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	03/17/2023

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

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intakes M100133539 and M100131917. Based on observation, interview and record review, the facility failed operationalize policies and procedures to ensure the residents rights were represented by their appointed patient advocate and act in the best interest of 1 (Resident #111), resulting in a resident with Alzheimer's dementia and mental illness to elope from the facility, denied legal advocate to be informed and/or represent the residents care and finances with no resources, and threatening an unsafe discharge to a motel. Findings include: Resident #111 (R111) Review of a Face Sheet revealed R111 originally admitted to the facility on [DATE] with pertinent diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbances, unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence. The primary emergency contact listed is Family Member (FM) 1. Review of the Minimum Data Set (MDS) dated [DATE] revealed R111 had a Brief Interview for Mental Status (BIMS) indicating she was cognitively intact with no behaviors and independent with cares. Review of the MDS dated [DATE] revealed R111 had a Staff Assessment for Mental Status indicating she was independently and consistently able to make decisions. She rejected care with no other behaviors and independent with cares. Review of a Medicaid Level of Care Determination document created 8/26/22 and conducted on 8/4/22 for R111 revealed R111 qualified for services through Door 2 for cognitive performance and was marked as having a memory problem and moderately impaired for cognitive skills for daily decision making. Review of the Preadmission Screening/Annual Resident Review (PASARR) for R111 dated 9/19/22 revealed she has dementia with behavioral disturbances, depression, and emotional disorders with onset usually occurring in childhood and adolescence. The PASARR dated 10/4/22 revealed R111 has dementia and mental illness with the same diagnoses as the former During an observation and an interview on 2/22/23 at 11:53 AM, R111 was ambulating in her room and did not want to talk to this surveyor. (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/22/23 at 12:40 PM, Complainant C1 reported R111 has Alzheimer's disease and dementia. Prior to admission to the facility, the resident was found wandering in a field with all her money that she withdrew from the bank in her sock. R111 went to the hospital and the Power of Attorney (POA) was activated in 6/2022. It is unclear if the resident eloped from the facility because the facility did not communicate that with the POA. Review of a Petition for Appointment of Guardian of Incapacitated Individual dated 12/29/22 for R111 revealed she lacks sufficient understanding or capacity to make or communicate informed decisions because of mental illness and physical illness or disability. She has a history of wandering on several occasions, at least once with no shoes on tens of miles away from her residence at that time . has been diagnosed with dementia. The document mentions of her experiences with extreme paranoia and extreme distrust and cannot be safely left alone. The social worker at the facility has asked family to pursue a Guardian indicating potential lack of capacity. (R111) does not pay her bills and refuses to allow anyone else to assist her due to her dementia and associated paranoia. Review of the Advance Directive Durable Power of Attorney for Healthcare (Patient Advocate Designation for R111 signed 2/2/21 revealed the resident designated her daughter (FM 1) to be her Patient Advocate and it was signed by two witnesses. Review of a Physician Determination of Incapacity document for R111 revealed on 6/11/22 two physicians deemed R111 incapacitated. In an interview on 2/23/23 at 10:13 AM Certified Nursing Assistant (CNA) C reported R111 is receptive to care but is usually independent. There are times when she does not make sense, but this day the resident does. In an interview on 2/23/23 at 10:35 AM, the Physician (MD) F Reported R111 is not incompetent. Prior to her admission to the facility, she was sick but got better. The resident refuses her medications because that is her religious right. MD F reported he spent an hour with her asking questions and she knows more than most at the facility. He reported he is unaware of her past profession and reported she likes to play games like telling the hospital one thing that is not true, yet when confronted she will say something different. MD F reported he has argued with physicians at the hospital who claim she is incompetent. When queried about R111 having dementia, MD F reported she may have a little dementia. When queried if the resident has the potential for being in and out of competency, he responded she might. Review of a Wandering Risk Scale with an effective date of 7/28/22 for R111 revealed she was categorized as a High Risk to Wander. The indicators were having a history of wandering and a medical diagnosis of dementia/cognitive impairment; diagnosis impacting gait/mobility or strength. Section G Complete 72 hours post admission- Has wandered aimlessly within the home of off the grounds. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a document titled Certificate of Physician as to Competency of an Individual dated 8/23/22 for R111 revealed the facility physician documented The patient exhibited the following symptoms: mental: currently competent. Based on tests and my examination of the patient, it is my professional opinion that (R111) is competent at this time. This document is signed by only one physician and states: This certificate will be used in legal proceeding. The information this certificate contains must be based on your personal examination of the patient. Please address each issue contained in the certificate including the nature, cause, extent, and probable duration of any disability that your patient may have which interferes with his/her ability to make responsible decisions about health care, food, clothing, shelter, or property. It is possible that your testimony about this information may be required at a hearing. Review of a document titled Physician Certification of Capacity signed and dated 11/17/22 for R111 revealed: As of this date, this resident is: Able to make medical decisions. This document is signed only by one physician as the document stated that is all that was required. In an interview on 2/23/23 at 10:45 AM, Licensed Practical Nurse (LPN) D reported she thinks R111 has has worked as a caretaker in the past at a home health care. When queried about R111 being educated on the refusal of her medications, LPN D reported she has been educated verbally but not sure if she was educated with a written acknowledgement. LPN D reported the resident was educated about refusing her medications when she had an inpatient stay at the psych hospital. LPN D reported R111 does make sense when she talks to the resident, but their conversations are limited. LPN D reported R111 is her own person and if something was to happen to the resident, she was not sure if they would contact anyone but would have to look at the face sheet to see if her daughter was an emergency contact. LPN D reported the facility was currently working on the resident establishing guardianship. LPN D then looked at the Face Sheet for R111 and acknowledged that the daughter of R111 should be contacted in the event that the resident would go to the hospital. LPN reported that depending on the day or time, R111's mood can go back and forth. She can be loud and short tempered. There was an incident when the resident left the facility, but she chose to leave and called for transportation herself. There was an incident when R111 started to get upset and threatened to punch a staff member. In an interview and record review on 2/23/23 at 12:19 PM the Business Office Manager (BOM) I reported she was told that R111 was competent and her own person in August 2022 when the resident signed a SNFABN (Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage) on 8/18/22 and marked on the form she was not appealing the decision on the form. Her benefits were set to end on 8/23/23. The resident was determined to not pay for her stay at the facility. On 1/5/23 her daughter became her emergency guardian and the facility received back pay for the months they did not receive any payments. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/24/23 at 9:53 AM, Family Member FM1 who is R111s daughter and emergency appointed guardian that was her original appointed advocate in 2021 reported that the resident had been a Certified Nurse's Aide for [AGE] years in the past at nursing homes and knows a lot. FM1 reported several incidents prior to admission to the facility about the resident unsafely and uncharacteristically wandering in the city and had other behaviors that were unsafe and had poor decision making. Prior to admission to the facility, R111 had her POA activated in June 2022 at the hospital. R111 signed the Five Wishes for her patient advocacy document in 2021 that made FM1 her patient advocate in the event that it would be activated. R111 is giving the facility a hard time because of her background history of being a CNA for so many years. FM1 reported R111 escaped from the facility in either October or November and heard she went to one of the residential houses and told them to call the police. She gave the police her [NAME] name. The police took her to the police station and somehow found her somewhere else later on in the middle of the night. FM1 reported she received a voicemail sometime during that night that her mother eloped and thinks it may have happened on the night of Thanksgiving. FM 1 reported she talked to the social worker when R111 was place at the facility and talked about guardianship. They started the process through the county who said her POA paperwork was already effective, and guardianship was just a formality and not necessary. She tried to reach out to the Social Worker and would not get much response. The family wanted to try to place her in a facility closer to home but the facility told them that would be hard because of her behaviors. Then in December the physician deemed her competent and tried to discharge the resident to a hotel. FM 1 became aware of this and was advised to reach out to the Ombudsman who reported they needed to give a 30-day notice prior to a discharge and could not just dump her. After Thanksgiving, R111 had some behaviors and the facility sent R111 out to a psychiatric hospital without informing FM 1. There are other times when R111 was sent to the hospital without FM 1 being notified. The DON apologized to FM 1 the week of this survey of an episode she was not made aware of until her aunt came to the facility to visit the resident. FM 1 has not been invited to care conferences either. In an interview on 2/24/23 at 11:00 AM the Nursing Home Administrator (NHA) reported R111 did leave the building on 11/24/22 but she did not elope because she was her own person and just wanted to get some potato chips and a pop. So, she called the police to come pick her up. She did not report the incident to the State Agency because it was not an elopement. The resident failed to sign herself out on the Leave of Absence (LOA) book. When asked if there was an incident report for this incident, the NHA provided a summary that was in her soft file in her office. Review of Nursing Progress notes for R111 dated 11/29/22 revealed the physician was notified the resident was hitting staff with her cane and was ordered to send to psych. Daughter was notified. Review of Nursing Progress notes for R111 revealed she was sent to the hospital on 12/1/22 for a medical clearance and was sent back to the facility. No documentation indicating FM 1 was notified. Review of Behavioral Health Records for R111 for an admission on 12/6/22 revealed an application for emergency admission. A progress note revealed: Patient is ultimately without mental faculties at this time necessary for logical discussion. (She refuses medications). Patient will need to be monitored carefully. Denies complete review of systems however she is a questionable historian. Her History and Physical psych exam revealed she is alert, talkative, religious preoccupation, and illogical. Her Assessment and Plan concluded she has Dementia of the Alzheimer type with behavioral disturbance and a mood disorder. She does not see herself as having a psychiatric illness. She is oriented to person, place and time and has a Remote memory. