. Findings: Resident #148 (R148) Review of an Admission Record revealed R148 was a [AGE] year-old male, originally admitted to the facility on [DATE], following a 63-day hospitalization for aspiration pneumonia, urinary tract infection and altered mental status. R148 had a gastrostomy tube for hydration and nutrition and an order for NPO. Review of an Admission Dietary Nutrition Assessment, dated 01/14/22, revealed that the assessment was not complete and was void of information regarding the following for R148: (a) weight on admission and weight history, (b) recent lab values, (c) estimated protein needs, (d) fluid requirements, and (e) current dietary order. Review of a Speech Therapy Evaluation and Speech Therapy Treatment Notes reflected the following concerns/information for R148: (a) (R148) would like to drink again, (b) was referred for speech therapy due to NPO status and tube fed, (c) had reduced cognitive communication skills (BIMS score 7/15), (d) oral motor structure and function-impaired, (e) insight-impaired, and (f) swallowing abilities-severe impairment. During an observation on 01/23/22 at 12:50 P.M., R148 did not have a call light system to use. There was no cord attached to the call light wall receptacle nor was there any other type of system (a bell for example) for R148 to alert staff of any needs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 01/23/22 at 1:11 P.M., R148 had a blue water cup, with a lid on it and a straw in it, half full of thin liquid, on the bedside table within reach of the resident. When asked if staff had supplied R148 with something to drink, R148 stated yes. When asked if R148 had been drinking fluids form the cup, R148 stated yes. Licensed Practical Nurse (LPN) N was questioned about R148's oral intake status and confirmed the order for NPO. During an observation on 01/24/22 at 11:47 A.M., R148 did not have a call light system to use. There was no cord attached to the call light wall receptacle nor was there any other type of system (a bell) for R148 to alert staff of any needs. During an observation on 01/25/22 at 9:10 A.M., R148 had received the roommates breakfast tray and was sitting on the edge of the bed eating food by hand. There was no staff supervision for R148. The observation was immediately reported to the Director of Nursing (DON) out of concern for R148's high risk of choking and not having a call light system. During multiple observations on 01/25/22 from 9:10 A.M. through 5:30 P.M., R148 did not have a call light system to use. There was no cord attached to the call light wall receptacle nor was there any other type of system (a bell) for R148 to alert staff of any needs. During multiple observations on 01/26/22 from 7:50 A.M. through 6:20 P.M., R148 did not have a call light system to use. There was no cord attached to the call light wall receptacle nor was there any other type of system (a bell) for R148 to alert staff of any needs. During an observation on 02/01/22 at 09:26 A.M. R148 had been moved to a new room. The new room did have a call light system in place, however, the call light was wrapped around the bedside table drawer handle, out of sight and out of reach of the resident. Resident #144 (R144) Review of an Admission Record revealed R144 was a [AGE] year-old female, admitted to the facility on [DATE] following a hospitalization to treat pneumonia, with pertinent diagnoses of congestive heart failure, diabetes mellitus, history of a stroke, and weakness. Review of hospital discharge paperwork dated 01/19/22, the following was noted regarding R144's condition: R144 was (a) unable to state where she was, (b) at times not making any sense, (c) mentation varies during treatment, sometimes talking appropriately then making no sense, and (d) recommended for skilled nursing due to confusion and safety concerns. Review of a facility Nursing Admission Assessment, completed 01/20/22, reflected that R144 had an unsteady gait and poor balance. Review of the Electronic Medical Record for R144 reflected that a Fall Risk Assessment had not been completed for R144 at admission. Review of a Bedside Kardex for R144 revealed the following safety intervention: make sure call light is within reach when the resident is in the room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 1/23/22 at 1:22 P.M., R144's call light laid on the meal tray from lunch, out of reach of the resident. During an observation on 01/24/22 at 8:15 A.M., R144's call light laid on the floor at the head of the bed, out of sight and out of reach. During an observation on 01/24/22 at 12:42 P.M., R144 could be heard at the nurses station, retching in the room. No available staff were visible on the unit to respond to R144. During an observation on 01/24/22 at 1:30 P.M., R144 was observed sitting up on the floor next to the bed, reaching for the wheelchair. R144 did not have any footwear on and was dressed in a hospital gown. The call light was on the floor at the head of the bed and out of reach of the resident (out of reach regardless of whether R144 was in bed or on the floor). Despite multiple call lights activated on the west hall, no staff were visible for 10 minutes. At that time and out of concern for R144's health and safety, the surveyor notified Registered