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Elopement Evaluation dated 12/14/22 for R111 upon readmission to the facility revealed the resident was ambulatory and had risk factors marked for Resident is cognitive impaired, poor decision-making skills, and/or pertinent diagnosis (Example, dementia, Organic Brain syndrome, Alzheimer's, delusions, hallucinations, anxiety disorder, depression, manic depression, and schizophrenia). The boxes marked for the resident having a history of wandering into unsafe areas and making statements that they are leaving were marked. The Elopement Care Plan not initiated was marked and to see comments - Own responsible person. Review of a Social Workers Progress note dated 12/26/22 for R111 revealed (Social Worker and Business Office Manager) went and met with (R111) about past due bill. (R111) stated she does not owe us anything. SW explained that without paying her past due bill that corporate said she needs to discharge as soon as possible. (R111) is in agreement of SW finding her a motel close to the Muskegon area for her to discharge to. SW phone daughter and left a voicemail informing her of the discharge plan. Review of a Medicaid Level of Care Determination document created 12/28/22 for R111 revealed she did not meet the LOCD medical/functional criteria for Medicaid NF Level of Care indicating she did not have cognitive or behavioral concerns. This document was signed by R111 on 12/28/22 indicating she received a copy of a denial of Medicaid NF Level of Care service based on the LOCD and understood her rights to appeal. Only the determination/signature page was provided, no assessment criteria provided. Review of a Social Workers Progress note dated 12/28/22 for R111 revealed SW phone [NAME] for Muskegon area to get services stated for (R111). SW waiting for call back. Review of the Care Plan for R111 revealed no intervention for discharge planning was implemented. Review of an Administration progress noted dated 12/28/22 for R111 revealed: Residents discharge was placed on hold as there are not any home health agencies in the area that are able to pick up her case due to being full at this time. Will continue to work on discharge with resident and her daughter per resident's request. Will assist by reenlisting resident in senior resources . Review of a Nursing Progress noted dated 12/29/22 at 7:37 PM for R111 revealed: Daughter called, requesting information about POC, transferred to Director. Review of a Post Discharge Plan of Care- To Home document for R111 recorded 12/28/22 with a planned discharge to the community on 12/29/22 to a hotel with a home health aide, nursing services, therapy services and social work services. No dietary needs addressed, no ombudsman notification documented, and the resident was provided a copy of her medications. Review of a Medicaid Level of Care Determination document created 2/3/23 and conducted on 8/4/22 for R111 revealed R111 qualified for services through Door 6 for Behaviors that included resisting care and delusions but not for wandering, verbal, or physically abusive behaviors. She did not qualify for Door2 indicating her memory is okay, she is independent with decision making, and expresses ideas clearly and without difficulty. Review of a Resident Elopement Assessment for R111 dated 2/28/23 revealed the resident is At Risk for an elopement. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/28/23 at 2:30 PM, Social Worker (SW) N reported she is a new social worker at the facility and was just recently filled in about R111s daughter seeking guardianship and their desire for R111 to move closer to home. SW N reported R111 is her own person based on the facility's' medical professional assessment. They would deem a resident incompetent based on their policy indicating two medical professionals have to deem her incompetent. SW N is not aware of two medical professionals deeming R111 incompetent prior to admission to the facility. SW N reported the last care conference on 2/16/23 R111 declined to attend to the care conference and did not have her representative attend and not sure why or if she was informed of a care conference. SW N was not aware of R111 having a psychiatric consult in December or reviewed the progress notes pertaining to her stay but reiterated she is her own person. She is allowed to leave the facility if she signs herself out. When questioned about why R111 did not sign consents and FM 1 did on 8/22/23 for vaccines, the day before she was deemed competent, the social worker did not have an answer. SW N reported R111 can answer questions when she chooses to answer them and seems to be cognitively aware when she speaks with her. SW N said R111 is not an elopement risk because she is her own person. When asked if the residents' representative should be contacted if she went to the hospital, the social worker reported no. When advised FM 1 was listed as her emergency contact, SW N then said she should be contacted. SW N reported the daughters desire to transfer the resident closer to home was on hold at this time because she is not her guardian. When asked if it was okay for R111 to leave the facility alone anytime especially at night, SW N reported she wouldn't want anyone to leave at night and would advise them to leave at a different time, but she is her own person. In an interview on 3/1/23 at 9:46 AM, Social Worker (SW) O reported she no longer works at the facility as of 12/28/22. SW O reported R111 would many times walk around in the parking lot at the facility alone because she was her own person, she did not need supervision and has that right. She would stay outside the building and staff would peek through the windows to check on her. The night of the elopement, R111 wanted some snacks so she called the police to take her to get some snacks. When queried if she knew a resident was walking around at night in the cold and the dark, would you just let them? SW O said No, but she was her own person and could go outside because she has that right. In an interview on 3/3/23 at 9:13 AM, the Director of Nursing (DON) reported that her expectations for residents who have advocates to be informed of resident care. R111 was her own person and until the courts recently got involved, the facility did not need to reach out to her daughter because the resident was her own person. The DON felt that if R111 was truly incompetent, then why didn't the psychiatric hospital deem her incompetent in December? The facility will send residents to the hospital, and they send them right back because nothing is wrong with the residents. When asked if she felt R111 eloped from the facility, she said I plead the 5th. When queried about FM 1 not being invited to the care conferences, the DON reported she was invited but could not make it. When queried about her being discharged to a motel in December, the DON reported the resident threatened the facility she was not going to pay them one red cent. Then the daughter was informed mostly because of the finances. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/9/23 at 4:33 PM, the Fire Chief (FC) P reported he was informed R111 called 911 herself and when they arrived on the scene, he was informed she was kicked out of a car. She was on the ground on the corner not far from the facility (about 100 yards) and had her cane and thinks she had some of her belongings. He called the nursing facility who denied a resident with the last name he gave them that was given by the resident, and then asked the facility if they were missing a resident, and the facility denied missing a resident. His first impression of R111 when he arrived was that she would answer things very well, but none of the information she gave made sense even though it was consistent. It made no sense why she was there. She had no complaints of injury. The police arrived on the scene and was aware they were going to take her to the County Sheriff headquarters. Review of an email correspondence dated 3/13/23 from the NHA revealed R111 did not have a LOA (Leave of Absence) safety assessment to leave the facility by herself or any education provided to her or her representative. Review of the Care Plan for R111 revealed on 2/16/23 she had a focus for a history of yelling, threatening, hitting, throwing objects, taking my name off the door plaque, and refusing medications related to the diagnoses of dementia and behavioral disorder. Review of the Care Plan for R111 revealed no indication she was a previous CNA at a Nursing Home Facility or being at risk for wandering/elopements. On 8/3/22 revealed a focus for Behavioral Symptoms due to her diagnoses of Dementia with behavioral disturbances. On 9/1/22 another focus for Behavioral Symptoms due to the resident using psychotropic medications. The care plan overall is not a person focused care plan. Review of a policy titled Residents' Rights Regarding Treatment and Advance Directives dated 11/1/22 revealed: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. 4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities. 5. The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions. 6. The facility will define and clarify medical issues and present them to the resident or legal representative as appropriate. 7. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. 8. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. 9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. 10. The facility will not discharge or transfer a resident should they refuse treatment either through an advance directive or directly unless the criteria for transfer or discharge are otherwise met. 11. Should the resident refuse treatment of any kind, the facility will document the following in the resident's chart . Review of a policy titled Competency Evaluation with no date of implementation or revision revealed: It is the policy of this facility to evaluate each employee to assure appropriate competencies and skills for performing his or her job and to meet the needs of facility residents. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Job Description for a Social Worker last reviewed 4/1/21 revealed their job summary is to 1. Identify each resident's social, emotional and psychological needs. 2. Develop and carry out a plan to develop the resident's full potential during their stay. 3. Educate patient/family regarding post-acute options and address issues of choice. 4. Assist team members with discharge planning activities. Review of a policy titled Discharge Planning Process dated 10/26/22 revealed: It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Review of a policy unnamed provided by the facility for determining decision making capacity last revised 3/11/22 revealed: . Based on these assessments and related discussions, the physician and staff will define an individual's decision-making capacity and will document the basis for such conclusions in the medical record. The staff and physician will review and discuss significant changes in the resident/patient's cognition or ability to make decisions over time, and will identify the implications for his/her ability to make or participate in healthcare decisions. Decision-making capacity may be partially or totally absent and can fluctuate or change over time. It is influenced by factors that affect brain and other organ system function, including medications and medical conditions.

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This Citation Pertains to intake #: MI00133943 Based on interview and record review, the facility failed to ensure chemical restraints were not utilized for staff convenience for R117. On 2/7/23 R117 was administered Roxanol (used for the treatment of severe pain) without clinical indication that R117 was experiencing pain and for the purpose of treating R117's behaviors of anxiety, restlessness, and agitation. This deficient practice resulted in an immediate jeopardy beginning on 2/7/23 when R117 arrived to the Emergency Department lethargic, minimally responsive, hypotensive, hypoxic, with bradypenia and pinpoint pupils suspect related to overmedication and places all residents who present with behaviors at high risk to experience serious harm, injury and/or death from use of chemical restraints. Findings: Resident #117 (R117) Review of an Admission Record revealed R117 was a [AGE] year-old female, originally admitted to the facility on [DATE], readmitted on [DATE], with pertinent diagnoses which included: dementia, unspecified severity, with other behavioral disturbance, unspecified symptoms and signs involving cognitive functions and awareness, anxiety disorder, autistic disorder, bipolar II disorder, and insomnia. Review of a Minimum Data Set (MDS) assessment for R117, with a reference date of 2/5/23 revealed a Brief Interview for Mental Status (BIMS) score of 99, out of a total possible score of 15, which indicated R117 was severely cognitively impaired. During an interview on 2/28/23 at 10:58 AM, Court Appointed Guardian (CAG) V reported Director of Nursing had approached her multiple times since R117's readmission on 1/30/23 regarding changing R117's code status to DNR and changing her to comfort care or hospice because of her behaviors only. CAG V reported that R117 had been sent to 4 psychiatric hospitals over the last year and she wanted R117 to remain in the facility because of how disruptive and upsetting being transferred out to different facilities was for R117. CAG V reported she was willing to consent to medication changes to keep R117 stable but became concerned and questioned the rationale of new medications and medication changes when the DON demanded that R117 be made a DNR and begin hospice/comfort care so facility staff could control her behaviors. CAG V questioned why the facility's contracted psychiatrist could not assess R117 and make changes and why the DON was demanding comfort medications for psychiatric diagnoses. CAG V reported there was no rationale provided to her and she became increasingly concerned that the facility staff were going to keep R117 overmedicated and sedated resulting in a poor quality of life. CAG V did not report that R117 had a history of pain requiring the use of opioid analgesic medications. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CAG V reported that in the afternoon on 2/7/23 the DON stated that if CAG V did not consent to the use of the roxanol, change R117's Code Status, and allow additional comfort medications then R117 would be sent to the hospital and could not return. CAG V stated that the DON called me and said they had given it (Roxanol) to her (R117) 40 minutes prior and she was still out of control and sent her to the hospital (refer to Nursing Progress Note dated 2/7/23 at 2:05 PM and 2/7/23 at 2:25 PM). CAG V reported that the hospital physician notified her that upon arrival to the Emergency Department R117 was almost comatose and nonresponsive with a dangerously low blood pressure. CAG V reported that the hospital physician felt that her conditional upon arrival was critical. Review of R117's Care Plan revealed no entries related to overall behaviors (interventions to implement when R117 is having increased behaviors, non-pharmacologic interventions for behaviors). Review of R117's Falls Care Plan created 12/10/22 revealed, Resident frequently puts herself on the floor .If (R117) puts self on floor staff to monitor for safety. Indicating R117 had a history of the behavior of placing self on floor. Review of R117's MDS assessment dated [DATE] revealed opioid medications were not administered in Section N-Medications and Pain was not triggered in Section V-Care Area Assessment (CAA) Summary. Review of R117's MDS assessment dated [DATE] revealed opioid medications were not administered in Section N-Medications and Pain was not triggered in Section V-Care Area Assessment (CAA) Summary. Review of R117's Care Plan revealed no entries related to pain and/or pain management (pain medications, non-pharmacologic interventions.) Review of R117's Hospital Records from hospital stay 1/19/23-1/30/23 revealed no documentation of pain. Discomfort noted related to constipation which resolved. Review of R117's Hospital Progress Note for discharge, dated 1/29/23 at 5:15 PM revealed, [AGE] year-old F (female) from (name omitted) Neuropsych unit with past medical history of autism, neurocognitive disorder, Seizure disorder presented with respiratory distress .She has sitter (one on one staff person that remains with resident at all times for safety) .She is stable and plan has been to discharge back to (psychiatric unit name omitted), per (name omitted) neuropsych request, Psychiatrist consulted however now we have been notified that per (name omitted) hospital, patient has finished management there and should go back to her NH (nursing home) in MI (Michigan) and case manager has started the process .Assessment/Plan .Continue sitter . Confirming that at the time of discharge from the hospital R117 required 1:1 (sitter) staff monitoring. Review of R117's Admission Nursing Comprehensive Evaluation dated 1/30/23 at 7:50 PM revealed a pain assessment resulting in 0 of 10 No Pain. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R117's Physician Readmission note/H&P (History and Physical) dated 1/31/23 at 10:33 AM revealed, (R117) is being seen at (facility) for readmission and for following of chronic conditions. She is post hospitalization for geriatric psychiatric problems. Comorbid conditions include HTN (hypertension), dyslipidemia (high cholesterol), generalized weakness and others. There have not been appetite changes. There have not been any new health care changes .Current emotional concerns includes dementia and bipolar disorder and anxiety . General: She is not in acute distress . Assessment and Plan: (R117) was seen today for follow-up. Diagnoses and all orders for this visit: Dementia with behavioral disturbance (Primary) Bipolar affective disorder, remission status unspecified (HCC) Anxiety Essential hypertension, benign-Dyslipidemia-Generalized weakness-Unsteady gait-Return in about 1 month (around 2/28/2023). Pain was not identified during the comprehensive assessment conducted by Medical Director (MD) F. Review of R117's Nursing Progress Note dated 1/31/23 at 2:05 PM, written by Director of Nursing (DON), revealed, This writer called and spoke to (R117's) Guardian (Court Appointed Guardian (CAG) V). This writer wanted to discuss (R117's) condition and increased behaviors. This writer spoke about possible Hospice/comfort measures for restlessness. (CAG V) was not wanting to discuss comfort measures. (CAG V) stated you are not just going to drug her up to make your job easier .(CAG V) still continued to state you cannot put her on Hospice. I spoke with your Nurse this morning. (CAG V) was again told that (R117's) behaviors have started already, and she was putting herself and others at risk with her aggression. (CAG V) continued to state No. She will not qualify for Hospice .(CAG V) was not wanting to discuss comfort measures stated she would get back with this writer . (Clarification obtained with DON regarding the name of R117's guardian documented in the progress note. DON confirmed R117's guardian as CAG V.) Review of R117's Nursing Progress Note dated 2/1/23 at 1:37 PM, written by DON, revealed, This writer spoke with (Community Mental Health Case Worker (CMHCW W). CMHCW W wants (R117) not to be sent out of facility again. This writer explained to (CMHCW W) that I had spoken to (CAG V) R/T (related to) comfort measures and that (CAG V) was not willing to agree to comfort measures. (CMHCW W) had asked what it would take to keep (R117) at the facility. This writer explained that while (R117) was out to Psych hospital her Guardian would not ok for increased medications as her medications were not working. (R117) was still agitated and restless. When (R117) returned to (facility) she continued to be agitated and restless and the Psych Hospital had decreased her meds R/T her Guardian who insisted She is not to be drugged up. (CMHCW W) stated she would speak with (R117) Guardian and call back. DON did not provide documentation (psychiatric hospital discharge notes, email correspondence with psychiatric facility, legal documentation, etc) prior to survey exit to support the allegation that CAG V refused medication changes at the psychiatric hospital. Review of R117's Hospital Progress Notes from 1/19/23-1/30/23 revealed R117 was sent from the neuropsychiatric unit to the hospital on 1/19/23 for a medical emergency following a seizure. Multiple psychiatric medication changes were made during R117's hospital stay through discharge back to the facility. Psychiatric medication changes during hospital course included: stop clonazepam (antianxiety medication), stop haloperidol (antipsychotic medication), dose decrease for risperdal (antipsychotic medication), and dose decrease for ativan (antianxiety medication). Hospital documentation did not reveal that CAG V refused medication changes. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R117's Nursing Progress Note dated 2/1/23 at 1:49 PM, written by DON, revealed, (CMHCW W) from CMH did call back after she had spoken to (R117's) Guardian. (CMHCW W) stated that Guardian was on board with the medication changes. Dr. was notified and new orders received. Ativan 1mg TID (three times a day) and Norco TID. Will monitor for tolerance and effectiveness. Review of R117's Physician Order dated 2/1/23 revealed an order for Hydrocodone-acetaminophen (Norco) 5-325mg 1 tablet three times a day to be administered at 8:00am, 2:00pm, and 8:00pm. Review of R117's Electronic Health Record revealed no documentation of pain from time of admission on 1/30/23-2/2/23. Daily pain assessments from 1/31/23-2/2/23 revealed a pain score of 0 out of 10 (no pain). R117's Electronic Health Record revealed no comprehensive assessment indicating R117 was experiencing pain (provocation/palliation, quality/quantity, region/radiation, severity, verbal and nonverbal cues) nor a rationale for beginning a new opioid analgesic to be administered routinely and not as needed for pain. Review of R117's Physician Order dated 2/1/23 revealed an order for lorazepam (Ativan) 1mg tablet three times a day to be administered at 8:00am, 2:00pm, and 8:00pm. Hospital discharge order was for Ativan 0. 5mg 2 times a day as needed for anxiety Max Daily Amount: 1 mg. Review of R117's Nursing Progress Notes revealed R117 began to have increased behaviors beginning on 2/5/23. * 2/5/23 at 6:00 AM Resident on the floor on her back 0530. No injuries .Resident was up all night, last dose of Ativan was not given. New schedule for last dose in place. Will continue to monitor. *2/6/23 at 8:07 PM res (resident) one on one most of day. arching back, maneuvering bottom to attempt to slide out of chair . *2/6/23 at 10:20 PM Resident continuously screaming, attempting to get out of bed, throwing her legs over the side, needing to be repositioned every 15 minutes or less . *2/7/23 at 3:20 AM Resident extremely restless throughout the night, needing to be repositioned several times. Staff observed resident nearly on the floor x3 throughout shift from scooting to the very edge of the bed .She appears to need 1:1 assistance to ensure safety. *2/7/23 at 10:35 AM .she was extremely restless, throwing her legs over the side of the bed, rocking back and forth and yelling out. Staff were unable to understand what (R117) was saying. (R117) was assisted into her chair. She then began to scoot towards the front of the chair, trying to scoot self to the floor. (R117 had a known behavior of placing self on floor as evidenced by Fall Care Plan dated 12/10/22). Review of R117's Nursing Progress Note dated 2/7/23 at 10:59 AM, written by DON revealed, This writer along with another Nurse Manger called (R117's) Guardian R/T (related to) her decline/increased behaviors/restlessness, multiple incidents of (R117) putting self on floor. (CAG V), Guardian, was not wanting any medications added at this time .This writer was very clear and stated multiple times to (CAG V) if she did not assist the facility with the proper care for (R117), we would not be able to meet her needs. (CAG V) requested a phone call from Dr. Will continue to monitor. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R117's Nursing Progress Note dated 2/7/23 at 11:57 AM, written by DON revealed, .Facility is having difficulties working with Guardian who does not want (R117's) medications increased or changed. Also, left VM for (CAG V), Guardian, to inform of increase of Risperdal in hopes of making (R117) more comfortable as she is still extremely restlessness. (Note: the DON reported CAG V would not allow medication changes despite documenting a new increase in Risperdal). Review of R117's Nursing Progress Note dated 2/7/23 at 2:05 PM, written by DON revealed, This writer spoke with (CMHCW W). (CMHCW W) was informed that (R117) was being sent back out to the hospital as staff could not get her comfortable and Guardian was not willing to work with staff as far as ordering more comfort medications . Review of R117's Nursing Progress Note dated 2/7/23 at 2:25 PM, written by DON revealed, This writer called (CAG V), Guardian, again to discuss the comfort medication Roxinol. (CAG V) did agree to the lowest dose to be given. 0.25ml Roxinol was given with no effect. (CAG V) was informed that (R117) would be sent out to the hospital again for further evaluation. (R117) continued to be a 1:1 and at this time facility could not meet her needs or safety concerns for herself or others .This writer explained that if she, (CAG V), was not willing to change (R117's) code status or allow comfort medications then facility could not meet her needs . At this point (R117) was still a 1:1 and facility could not accommodate that if all were not on the same page. (CAG V) stated yeah I know. You are not going to just give her drugs. This writer again attempted to explain it was not about drugs it was about getting (R117) comfortable. It was explained again that (R117) was extremely agitated and restless. (R117) was continuously screaming open!!!owww!!! (CAG V) continued to Deny comfort medications. (R117) was sent to (name omitted) hospital at this time. (Note: the DON reported CAG V would not allow comfort medications despite documenting CAG V consented to the administration of Roxanol). Review of R117's Controlled Medication Prescription dated 2/7/23 revealed, Roxanol (morphine sulfate) 20mg/ml (milligrams per milliliter) .Directions: 0.25ml (5mg) q2* prn (every 2 hours as needed). There was no clinical indication documented in the order for the use of the Roxanol. Review of the Food and Drug Administration (FDA) prescribing information for morphine sulfate (Roxanol) revealed Morphine sulfate is an opioid agonist indicated for the management of pain not responsive to non-narcotic analgesics. Indicating morphine/roxanol is clinically indicated to manage pain and not for the use of behavior management, restlessness, or agitation. Review of R117's Medication Administration Record revealed Roxanol (morphine sulfate) was administered on 2/7/23 at 12:21 PM for anxiety; restlessness. No pain assessment or documentation was completed at the time of the Roxanol administration confirming the Roxanol was administered to control behavior and not for pain control. Review of R117's Electronic Health Record revealed no documentation of a root cause analysis for R117's increased behaviors: physical assessment, pain assessment, laboratory testing, diagnostic testing, or medication tolerance/effectiveness. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/2/23 at 9:17 AM, Licensed Practical Nurse (LPN) Y reported that she was R117's licensed nurse on 2/7/23. On the day the morphine was administered (2/7/23 at 12:21 PM) R117 had increased behaviors. LPN Y reported that R117 was non-stop moving and attempting to throw herself on the ground. LPN Y reported that R117 had required a 1:1 to keep her in her gerichair. LPN Y reported that R117 had to have a 1:1 at all times and with the number of scheduled staff it was not feasible. LPN Y reported that R117 was not tested for a Urinary Tract Infection (UTI), and they (facility staff) did not feel that was the cause of her increased behaviors. No other testing (labs, xrays, etc) or assessments (pain assessment or comprehensive physical assessment) were completed on 2/7/23. LPN Y reported that the morphine was not effective in controlling R117's restlessness and agitation and R117 was sent to the hospital. Confirming the administration of Roxanol was for staff convenience to control behaviors and due to the insufficient number of staff to provide R117 with a 1:1. During an interview on 3/16/23 at 2:20 PM, Staff Scheduler (SS) I verified that on 2/7/23 there were 2 nurses scheduled and 1 nurse on orientation, 2 CNAs (Certified Nursing Assistants) scheduled on the Memory Care Unit, and 2 CNAs scheduled on the East/West/Central Units. 3 CNAs were scheduled from 6am-6pm and 1 CNA scheduled from 6am-2pm and 1 CNA scheduled 2pm-6pm. R117 resided on the East/West/Central Units. During an interview on 3/2/23 at 3:22 PM, Nursing Home Administrator (NHA) reported that she was familiar with R117 and her condition prior to her transfer to the hospital on 2/7/23. NHA reported that the provider ordered the Roxanol for R117 because she was so agitated. NHA reported there were no additional Progress Notes following the administration of the Roxanol from the provider and the only documentation related to the rationale for the administration of the Roxanol was from the Nursing Progress Notes. During an interview on 3/3/23 at 12:36 PM, Director of Nursing (DON), with survey team present, DON reported that R117 had been a 1:1 because of her increased behaviors prior to her transfer to the hospital on 2/7/23. DON reported R117 had severe psych issues and was uncomfortable and exhibited a lot of agitation and restlessness. She was uncomfortable but don't know if it was psych or physical. DON reported that one day R117 was yelling out oww oww oww (documented x1 on 2/7/23 at 2:25 PM at the time of transfer to hospital). DON could not provide a medical diagnosis confirming a terminal illness and referred to R117's psychiatric distress only. DON reported that admitting R117 to a hospice program would allow R117 to receive more 1:1 care from hospice staff and additional medications could be utilized. When asked why R117 could not have medication changes for psychiatric stabilization and symptom management without being placed on hospice/comfort care, DON did not provide an explanation. When asked if the physician and nurses completed a comprehensive assessment and evaluation to identify the root cause of R117 being uncomfortable both mentally and/or physically DON stated, we missed that. DON reported that R117's behaviors were endangering herself and nurses and had escalated to R117 biting and breaking the skin of a facility nurse. Review of R117's Electronic Health Record revealed the behavior reported by the DON occurred on 12/12/22 (Nursing Progress Note dated 12/12/22 at 8:53 AM) resulting in R117's transfer to the hospital and subsequent transfer to an Indiana psychiatric facility on 12/13/22 (R117 did not return to the facility until 1/30/23) and did not occur between 1/30/23-2/7/23. On 3/16/23 at 12:08 PM, an interview was conducted with NHA, DON, with the survey team and survey manager present. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Only documentation of R117 Biting was of her biting down on a spoon during meals on 2/1/23 at 4:04 PM and 2/6/23 at 12:10 PM. There was no documentation that she had attempted to bite staff from 1/30/23-2/7/23. *Review of R117's MDS assessment dated [DATE] revealed: MDS Section E-Behaviors revealed R117 did not exhibit physical behavioral symptoms directed toward others (e,g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and did not exhibit other behavioral symptoms not directed toward others. Verbal behaviors were identified. The MDS reflected that R117's behaviors did not put the resident at significant risk for physical illness or injury, did not significantly interfere with the resident's care and did not put others at significant risk for physical injury. The MDS reflected R117 did not reject evaluation or care which would include: (bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being . The MDS reflected that R117's behaviors had improved compared to prior assessment. *Hospital records dated 2/7/23 revealed R117 was administered Norco in the event that she is in pain and unable to communicate so. Confirming the lack of clinical indication for the use of the opioid. Review of the Emergency Department Provider Note dated 2/7/23 at 2:07 PM revealed, HISTORY OF PRESENT ILLNESS: The patient is a [AGE] year-old female who has a history of bipolar disorder, dementia, and hypertension. She has a legal guardian. History and review of systems is limited secondary to dementia and altered mental status. The history provided was obtained by the guardian (CAG V) and her primary nurse (facility). She has been seen at (facility) intermittently over the last year. In reality, she has been in and out of multiple psychiatric facilities secondary to behavioral disturbances. Her most recent Admission was last week. Since returning to (facility), she has had increased behavior disturbances again. She has been flailing around, hitting at staff, screaming out loud, throwing herself on the floor, disturbing other residents. Her Risperdal has been increased, they have also change her lorazepam from as needed to scheduled, they also started Norco in the event that she is in pain and unable to communicate so. Today, they added 5mg Roxanol. They waited approximately 45 minutes prior to transfer. However she continued to have behavioral disturbances and was then sent here. Per EMS, she has been essentially sleeping. Upon arrival, she is minimally responsive. She does open her eyes with painful stimuli or verbal stimuli, however she does not follow commands . Pulmonary: Effort: Bradypnea present. Breath sounds: Decreased breath sounds present . Neurological: Mental Status: She is lethargic and disoriented . (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R117's Admission History and Physical dated 2/7/23 at 6:25 PM revealed, Assessment and plan: The patient is a [AGE] year-old female who has a past medical history of bipolar disorder and dementia. She is well-known for severe behavioral disturbances. She has been in and out of multiple psychiatric facilities over the last year. She has been back at her current assisted living center for the last week. During this time they have noted worsening behavioral disturbances. She has had increases in her medications including her Risperdal dose, her lorazepam was when necessary but is now scheduled, she has also been started on Zyprexa. Today, they added when necessary Roxanol. Prior to arrival, she did receive 5 mg of morphine. Initially, patient was minimally responsive, opening eyes and moving extremities to painful stimuli. She was mildly hypoxic (low oxygen level) in the mid 80s. Pinpoint pupils were present. Suspect this is related to overmedication .Workup today does show an acute urinary tract infection. Rocephin has been ordered. In addition, she has a hypernatremia which is changed since December when she had a hyponatremia. Although this may be related to her dehydrated state, trending the comprehensive metabolic panel will be indicated. Throughout her visit, she has been intermittently hypoxic .She also remains obtunded although improved. I suspect that this is related to polypharmacy and overmedication. However, patient will need to be weaned off of oxygen . Clinical Impressions as of 02/07/23 1724 (5:24 PM) *Altered mental status, unspecified altered mental status type *Dementia with behavioral disturbance *Acute UTI *Hypoxemia *Polypharmacy *Hypernatremia . During an interview on 3/01/23 at 3:18 PM, Hospital Social Worker (HSW) T reported that when R117 arrived at the Emergency Department on 2/7/23 she was lethargic and overly sedated because she had been overmedicated at the facility. HSW T stated that it was reported that R117 was administered morphine for behavioral control and the facility was pursuing hospice care in order to manage her behaviors. HSW T reported that R117 was diagnosed with an acute UTI and Clostridioides difficile (c-diff infection is a severe and sudden infection in the colon) and when those infections were treated R117 returned to her physical and mental baseline. During an interview on 2/24/23 at 8:36 AM, Hospital Unit Manager (HUM) S reported that R117 had increased behaviors while at the facility resulting in the facility increasing medications and adding new medications. HUM S reported that when R117 arrived at the Emergency Department on 2/7/23 she was overmedicated and obtunded. HUM S reported that once she was admitted to the hospital, the physician had to stop her medications and slowly add medications back to ensure R117 was on an appropriate regimen of medication and did not become overmedicated again. HUM S reported that R117 was diagnosed with an acute UTI which was likely the cause of her behavioral issues. HUM S reported that when R117 was admitted to the hospital she was a little squirrely but once her medication regimen was adjusted and her UTI was treated, her behaviors resolved, and she no longer required a 1:1 sitter. (Elderly patients with UTIs often experience behavioral symptoms and confusion). Review of the Drug Interaction Report revealed the concomitant use of Ativan (lorazepam), Norco (hydrocodone/acetaminophen), and Roxanol (morphine sulfate) has the potential to result in profound sedation, respiratory depression, coma, and death. Review of R117's Medication Administration Record (MAR) and Controlled Drug Record (CDR) revealed that on 2/7/23, R117 received the following controlled substances: *Roxanol (morphine) 5mg at 12:20 PM per CDR and MAR (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Norco (hydrocodone/acetaminophen) 5/325mg documented as administered at 8:00 AM on MAR and documented as administered at 1:30 PM on CDR. *Ativan 1mg documented as administered at 8:00 AM and 1:30 PM on CDR. Review of R117's Controlled Drug Record for Ativan (lorazepam) 1mg tab 1 tab by mouth three times a day revealed 2 entries on 2/7/23 at 8:00 AM and 1:30 PM. No additional Controlled Drug Record for Ativan 1mg TID provided although initially ordered on 2/1/23 and documented as administered in R117's MAR on 2/1/23 at 8:00 PM, 2/2/23 at 8:00 AM, 2:00 PM, and 8:00 PM, 2/3/23 at 8:00 AM and 2:00 PM, and 2/6/23 at 2:00 PM and 8:00 PM. Did not receive prior to survey exit. (Requested via email to NHA all of R117's CDR's for 6 months on 3/2/23 at 12:42 PM and was not provided with all of R117's CDRs. Requested via email to NHA specifically the CDR for Ativan 1mg TID with dates listed above on 3/3/23 at 12:11 PM and requested via email to NHA all CDRs for R117 from 1/31/23 to 2/7/23 on 3/15/23 at 9:11 AM.) Review of R117's Electronic Health Record revealed no comprehensive assessment, medical diagnosis, nor documentation from other medical providers/institutions indicating R117 was terminally ill (with a life expectancy of 6 months or less) and required hospice care nor a serious/life threatening disease where comfort care (palliative care) should be implemented to improve quality of life. On 3/15/23 at 1:30 PM the Administrator was verbally notified and received written notification of the immediate jeopardy that was identified on 2/7/23 due to the facility's failure to ensure chemical restraints were not utilized for staff convenience. A written plan for removal for the immediate jeopardy was received on 3/15/23 and the following was verified on 3/17/23: The following was implemented immediately as listed: *Resident 117 no longer resides at the facility *All Residents on Ro[TRUNCATED]