Nurse-Unit Manager (RN/UM) G of the observation. RN/UM G and RN H responded and began assessing R144. At 1:45 P.M. and while RN/UM G was out of the room procuring a different blood pressure cuff, R144's LOC (level of consciousness) was assessed and found to be oriented to name and date of birth only. R144's speech was somewhat slurred and at times incoherent, and R144 could not state the name of the facility, what day of the week it was, nor identify the correct month of the year. After several unsuccessful attempts to obtain a blood pressure (due to lack of properly functioning equipment), R144 was assisted back to bed with the use of a gait belt and 2-person assist. Staff searched the resident's room and could not locate any type of footwear including grippy socks. Review of a Neuro Checks form initiated for R144 on 01/24/22 at 1:45 P.M., reflected 3 hourly checks that were scheduled to start at 3:30 P.M. and continue until 5:30 P.M., were not completed. The Neuro Check form only monitored blood pressure and the position of the resident when the blood pressure was obtained, respirations, pulse and type, and temperature. The Neuro Checks form used by the facility does not meet the standard of practice for the monitoring of a resident who had an unwitnessed fall. The standard of practice for the nursing assessment of a resident with an unwitnessed fall includes level of consciousness, pupillary reaction, motor function and vital signs: ([NAME], W. J., [NAME], F. D., [NAME], J. K., [NAME], J. F., & Neighbors, M. (2019) Medical-Surgical Nursing Health and Illness Perspectives (11th ed.). St. Louis: Mosby.) During an observation on 01/25/22 at 10:48 A.M., R144's call light was activated and R144 stated, I can't wait any longer, my stomach hurts, I have to lay down. R144 self transferred to bed, laid on top of the covers, and the oxygen cannula was displaced from the nares. During an observation on 01/25/22 at 11:44 A.M., R144 laid under the covers, 02 cannula in place, and the call light laid on the floor out of sight and out of reach. During an observation on 01/31/22 at 8:09 A.M. R144 sat in a wheelchair positioned bedside. The call light was tucked down between the mattress and the bed frame at the head of the bed, out of sight and out of reach. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of a facility policy Resident Safety, last reviewed 12/20/20, reflected the following: (1) All residents will have access to a nurse call device while in their room. The device will be operable by the resident with consideration for any physical disabilities or limitations they may have. (2) All staff members have responsibility to respond to nurse call alerts, (3) Nursing staff are responsible for assuring that call light cords are within reach of all residents, (4) It is the responsibility of staff to round throughout the shift to assure call lights remain within reach of residents, and (5) resident call must be addressed immediately, call lights must be answered quickly. Resident #8 (R8) Review of an Admission Record revealed R8 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses of traumatic brain bleed, Down's Syndrome, and moderate intellectual disabilities. Review of R8's Care Plans reflected the following information related to the plan of care and interventions required by staff to ensure the resident's safety: (a) does not communicate immediate needs; staff need to anticipate all needs, (b) main mode of transportation is: wheelchair with total assistance x 1 staff, (c) foot pedal strap to bilateral foot pedals, to aide in feet positioning during transportation. During an observation on 01/24/22 at 2:37 P.M. an unidentified staff person pushed R8 in a wheelchair from the dinning area to the resident's room. The footpedals were on the wheelchair but R8's feet were dragging on the floor between the foot pedals. Resident #42 (R42) Review of an Admission Record revealed R42 was a [AGE] year-old female, admitted to the facility for skilled rehabilitation services following a right ankle fracture. R42 admitted to the facility with relevant diagnoses of diabetes mellitus, history of falls, muscle weakness, and cognitive communication deficit. During an observation on 01/31/22 at 11:59 A.M., R42 returned to the facility from an outside appointment and was being pushed in a wheelchair by employee A without the use of any foot pedals. Review of a Bedside Kardex, used to alert staff of specific residents' needs in order to complete certain activities of daily living (ADL's), reflect the following care needs were not assessed for R42, relative to how much assistance and how many staff persons were needed to safely perform: (a) bathing/showering, (b) bed mobility, (c) getting dressed, (d) use of supportive devices such as crutches, canes or splints, (e) ambulating, (f) eating, (g) going to the bathroom, and (h) complete personal hygiene. Resident #153 (R153) Review of an Admission Record revealed R153 was an [AGE] year old male, admitted to the facility on [DATE], with pertinent diagnoses of chronic obstructive pulmonary disease (COPD), dyspnea (difficulty breathing), congestive heart failure, and dementia. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of an Etar for R153, dated 1/01/2022 - 1/31/2022, revealed an order for: wanderguard to left ankle; check placement every shift two times a day for safety. Documentation reflected that placement was not checked on 6 different shifts. Review of the facility policy/procedure Elopements and Wandering Residents, last revised 11/22/2019, reflected the following: The facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents by .(a) review physical plant to be sure door alarms are properly locked to prevent resident entry, (b) the facility is equipped with door locks/alarms to help avoid elopement, (c) alarms are not a replacement for necessary supervision, and (d) the facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including the assessment and identification of hazards and risk . Review of elopement log book documentation Test operation of doors, locks, and alarms, reflected that the last audit completed of the facilities 16 doors and alarmed exits took place on 07/28/21. During an interview on 01/26/22 at 3:45 P.M., Certified Nurse Aide (CNA) P could not locate the elopement book that identified all residents assessed to be at risk for elopement. During an interview on 01/26/22 at 4:00 P.M., the DON was questioned about the residents who had been assessed for and identified as elopement risks. The DON could not locate the elopement book and ran an order listing report that identified 3 residents (R153, R42, and R5) who currently utilized a wander-guard device. After reviewing the order listing report, the DON suggested there may be additional residents who utilized a wander-guard (but were not listed on the report) and the DON commenced a room to room check, to verify which residents had a wander guard. After completing the room to room check of all residents in the facility, the DON identified 3 additional residents (R35, R12, and R40) that utilized a wander-guard. After running the order listing report and completing a room to room check of all the residents in the facility, R144 still had not been identified as a person who was an elopement risk, despite wearing a wander guard and having a care plan in place (initiated 01/20/22) related to being an elopement risk. Locked Unit During an interview on 01/24/22 at 12:22 P.M., CNA O reported that there was not a back up system in place, on the locked memory care unit, for staff to be able to determine a residents code status. If the Electronic Health Record (EHR) went down there would be no way to access that information. During an interview and observation on 01/24/22 at 12:28 P.M., CNA Y reported not having access to the Electronic Health Record and did not know how else to determine a resident's code status. CNA Y stated that the only phone on the Memory Care Unit was not plugged in because of a resident's behaviors. CNA Y reported that the walkie talkies did not work, and did not have a key fob to exit the Memory Care Unit. CNA Y was asked what steps would be taken in an emergency, or if a resident coded, and responded, That's a really good question. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 01/25/22 at 10:02 A.M., CNA PP reported that the Man Down button, walkie talkies, and the phone on the locked unit (Memory Care Unit) did not work. The phone cord was removed because of a resident's behaviors. CNA PP reported having a key fob to exit the unit, (the doors remained locked and use of the key flab was the only way to exit the unit) but the coworker did not. CNA PP reported that it was dangerous and would not know what to do in an emergency if left alone on the unit (CNA PP indicated being the only staff person on the unit many times). CNA PP reported the Memory Care Unit was unsafe and voiced concerns about what would happen if a resident coded on the unit without the ability to communicate with other units or have staff to assist. During an interview on 01/25/22 at 10:05 A.M., CNA OO stated today was the first day as a CNA at this facility and had not been given access to the EHR (electronic health record) to determine a resident's code status. CNA OO did not have a key fob to exit the unit and when CNA PP would go on break, CNA OO was left alone on the unit, without orientation, without a way to communicate with the other staff, and without the ability to document in or access the EHR. During an observation and interview on 01/26/22 at 2:15 P.M., Dietary Aide (DA) S attempted to bring a resident tray to the Memory Care Unit. DA S was let in by the surveyor and reported that most staff did not have a key fob to gain access to the unit, there was no known code to type in to unlock the doors, and indicated that during an emergency very few staff would be able to access the Memory Care Unit to assist. Crash Carts During an observation on 01/26/22 at 12:01 P.M. the emergency oxygen tank on the crash cart for the East/West halls was empty. The daily check list used by staff to check the crash cart was not located on the cart but rather in a book behind the nurses desk. Documentation showed that the crash cart was last checked on 01/13/22. During an interview on 1/26/22 at 12:08 P.M., the Director of Nursing did not know if there was a crash cart on the locked memory unit or, if there was one, where it was located. At the time of the interview, there was not a nurse working on the locked