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Ashley Healthcare Center	103 West Wallace Street Ashley, MI 48806

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intakes M100133539, M100131917, and M100135028 Based on interview and record review, the facility failed to report an elopement to the State Agency for 1 (Resident #111), resulting in an incident of elopement to not be reported. Findings include: Resident #111 (R111) Review of a Face Sheet revealed R111 originally admitted to the facility on [DATE] with pertinent diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbances, unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence. Review of the Minimum Data Set (MDS) dated [DATE] revealed R111 had a Brief Interview for Mental Status (BIMS) indicating she was cognitively intact with no behaviors and independent with cares. Review of the MDS dated [DATE] revealed R111 had a Staff Assessment for Mental Status indicating she was independently and consistently able to make decisions. She rejected care with no other behaviors and independent with cares. In an interview on 2/24/23 at 9:53 AM, Family Member FM1 who is a Nurse Practitioner and the daughter of R111 as well as the residents advocate, reported that the resident FM1 reported R111 escaped from the facility in either October or November and heard she went to one of the residential houses and told them to call the police and gave them her [NAME] name. When the police came, they took her to the police station and somehow found her somewhere else in the middle of the night. FM1 reported she received a voicemail sometime during that night that her mother eloped and thinks it may have happened on the night of Thanksgiving. In an interview, the Nursing Home Administrator (NHA) reported R111 did leave the building on 11/24/22 but she did not elope because she was her own person and just wanted to get some potato chips and a pop. So, she called the police to come pick her up. She did not report the incident to the State Agency because it was not an elopement. The resident failed to sign herself out on the Leave of Absence (LOA) book. When asked if there was an incident report for this incident, the NHA provided a summary that was in her soft file in her office. When asked if the NHA thought this was an elopement, she said if you say so. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/9/23 at 5:08 PM, Certified Nursing Assistant (CNA) Q verified she worked the night of 11/24/23 when R111 left the facility. CNA Q reported they were short staffed that night and did not recall seeing R111 near the front doors that night or acting suspicious. CNA Q reported she has never personally seen R111 leave her room. CNA Q thinks R111 got out of the building when another resident came back to facility around 11:00 PM from visiting family. That resident was a 2 person assist back to bed and needed to be changed but that only took about 5 minutes. CNA Q and the nurse that was working that unit were the only ones on that side who assisted the resident to bed and changed him. The other 2 staff were on the memory care unit and the front doors were not locked. CNA Q reported she remembered when they were getting ready to lock the front doors, she saw the EMS outside of the assisted living center next door. CNA Q confirmed R111 got out of the building, and they did not even know it. When they finally realized she was missing, they called the administrator first and then they called the police. When the police brought the resident back to the facility, they put her on 15-minute checks, and she was not happy about it. R111 was on the memory care unit in the past but she did not like being there and would get aggressive, so she went back to the other unit where she is now. R111 would also refuse the wander guard in the past. Since the surveyors have been in the building, she has a wander guard now but does not like it to be checked. CNA Q reported she was told that the resident in the past was in a facility in Muskegon when R111 left and walked an hour away. When queried if R111 answers questions appropriately, CNA Q reported she answers basic questions appropriately. Review of the Police Report with a dispatch date of 11/24/22 at 10:13 PM, arrival time of 10:31 PM, and a clear time of 2:39 AM for a suspicious situation involving R111 revealed: On 11/24/2022 at approximately (10:13 PM), I (Deputy) was dispatched to the intersection of S. Park St./ W. [NAME] St. for a medical complaint. Dispatch advised a woman was thrown from a vehicle and needed assistance. Prior to my arrival, (the Fire Department) arrived on scene and made contact with the woman. (The Fire Department) state, the woman does not appear to have been thrown from a vehicle and is sitting in someone's yard without injuries. The resident reported she was dropped off by her daughter and another male and gave the officer a different last name and date of birth. The officers then took her to a gas station in Ithaca at 11:08 PM per the resident's request. At approximately 1:35 AM, Dispatch received a call from (Nursing Facility) stating one of their patients ran away from the facility. The officer then returned to the gas station in Ithaca and confirmed the resident was the missing person from the facility and brought her back.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intakes M100133539, M100131917, and M100135028. Based on interview and record review, the facility failed to acknowledge, identify, investigate and implement measures to prevent an elopement for 1 (Resident #111) resulting in the potential for the resident to elope from the facility again. Findings include: Resident #111 (R111) Review of a Face Sheet revealed R111 originally admitted to the facility on [DATE] with pertinent diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbances, unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence. Review of the Minimum Data Set (MDS) dated [DATE] revealed R111 had a Brief Interview for Mental Status (BIMS) indicating she was cognitively intact with no behaviors and independent with cares. Review of the MDS dated [DATE] revealed R111 had a Staff Assessment for Mental Status indicating she was independently and consistently able to make decisions. She rejected care with no other behaviors and independent with cares. In an interview on 2/22/23 at 12:40 PM, Complainant C1 reported R111 has Alzheimer's disease and dementia. Prior to admission to the facility, the resident was found wandering in a field with all her money that she withdrew from the bank in her sock. R111 went to the hospital and the Power of Attorney (POA) was activated in 6/2022. It is unclear if the resident eloped from the facility because the facility did not communicate that with the POA. In an interview on 3/1/23 at 9:46 AM, Social Worker (SW) O reported she no longer works at the facility as of 12/28/22. SW O reported R111 would many times walk around in the parking lot at the facility alone because she was her own person, she did not need supervision and has that right. She would stay outside the building and staff would peek through the windows to check on her. The night of the elopement, R111 wanted some snacks so she called the police to take her to get some snacks. When queried if she knew a resident was walking around at night in the cold and the dark, would you just let them? SW O said No, but she was her own person and could go outside because she has that right. In an interview on 2/24/23 at 11:00PM the Nursing Home Administrator (NHA) reported R111 did leave the building on 11/24/22 but she did not elope because she was her own person and just wanted to get some potato chips and a pop. So, she called the police to come pick her up. She did not report the incident to the State Agency because it was not an elopement. The resident failed to sign herself out on the Leave of Absence (LOA) book. When asked if there was an incident report for this incident, the NHA provided a summary that was in her soft file in her office. When asked if the NHA thought this was an elopement, she said if you say so. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/9/23 at 5:08 PM, Certified Nursing Assistant (CNA) Q verified she worked the night of 11/24/23 when R111 left the facility. CNA Q reported they were short staffed that night and did not recall seeing R111 near the front doors that night or acting suspicious. CNA Q reported she has never personally seen R111 leave her room. CNA Q thinks R111 got out of the building when another resident came back to facility around 11:00 PM from visiting family. That resident was a 2 person assist back to bed and needed to be changed but that only took about 5 minutes. CNA Q and the nurse that was working that unit were the only ones on that side who assisted the resident to bed and changed him. The other 2 staff were on the memory care unit and the front doors were not locked. CNA Q reported she remembered when they were getting ready to lock the front doors, she saw the EMS outside of the assisted living center next door. CNA Q confirmed R111 got out of the building, and they did not even know it. When they finally realized she was missing, they called the administrator first and then they called the police. When the police brought the resident back to the facility, they put her on 15-minute checks, and she was not happy about it. R111 was on the memory care unit in the past but she did not like being there and would get aggressive, so she went back to the other unit where she is now. R111 would also refuse the wander guard in the past. Since the surveyors have been in the building, she has a wander guard now but does not like it to be checked. CNA Q reported she was told that the resident in the past was in a facility in Muskegon when R111 left and walked an hour away. When queried if R111 answers questions appropriately, CNA Q reported she answers basic questions appropriately. Review of the Police Report with a dispatch date of 11/24/22 at 10:13 PM, arrival time of 10:31 PM, and a clear time of 2:39 AM for a suspicious situation involving R111 revealed: On 11/24/2022 at approximately (10:13 PM), I (Deputy) was dispatched to the intersection of S. Park St./ W. [NAME] St. for a medical complaint. Dispatch advised a woman was thrown from a vehicle and needed assistance. Prior to my arrival, (the Fire Department) arrived on scene and made contact with the woman. (The Fire Department) state, the woman does not appear to have been thrown from a vehicle and is sitting in someone's yard without injuries. The resident reported she was dropped off by her daughter and another male and gave the officer a different last name and date of birth. The officers then took her to a gas station in Ithaca at 11:08 PM per the resident's request. At approximately 1:35 AM, Dispatch received a call from (Nursing Facility) stating one of their patients ran away from the facility. The officer then returned to the gas station in Ithaca and confirmed the resident was the missing person from the facility and brought her back.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake MI000132265 Based on interview and record review the facility failed to ensure residents were not involuntarily discharged or transfered, given appropriate notice of transfer and/or discharge and the right to appeal for 1 resident (Resident #112) resulting in the resident being discharged without documented clinical rational and without appropirate notification. Findings: Review of a policy Transfer and Discharge (Including AMA) (Against Medical Advice) implemented on 11/02/2022 reflected It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances. The policy specified Facility-initiated transfer or discharge is a transfer or discharge which the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. Resident #112 (R112) Review of a Face Sheet reflected R112 admitted to the facility on [DATE] at 9:56 AM from another long-term care facility and discharged from the facility on 10/18/2022 at 7:00 PM. R112's diagnoses at admission included Cerebral infarction (stroke), major depressive disorder, recurrent, mild; vascular dementia, unspecified severity with other behavioral disturbance, acute embolism and thrombosis of unspecified deep veins of the left lower extremity (blood clot), metabolic encephalopathy, high blood pressure, aphagia (difficulty speaking) and dysphagia (difficulty swallowing) following stroke. Guardian LL was listed as R112's primary contact and indicated guardianship but the facility did not have the guardianship paperwork as of the time of admission. Review of referral information (information used to determine if a resident needs can be met) provided to the facility on [DATE] (the day before R112 admitted to the facility) reflected notes and entries in the clinical records provided that indicated R112 was an elopement risk and exhibited wandering behaviors. The documentation reflected that R112 indeed eloped on one occasion and was re-directed to a secure area and the need for placement in a locked memory care unit. Additionally, the records reflected multiple referrals had been attempted and declined due to other facilities could not meet her needs. Review of a Resident Progress Notes dated 10/18/2022 reflected Resident (R112) dropped off to the facility at 10am accompanied by transportation driver and CNA (Certified Nurse Aide) with a wander guard on LT (left) ankle. Resident ambulatory one person assist to ambulate and transfers. Resident a/ox2-3 (alert and oriented) difficulty speech, resident do not like to be touch will become aggressive per the report from the Nurse. Resident w/o (without) and (sic) skin tears redness on coccyx. Resident is also an elopement risk wander guard on RT (right) ankle, resident went to several doors trying to elope. Staff is with resident one on one. MD (Medical Doctor) was in the building and referred resident to MCU (Memory Care Unit), MCU is currently full. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Resident Progress Notes dated 10/18/2022 at 6:00 PM reflected Writer arrived to shift 6pm received report from previous nurse/manager to send resident (R112) to ER (emergency room) per manager request STAT (right away). Review of a Resident Progress Notes dated 10/18/2022 at 7:05 PM reflected Resident (R112) sent to ER via ambulance per manager/don (Director of Nursing) (name omitted) request. Manager (name omitted), spoke with EMT (Emergency Medical Technician) service via telephone regarding resident (R112) transferring out. Review of a Resident Progress Notes dated 10/19/2022 at 11:43 AM, SW (social worker) received call from hospital, (name omitted), needing hospital discharge information from when we received resident. Faxed hospital paperwork to (name and phone number omitted). Review of a hospital ER History and Physical dated 10/18/2022 at 7:56 PM revealed This is a [AGE] year-old female . who was brought here today to the emergency department via EMS (Emergency Medical Services) from (name of facility) for evaluation of wandering. (Name of Facility) unfortunately did not call report to the emergency department and thus we have no information at this exact time. However, EMS states that they (the facility) called 911 as the patient was reported to be wandering risk. They state that when they arrived the patient was laying in her bed quietly, and not agitated, or wandering. However, staff at the (name of facility) reported to EMS that the patient was ordered to be sent here by the director of nursing secondary to her wander risk. EMS further advises that the patient arrived to (name of facility) this morning around 9AM and is otherwise new patient to them. (Name of facility) is unable to provide any additional history of the patient. The patient herself is unable to provide any history. However, when I do ask her if she has any pain, or if she is feeling well she answers yes. Repetitively. There are no further concerns or complaints at this time. Further review of the hospital records reflected ED Course and MDM (Medical Decision Making dated 10/18/22 reflects Nursing staff have contacted the patient's emergency contact. Unfortunately the patient is new to them within the last 1 week and they do not have any further information on the patient .at 2300 (11PM): Case is signed out to my attending (name omitted) at the end of my shift. At this time (name of facility) is refusing to accept the patient back into their care. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Pre-Hospital Care Report dated 10/18/2023 reflected Arrived on scene at (name of facility) to find the front door locked. We were not able to gain access for approximately 5 minutes. We has to have medcom contact the facility to open the door. Upon making entry into the building we were greeted by a female who did not identify herself who was wearing dark colored scrubs and just waived her hand at us in a motion to follow her. We followed this female to the back hallway near the nurses station the female walked down the hallway looking at multiple doors then turned to speak to us saying hold on let me see which room she is in. The female went to the nurses station and returned to point into room [ROOM NUMBER] where I could see while elderly female sitting in a wheelchair. The female pointed at the person in the chair. I began speaking to the PT (patient) in the chair at which point a CNA came into the room and said that the listed patient wer'e there for is the person laying in the bed that was behind a curtain that was pulled. I observed the elderly female laying in her bed on her right lateral side. The PT was awake and resonded to my questions with random mumbling that I could not understand. The CNA informed me that the PT was brought to the facility earlier in the day around 10AM. The female that led us to the hallway was the nurse according to the CNA. This person was verbally identified by the person at the nurse station as (name omitted). The nurse explained that this PT was brought into the facility earlier in the day and she was not aware as to why she was being sent out other then she was told the PT was outside the level of care the facility can provide. The PT did not appear to be in any distress or have any medical complaints requiring ambulance. Per hospital records, R112 remained in the hospital ER for 6 days until alternative long-term care placement was obtained on 10/24/2022. ER nursing notes indicated that R112 did have some wandering behavior and anxiety but was easily redirectable and overall cooperative with care. During an interview on 3/2/2023 at 10:37 AM, the Director of Nursing (DON) reported that no where in the referral information reviewed prior to R112's admission was there an indication R112 was an elopement risk. When R112 was admitted to the facility they did not have a bed for her on the MCU. The DON reiterated they had no idea R112 was an elopement risk. The DON reported there were not severe behaviors documented in the clinical records and there was not evidence the Guardian LL was notified R112 was sent to the ER. The DON was asked to provide any evidence to prove the facility initiated an involuntary discharge with appeal rights described to the guardian. As of the date of the survey exit no additional documentation was provided. During an interview via email on 3/2/23 at 1:02 PM, Long Term Care Ombudsman (LTCO) X reported she had not received involuntary discharge notices/notice of transfer documentation from the facility. LTCO X stated, As a matter of fact, I just provided my email to the social worker, (Social Worker N), last week.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intakes: MI00132265, MI00133943, and MI00131756 Based on interview and record review, the facility failed to ensure appropriate notifications were made to residents/responsible parties upon facility initiated discharge for 3 residents (Resident #112, #117, and #110) resulting in residents/responsible parties being insufficiently prepared for transfer/discharge and without a right to appeal the transfer/discharge. Findings: Review of a policy Transfer and Discharge (Including AMA) (Against Medical Advice) implemented on 11/02/2022 reflected It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances. The policy specified Facility-initiated transfer or discharge is a transfer or discharge which the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. Resident #112 (R112) Review of a Face Sheet reflected R112 admitted to the facility on [DATE] at 9:56 AM from another long-term care facility and discharged from the facility on 10/18/2022 at 7:00 PM. R112's diagnoses at admission included Cerebral infarction (stroke), major depressive disorder, recurrent, mild; vascular dementia, unspecified severity with other behavioral disturbance, acute embolism and thrombosis of unspecified deep veins of the left lower extremity (blood clot), metabolic encephalopathy, high blood pressure, aphagia (difficulty speaking) and dysphagia (difficulty swallowing) following stroke. Guardian LL was listed as R112's primary contact and indicated guardianship but the facility did not have the guardianship paperwork as of the time of admission. Review of referral information (information used to determine if a resident needs can be met) provided to the facility on [DATE] (the day before R112 admitted to the facility) reflected notes and entries in the clinical records provided that indicated R112 was an elopement risk and exhibited wandering behaviors. The documentation reflected that R112 indeed eloped on one occasion and was re-directed to a secure area and the need for placement in a locked memory care unit. Additionally, the records reflected multiple referrals had been attempted and declined due to other facilities could not meet her needs. Review of a Resident Progress Notes dated 10/18/2022 reflected Resident (R112) dropped off to the facility at 10am accompanied by transportation driver and CNA (Certified Nurse Aide) with a wander guard on LT (left) ankle. Resident ambulatory one person assist to ambulate and transfers. Resident a/ox2-3 (alert and oriented) difficulty speech, resident do not like to be touch will become aggressive per the report from the Nurse. Resident w/o (without) and (sic) skin tears redness on coccyx. Resident is also an elopement risk wander guard on RT (right) ankle, resident went to several doors trying to elope. Staff is with resident one on one. MD (Medical Doctor) was in the building and referred resident to MCU (Memory Care Unit), MCU is currently full. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Resident Progress Notes dated 10/18/2022 at 6:00 PM reflected Writer arrived to shift 6pm received report from previous nurse/manager to send resident (R112) to ER (emergency room) per manager request STAT (right away). Review of a Resident Progress Notes dated 10/18/2022 at 7:05 PM reflected Resident (R112) sent to ER via ambulance per manager/don (Director of Nursing) (name omitted) request. Manager (name omitted), spoke with EMT (Emergency Medical Technician) service via telephone regarding resident (R112) transferring out. Review of a Resident Progress Notes dated 10/19/2022 at 11:43 AM, SW (social worker) received call from hospital, (name omitted), needing hospital discharge information from when we received resident. Faxed hospital paperwork to (name and phone number omitted). Review of a hospital ER History and Physical dated 10/18/2022 at 7:56 PM revealed This is a [AGE] year-old female . who was brought here today to the emergency department via EMS (Emergency Medical Services) from (name of facility) for evaluation of wandering. (Name of Facility) unfortunately did not call report to the emergency department and thus we have no information at this exact time. However, EMS states that they called 911 as the patient was reported to be wandering risk. They state that when they arrived the patient was laying in her bed quietly, and not agitated, or wandering. However, staff at the (name of facility) reported to EMS that the patient was ordered to be sent here by the director of nursing secondary to her wander risk. EMS further advises that the patient arrived to (name of facility) this morning around 9AM and is otherwise new patient to them. (Name of facility) is unable to provide any additional history of the patient. The patient herself is unable to provide any history. However, when I do ask her if she has any pain, or if she is feeling well she answers yes. Repetitively. There are no further concerns or complaints at this time. Further review of the hospital records reflected ED Course and MDM (Medical Decision Making) dated 10/18/22 reflects Nursing staff have contacted the patient's emergency contact. Unfortunately the patient is new to them within the last 1 week and they do not have any further information on the patient .at 2300 (11PM): Case is signed out to my attending (name omitted) at the end of my shift. At this time (name of facility) is refusing to accept the patient back into their care. (continued on next page)

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Ashley Healthcare Center	103 West Wallace Street Ashley, MI 48806