memory unit. 29073 Resident #6 (R6) Review of a facility Admission Record reflected R6 originally admitted to the facility on [DATE] with diagnoses that included a history of a stroke, bipolar disorder, major depressive disorder, high cholesterol, high blood pressure, conversion disorder with seizures or convulsions, drug induced Parkinsonism, osteoarthritis of the knee, Chronic Obstructive Pulmonary Disease (COPD), benign prostatic hyperplasia with lower urinary tract symptoms, hypothyroidism and gastro-esophageal reflux disease. Review of an admission Minimum Data Set (MDS) dated [DATE] reflected R6 was cognitively intact as evidenced by a Brief Interview for Mental Status assessment score of 13/15 and needed limited assistance from one person for transfers, dressing, toilet use, personal hygiene, and bathing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Census Data in the EMR reflected R6 admitted to the facility on [DATE], discharged to the hospital from 10/28/21-11/2/21, readmitted to the facility on [DATE], discharged to the hospital again from 11/12/21-11/18/21, readmitted to the facility on [DATE]. R6 had an unpaid hospital leave on 12/6/21, returned to the facility the same day and was hospitalized again from 12/18/21-12/31/21. Review of a COMS (R) Post Fall Evaluation note dated 9/15/21 at 3:49 p.m. reflected Called to resident (R6's) room. Resident found in wheelchair with grippy socks in place. He stated that he had fallen in the bathroom after trying to transfer unassisted. Denied pain. Skin assessment completed and no issues noted. Educated on call light use and waiting for assistance. (MD AA) and family member (name) notified of fall. No new orders obtained. According to the report the call light had been activated but R6 did not wait for assistance. No further details surrounding the fall were documented and additional interventions to prevent another fall were not added to the care plan. Review of the Care Plan Report, canceled in its entirety on 11/11/21 after R6 was hospitalized reflected that on 9/9/21 (date of admission), R6 was identified as needing assistance with Activities of Daily Living (ADLs), however the plan did not specify how many staff or what level of assistance was needed for bed mobility, transfers, personal hygiene, eating, bed mobility or toileting. The canceled care plan indicated that R6 was at risk for falls related to conversion disorder with seizures or convulsions and secondary Parkinsonism with the goal (R6) will have no serious injury related to falls AEB (as evidenced by) documentation thru next review. Interventions to meet the stated goal included Assistive Devices (non-specific); ensure call light or bathroom call light are answered promptly; ensure call light is within reach; monitor for signs and symptoms of fatigue; encourage rest periods as needed; nurse will assess resident for changes in physical or mental status and notify Dr. as needed and follow up with recommendations. Review of a Physical Therapy PT Discharge Summary for the dates of service 9/17/21-10/28/21 reflected that R6 had been discharged from physical therapy due to being discharged to the hospital. Review of the report reflected R6 had not met the majority of short or long-term goals, including reducing the risk for falls. According to the report a short-term goal was that R6 would Safely ambulate on level surfaces 150 feet using two wheeled walker with CGA (Contact Guard Assistance) with normalized gait pattern 90% of the time to facilitate increased participation in functional activity was not met. Review of an Order Recap Report for the date range 9/01/21-1/29/22 reflected R6 was prescribed Cyclobenzaprine HCl Tablet 5 MG (milligram) Give 5 mg by mouth three times a day for muscle pain for 5 days. Started on 12/13/21 and discontinued on 12/14/21. A second order for Cyclobenzaprine HCl Tablet 5 MG (milligram) Give 5 mg by mouth two times a day for muscle pain for 5 days started on 12/14/21 and ended on 12/19/2021. Cyclobenzaprine HCl is a muscle relaxer with side effects that include but are not limited to dry mouth or throat, headache, blurred vision, drowsiness, dizziness and fatigue. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of an Incident Note dated 12/18/21 at 3:05 A.M. reflected CNA (Certified Nurse Aide) doing rounds down hallway when coming back up hallway heard noise then yell. Found resident (R6) lying inside bathroom door facedown with feet just outside of door and lying up against the wall left side. When asked resident what happened he stated got dizzy and passed out but tried to catch himself on the wall with his left hand. Resident call light was not in use and he does have urinal at bedside that was empty. He also took off his oxygen and saturation was 90%, did have increased confusion A&Ox2 (alert and oriented to person and place). During assessment resident was assisted onto his right side where he yelled out in pain and unable to move his left leg at the hip, pain level 8/10 at this time. Other nurse notified doctor, the DON (Director of Nursing) and 911 was called. Resident also had hematoma to left side of forehead it is raised approximately measuring 5 cm x 3 cm, abrasion to left elbow and hematoma present. Resident was transported via (ambulance company) to (hospital). Attempted to contact family members one number no in service and left message with other contact. Review of a Hospital Discharge Summary dated 12/31/21 reflected [AGE] year old male with PMHx (previous medical history) of HTN (high blood pressure), COPD on 2L NC (2 liters via nasal cannula), Afib (atrial fibrillation) (on eliquis), hypothyroidism, heart failure, s/p PPM (status-post permanent pacemaker), acute decompensated HF (heart failure) with preserved EF (ejection fraction) admitted following mechanical fall. Imaging showed left intertrochanteric fracture of the left femur, S/P Left hip ORIF (open reduction, internal fixation) with nail placement surgery. Following surgery, he was found to be hypotensive and in atrial fibrillation was started on Phenylphrine and received two liters of IVF (intravenous fluid) boluses and was transferred to ICU (intensive care unit) for close monitoring. Review of the Electronic Medical Record (EMR) for evidence of care planning reflected R6 did not have an active care plan in place for any focus areas. Attempts to open a current care plan or Kardex (an at a glance care guide) resulted in documents annotated No Data Found. Further review of the EMR revealed a historic care plan that had been canceled as of 11/11/21 due to R6 discharged from the facility for a hospitalization [DATE]-[DATE]. No evidence a new care plan had been developed or implemented upon readmission to the facility on [DATE] was found. On 1/24/22 the DON was asked to provide the fall incident report dated 12/18/21 and the accompanying investigation. According to the DON, only the incident report was available and no additional information could be found. Attached to the incident report was an Investigation Follow-Up form that was not filled out. Circumstances surrounding the fall were not reviewed and without a care plan in place, no interventions had been developed or implemented prior to the fall that may have prevented the serious injury. 39056 Resident #3 (R3) Review of an Admission Record revealed R3 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: schizoaffective disorder and bipolar disorder. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of a Minimum Data Set (MDS) assessment for R3, with a reference date of 9/2/21 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated R3 was cognitively impaired. Review of the Functional Status revealed that R3 required supervision with one person for personal hygiene/showering. Review of R3's Care Plan last revised on 10/11/21 revealed, FALLS: I am at risk for falls r/t (related to) SOB (shortness of breath), schizoaffective disorder, and insomnia . Review of R3's Care Plan last revised on 8/27/21 revealed, Resident requires (assistance level) X (how many staff) for Bathing/Showering. (It did not specify the number of staff nor the level of assistance needed for Bathing/Showering) During an observation on 1/26/22 at 12:28 P.M., the shower door on the Memory Care Unit was not functional. During an observation on 1/31/22 at 8:03 A.M., R3 entered the unlocked shower room on the Memory Care Unit alone and closed the door. An unidentified CNA who had stayed over from 3rd shift observed R3 enter the shower room, and on two occasions put an ear to the door to listen for R3. At 8:12 A.M., R3 exited the shower room. Review of the facility Repair Requisition dated 1/21/22 for the Memory Care Unit revealed, Shower Room lock don't lock anymore. On 1/31/22 at 10:53 A.M. the facility administration was notified of the Immediate Jeopardythat was identified on 1/27/22 at F-689 as the result of the facility failure to prevent accidents and hazardous situations for 17 residents (Resident #148, Resident #144, Resident #42, Resident # 8, Resident #153, all 11 residents on the locked memory care unit, Resident #6, and Resident #3), resulting in an Immediate Jeopardy, when beginning on 01/23/22, the facility failed to (a) follow a strict ordered diet of NPO (nothing by mouth) and provide a functioning call light system for Resident #148, (b) implement standard safety protocols to prevent a fall and correctly assess for neurological changes after an unwitnessed fall for Resident #144, (c) safely transport Resident #8 and Resident #42 in a wheelchair, and assess Resident #42's level of staff assistance needed to safely complete activities of daily living, (d) follow the physician order to check wanderguard placement twice daily for Resident #153 and provide a system for staff to quickly identify which residents were at risk for elopement, (e) provide a system for staff in the locked memory care unit to, (1) access health records, (2) locate the crash cart, and (3) contact other staff in case of an emergency, and maintain and audit for properly stocked crash carts, (f) develop a plan of care to prevent a fall with fracture for Resident #6, and (g) secure a shower room on the locked memory unit, to prevent Resident #3 from accessing the shower room independently. As of date of exit, 2/3/22 at 4:00 P.M., the facility had not developed an approved plan to remove the Immediate Jeopardy and the State Agency was not able to verify the residents living at the facility were free from the potential for serious injury, serious harm and or death.