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Pre-Hospital Care Report dated 10/18/2023 reflected Arrived on scene at (name of facility) to find the front door locked. We were not able to gain access for approximately 5 minutes. We has to have medcom contact the facility to open the door. Upon making entry into the building we were greeted by a female who did not identify herself who was wearing dark colored scrubs and just waived her hand at us in a motion to follow her. We followed this female to the back hallway near the nurses station the female walked down the hallway looking at multiple doors then turned to speak to us saying hold on let me see which room she is in. The female went to the nurses station and returned to point into room (number omitted) where I could see while elderly female sitting in a wheelchair. The female pointed at the person in the chair. I began speaking to the PT (patient) in the chair at which point a CNA came into the room and said that the listed patient were there for is the person laying in the bed that was behind a curtain that was pulled. I observed the elderly female laying in her bed on her right lateral side. The PT was awake and responded to my questions with random mumbling that I could not understand. The CNA informed me that the PT was brought to the facility earlier in the day around 10AM. The female that led us to the hallway was the nurse according to the CNA. This person was verbally identified by the person at the nurse station as (name omitted). The nurse explained that this PT was brought into the facility earlier in the day and she was not aware as to why she was being sent out other then she was told the PT was outside the level of care the facility can provide. The PT did not appear to be in any distress or have any medical complaints requiring ambulance. Per hospital records, R112 remained in the hospital ER for 6 days until alternative long-term care placement was obtained on 10/24/2022. ER nursing notes indicated that R112 did have some wandering behavior and anxiety but was easily redirectable and overall cooperative with care. During an interview on 3/2/2023 at 10:37 AM, the Director of Nursing (DON) reported that no where in the referral information reviewed prior to R112's admission was there an indication R112 was an elopement risk. When R112 was admitted to the facility they did not have a bed for her on the MCU. The DON reiterated they had no idea R112 was an elopement risk. The DON reported there were not severe behaviors documented in the clinical records and there was not evidence the Guardian LL was notified R112 was sent to the ER. The DON was asked to provide any evidence to prove the facility initiated an involuntary discharge with appeal rights described to the guardian. As of the date of the survey exit no additional documentation was provided. 39056 Resident #117 (R117) Review of an Admission Record revealed R117 was a [AGE] year-old female, originally admitted to the facility on [DATE], readmitted on [DATE], with pertinent diagnoses which included: dementia, unspecified severity, with other behavioral disturbance, unspecified symptoms and signs involving cognitive functions and awareness, anxiety disorder, autistic disorder, bipolar II disorder, and insomnia. During an interview on 2/28/23 at 10:58 AM, Court Appointed Guardian (CAG) V reported that R117 was transferred to a psychiatric facility in Indiana on 12/13/22 without her knowledge. CAG V reported that she was not aware of the transfer until approximately 2 weeks later when an OBRA Coordinator from the county called with questions. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CAG V reported that she was also not provided a bed hold and/or appeal documentation when R117 was transferred to the hospital on 2/7/23. During an interview via email on 3/2/23 at 3:41 PM, NHA confirmed that a the Bed Hold was not provided to CAG V at the time of transfer on 2/7/23. During an interview on 3/03/23 at 1:45 PM, Nursing Home Administrator (NHA) verified that CAG V was not notified that R117 was sent to a psychiatric facility on 12/13/22 until 12/28/22 and reported CAG V was upset that she had not been notified that R117 had been out of the facility for so long without her being notified. NHA reported that the facility social worker forgot to notify R117's guardian and the physician at the time of discharge. NHA reported that Licensed Nurses and Social Work were educated on 12/28/22 on the following: Education provided to licensed nursing staff and social work regarding notifying responsible party and physician for all change in condition and transfers completed. Policy on transfers and discharge were reviewed with staff. To include *Provide a notice of transfer and the facilities (sic) bed hold policy to the resident and responsible party as directed. Resident #110 (R110) Review of an Admission Record revealed R110 was admitted to the facility on [DATE]. Review of R110's Nursing Progress Note dated 10/5/22 revealed, Received in report that resident had left the facility AMA. Resident called facility at 2100 (9:00 PM) inquiring if his bed was on hold. Informed resident to contact the facility in the morning. Review of R110's Electronic Health Record revealed no documentation that the provider was notified that R110 left the facility AMA or that facility staff attempted to follow up with R110 after he contacted the facility on 10/5/22 at 9:00 PM. Review of R110's Against Medical Advice form dated 10/5/22 revealed it was signed by only R110 and no other witness signatures. There was no time documented to verify the time R110 left the facility AMA. On 3/10/23 at 10:21 AM, NHA was asked (via email) to provide documentation that the physician was notified that R110 left the facility AMA on 10/5/22 and follow-up documentation related to the nursing progress note dated 10/5/22 at 11:19 PM. No additional documentation provided prior to survey exit. During an interview via email on 3/2/23 at 1:02 PM, Long Term Care Ombudsman (LTCO) X reported she had not received involuntary discharge notices/notice of transfer documentation from the facility. LTCO X stated, As a matter of fact, I just provided my email to the social worker, (Social Worker N), last week.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake: MI00133943 Based on interview and record review, the facility failed to allow a resident to return to the facility after a hospital leave of absence for 1 resident (Resident #117) reviewed for facility-initiated transfers, resulting in Resident #117 being denied return to the facility. The reasonable person would be distressed at the prospect of not returning to their home after a hospitalization . Findings: Resident #117 (R117) Review of an Admission Record revealed R117 was a [AGE] year-old female, originally admitted to the facility on [DATE], readmitted on [DATE], with pertinent diagnoses which included: dementia, unspecified severity, with other behavioral disturbance, unspecified symptoms and signs involving cognitive functions and awareness, anxiety disorder, autistic disorder, bipolar II disorder, and insomnia. Review of a Minimum Data Set (MDS) assessment for R117, with a reference date of 2/5/23 revealed a Brief Interview for Mental Status (BIMS) score of 99, out of a total possible score of 15, which indicated R117 was severely cognitively impaired. MDS Section E-Behaviors revealed R117 did not exhibit physical behavioral symptoms directed toward others (e,g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and did not exhibit other behavioral symptoms not directed toward others. Verbal behaviors were identified. The MDS reflected that R117's behaviors did not put the resident at significant risk for physical illness or injury, did not significantly interfere with the resident's care and did not put others at significant risk for physical injury. The MDS reflected R117 did not reject evaluation or care which would include: (bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being . The MDS reflected that R117's behaviors had improved compared to prior assessment. Review of R117's Care Plan revealed no entries related to overall behaviors (interventions to implement when R117 is having increased behaviors, non-pharmacologic interventions for behaviors). (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R117's Electronic Health Record revealed a Hospital Progress Note for discharge, dated 1/29/23 at 5:15 PM, [AGE] year-old F (female) from (name omitted) Neuropsych unit with past medical history of autism, neurocognitive disorder, Seizure disorder presented with respiratory distress .She has sitter (one on one staff person that remains with resident at all times for safety) .She is stable and plan has been to discharge back to (psychiatric unit name omitted), per (name omitted) neuropsych request, Psychiatrist consulted however now we have been notified that per (name omitted) hospital, patient has finished management there and should go back to her NH (nursing home) in MI (Michigan) and case manager has started the process .Assessment/Plan .Continue sitter, 1-1 feeding assist , Ongoing SLP (speech therapy) eval . Psychiatric medication changes during hospital course included: stop clonazepam (antianxiety medication), stop haloperidol (antipsychotic medication), dose decrease for risperdal (antipsychotic medication), and dose decrease for ativan (antianxiety medication). Indicating the facility was aware R117 required a sitter at the time of readmission to the facility. Review of R117's Discharge Orders from the hospital dated 1/30/23 revealed, Lorazepam (Ativan) Take 1 tablet (0.5 mg total) by mouth 2 (two) times a day if needed for anxiety (psychosis). Max Daily Amount: 1 mg. Confirming R117 was on Ativan as needed prior to admission to the facility. During an interview on 3/2/23 at 9:17 AM, Licensed Practical Nurse (LPN) Y reported that she was R117's licensed nurse on 2/7/23. On the day the morphine was administered (2/7/23 at 12:21 PM) R117 had increased behaviors. LPN Y reported that R117 was non-stop moving and attempting to throw herself on the ground. LPN Y reported that R117 had required a 1:1 to keep her in her gerichair. LPN Y reported that R117 had to have a 1:1 at all times and with the number of scheduled staff it was not feasible. During an interview on 3/3/23 at 12:36 PM, Director of Nursing (DON) reported that R117 was a 1:1. DON stated, For an ongoing basis we don't have the staff to do that (provide 1:1 monitoring). Confirming the administration of Roxanol was for staff convenience due to the insufficient number of staff to provide R117 with a 1:1. During an interview on 3/16/23 at 2:20 PM, Staff Scheduler (SS) I verified that on 2/7/23 there were 2 nurses scheduled and 1 nurse on orientation, 2 CNAs (Certified Nursing Assistants) scheduled on the Memory Care Unit, and 2 CNAs scheduled on the East/West/Central Units. 3 CNAs were scheduled from 6am-6pm and 1 CNA scheduled from 6am-2pm and 1 CNA scheduled 2pm-6pm. R117 resided on the East/West/Central Units. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/23 at 8:36 AM, Hospital Unit Manager (HUM) S reported that the facility had been refusing to allow R117 to return for over a week now. HUM S reported that one of the barriers to allowing R117 to return is an order for Ativan as needed (not scheduled routinely) which they consider a (chemical) restraint. HUM S reported that she had admitted with an order for Ativan as needed. HUM S reported that once she was admitted to the hospital, the physician had to stop her medications and slowly add medications back to ensure R117 was on an appropriate regimen of medication. HUM S reported that the hospital physician did not want to order Ativan scheduled and order it as needed to prevent R117 from becoming overmedicated again. HUM S reported that R117 was diagnosed with an acute UTI which was likely the cause of her behavioral issues. HUM S reported that when R117 was admitted to the hospital she was a little squirrely but once her medication regimen was adjusted and her UTI was treated, her behaviors resolved, and she no longer required a 1:1 sitter. HUM S reported that the facility felt that the video monitor that was being utilized was an extra precaution as R117 could not call out like other patients and hospital setting, rules, and regulations are different than a long-term care facility (LTC facilities have the ability to provide increased supervision with activities, communal meals, ability to have residents sit in common areas). HUM S reported that the facility considered the video monitor a 1:1 and therefore could not allow her to return. HUM S reported that R117 required hoyer transfers and extensive ADL (Activities of Daily Living) assistance when she was first admitted but was now able to walk with staff and roll herself unassisted for incontinence care. UM S reported that at times R117 will refuse a vital sign assessment but allows the assessment when reapproached. HUM S stated we are concerned as to why they wouldn't take her back and reported the facility is requiring R117 to be made a DNR (Do Not Resuscitate) or they won't take her back. HUM S reported that AC Z was sent to the hospital to evaluate R117 but never went into the room. During an interview on 3/01/23 at 3:18 PM, Hospital Social Worker (HSW) T reported that when R117 arrived at the Emergency Department on 2/7/23 she was lethargic and overly sedated because she had been overmedicated at the facility. HSW T reported that R117 was diagnosed with an acute UTI and Clostridioides difficile (c-diff infection is a severe and sudden infection in the colon) and when those infections were treated R117 returned to her physical and mental baseline. HSW T reported that the refusal to allow R117 was not the first time we've had this issue with (the facility) and they continued to find reasons they would not allow R117 to return. HSW T reported that because of the continued refusal to allow R117 to return and the conditions they required to allow her to return, alternate placement had to be facilitated by the hospital discharge team, R117's Court Appointed Guardian, and R117's Community Mental Health Case Worker without any assistance from the facility. Review of R117's Hospital Records (hospital stay from 2/7/23 through 3/8/23) revealed the following entries: *2/9/23 at 12:31 PM (Admissions Coordinator (AC) Z) at NH (nursing home) states 1:1 is not an issue. *2/14/23 at 11:15 AM (AC Z) from (facility) called stated she has arranged with the Discharge Planner yesterday to do an on site visit to determine if they are able to meet the patients needs. She states that (R117) has been declining and does (not) feel that she should be making that decision. She will have their director of nursing reach out to us to determine if they are able to meet her needs and have her return to (facility). (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*2/15/23 at 1:43 PM Asked (hospital provider) .if she (R117) was ready for discharge and he stated (facility) would not take her back . *2/15/23 at 3:13 PM Attempting to reach (AC) Z at (facility). Received voice mail, left message to call back as soon as possible as pt is being discharged back to facility tomorrow. *2/16/23 at 12:22 PM Received call from (facility). (NHA) and (DON) were on speaker phone. (NHA) stated they were not equipped to take her back. Stated pt (patient) was difficult and that guardian would not allow them to change any of her medications. She needed hospice and DNR status and guardian had court date for that so pt could go in to that ward but has to have these orders. Pts guardian cancelled the request with the courts. Informed them that pt lives there and they will have to deal with the guardian and new facility. We can not keep pt until guardian get new court date. Informed them that pt is much better cognitively, that doctor had changed her medication she was on. They stated that she they saw in nurses note that pt had been monitored on video and they are not allowed to do that there. With all of this they could not take her back. Asked if they would please talk with manager and they agreed. Transferred call to (HUM S). *2/21/23 at 1:10 PM Discussed barriers to discharge back to (facility) with (NHA). She states that it is because of the use of ativan prn. Per (NHA) she states this is considered restraints. She agreed that if Ativan was used routinely, this would remove that barrier for discharge back to (facility). *2/21/23 at 1:35 PM Call made to (AC Z). No answer, went to voicemail. Asked if she would call me back as we needed to return pt to their facility as she has been here for 14 days. Left phone number as well. *2/21/23 at 2:21 PM Called (facility) direct line and asked for (AC Z). Nurse stated They are in a meeting. Left message to please call when meeting adjourns. *2/22/23 at 7:26 AM Spoke with Ombudsman (Long Term Care Ombudsman LTCO X) about patient's case. She states she will call (facility) tomorrow morning. *2/28/23 at 12:04 PM Spoke with NHA at (facility) nursing home. She state pt returned from (Indiana Hospital) on 1-30-2023 on Kepra She also states upon pt return from psych facility they saw no changes in her behavior, it was the same as when she went. Indicating there was additional communication with the hospital regarding R117 after 2/20/23 despite DON reporting the contrary. On 3/16/23 at 12:08 PM, an interview was conducted with NHA, DON, with the survey team and survey manager present. DON reported that following R117's return to the facility on [DATE], she had increased behaviors and had not improved psychiatrically while at an Indiana psychiatric facility. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON was again asked to clarify how being a DNR, comfort care, and/or hospice would be required to meet R117's needs with documentation written by the DON that R117 required these services because of her behaviors only. Reported to DON that no medical rationale was provided, and psychiatric symptoms alone were documented for the need for DNR or comfort care. DON stated, I wish everyone would stop saying DNR. The following Nursing Progress Note entry written by the DON was used for reference (2/7/23 at 2:25 PM) This writer explained that if she, (CAG V), was not willing to change (R117's) code status or allow comfort medications then facility could not meet her needs. DON was asked what needs could not be met if (R117) remained a full code or did not allow comfort medications? DON did not provide a response or clarification. It was identified during the onsite survey that the facility failed to allow R117 to return unless R117's code status was changed from a Full Code to Do Not Resuscitate (DNR) and receive end of life care (hospice/comfort care) when no clinical indication necessitated the change in code status. (Refer to noncompliance cited at F678- Cardio Pulmonary Resuscitation). Review of R117's Nursing Progress Note dated 2/20/23 at 2:11 PM, written by DON revealed, This writer and Administrator received a call from (hospital name omitted) regarding (R117). Per Case Manager and Nursing Supervisor (R117) was happy, no behaviors and doing well and wanted to send (R117) back to facility today. Prior to (R117) being sent to hospital she was kicking, biting, spitting, Biting staff (bit Nurse and broke skin). (R117) was extremely restless. (R117) was throwing self on floor yelling/screaming, kicking dining room chairs and tables with other residents present. At this time (R117) continues to be a 1:1 with camera surveillance at hospital or Nursing Students setting with (R117) at bedside. This writer and Administrator requested a referral be sent including progress notes for last 2 weeks and medication list. Nursing Supervisor/Case Manager sent only medication administration for this date 2-20 no progress notes. According to medication administration from Hospital (R117) was given Ativan at 8:50 am on this date for behaviors. Admission Liaison was asked to go to (hospital name omitted) and do an on-site with (R117). When Admission Liaison arrived at hospital (R117) was yelling/screaming fighting staff and refusing care. Staff at Hospital were not wanting to give more information for last 2 weeks. This writer and Administrator requested again progress notes. (Hospital name omitted) Case Manager and Supervisor did send progress notes dated for 2-20-23 and were documented within minutes of ending phone conversation. Per the notes from hospital there were 3 entries within 10 minutes of each other stating (R117) is smiling, walking in hallway. Nursing student setting at bedside as (R117) was documented to be restless and throwing feet off bed and screaming. Guardian continues to not allow comfort medications for restlessness/behaviors. It was explained that at this time (facility) could not meet (R117's) needs without support from Guardian. Nursing Supervisor stated, she is ready for discharge, and she is not appropriate for a DNR status. So, again it was explained that we could not meet her needs as there has been no Psych evaluation or change in medications. It was also explained that with (R117's) behaviors she is putting other residents at risk. (Hospital name omitted) has been asked to send more information but still have not received any further information. Confirming the facility was continuing to require CAG V to allow comfort medication for restlessness/behaviors as a condition for R117's return to the facility without a supporting medical diagnosis. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*DON directed AC Z to assess R117 while an inpatient at the hospital despite AC Z having no clinical qualifications to complete a comprehensive assessment as well as documentation in the hospital Case Manager Progress Note dated 2/14/23 at 11:15 AM that AC Z reported she was not qualified to assess R117. HUM S reported AC Z did not visually observe R117. DON did not assess R117 and relied on an assessment performed by a non-clinical staff member and was not aware that R117 had been diagnosed with C-diff (verified via interview on 3/16/23 at 12:08 with DON and NHA). *DON alleged CAG V does not allow medication changes for R117 despite documentation that Norco 5/325mg TID (three times a day) was started on 2/1/23, Ativan 1mg TID was changed/increased on 2/1/23, Risperdal was increased on 2/7/23, and Morphine 5mg every 2 hours as needed was started (and administered) on 2/7/23. *DON reported that R117's behaviors were endangering herself and nurses and had escalated to R117 biting and breaking the skin of a facility nurse. Review of R117's Electronic Health Record revealed the behavior reported by the DON occurred on 12/12/22 (Nursing Progress Note dated 12/12/22 at 8:53 AM) resulting in R117's transfer to the hospital and subsequent transfer to an Indiana psychiatric facility on 12/13/22 (R117 did not return to the facility until 1/30/23) and did not occur between 1/30/23-2/7/23. This was confirmed by NHA on 3/16/23 at 12:08 PM. *DON documented that the hospital had not provided further information despite NHA communicating with hospital staff on 2/28/23 regarding R117's medications and possible root cause of R117's increased behaviors (Keppra). During an interview via email on 3/2/23 at 3:41 PM, NHA stated, I was just in contact with (HSW T) who called me on Tue (2/28/23) I believe about her (R117's) meds. *DON alleged the hospital did not make medication changes for R117 nor had R117 had a psychiatric evaluation. Review of the hospital records revealed documentation of medication changes beginning on admission due to oversedation and again on 2/12/23, 2/18/23, 2/19/23, and 2/28/23. *2/12/23 Plan to change Risperdal to 2 mg tid (three times a day) - monitor for oversedation *2/18/23: Patient with increased somnolence on tid Risperdal dosing. Plan to change to BID - nurse has been holding afternoon dose due to somnolence. *2/19/23: Patient stable. No new concerns. Added back prn dose of Risperdal daily for breakthrough behavioral concerns. *2/28/23: Regarding her behavioral symptoms, continue Risperdal at 2mg bid (twice a day). Continued on Depakote 750 mg bid- Depakote level is 92.8 ug/ml. She is on Keppra which could be causing behavioral side effects . Plan made to taper and potentially stop Keppra in near future since it is associated with mood symptoms. During an interview on 02/28/2023 at 10:58 AM, R117's Court Appointed Guardian (CAG) V reported that R117 had not been but should have been assessed by the facility's psychiatrist. During an interview on 3/2/23 at 3:22 PM, NHA reported that R117 was not at the facility long enough since her readmission on 1/30/23 to be assessed by the contracted psychiatric provider. (continued on next page)

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

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview via email on 3/3/23 at 1:40 PM, NHA verified that R117 had not been seen by the contracted psychiatric provider since 9/22/22. During an interview on 03/01/2023 at 12:00 PM, AC Z reported that when a resident is sent out to the hospital for evaluation, we (the facility) know that we need to take them back and if it isn't feasible find placement after they return. On 3/2/23 at 12:42 PM via email and 3/3/23 at 12:11 PM via email the Nursing Home Administrator was asked to provide the following documentation: transfer documentation/information conveyed to receiving hospital, and facility initiated discharge documentation (the specific resident needs the facility could not meet; the facility efforts to meet those needs; and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility). The requested documentation was not provided prior to survey exit. Review of the facility policy Transfers and Discharges (Including AMA) dated 11/1/22 revealed, Policy: It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances .12. Emergency Transfers/Discharges - initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified). a. Obtain physicians' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis. b. Contact an ambulance service and provider hospital, or facility of resident's choice, when possible, for transportation and admission arrangements. c. For a transfer to another provider, ensure necessary information listed in #9 of this policy is provided along with, or as part of, the facility's transfer form. d. The original copies of the transfer form and Advance Directive accompany the resident. Copies are retained in the medical record. e. Provide orientation for transfer or discharge to minimize anxiety and to ensure safe and orderly transfer or discharge, in a form and manner that the resident can understand. f. Document assessment findings and other relevant information regarding the transfer in the medical record. g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated. h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices. i. The resident will be permitted to return to the facility upon discharge from the acute care setting. j. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility will have evidence that the resident's status at the time the resident seeks to return to the facility meets one of the specified exemptions (see #2, a-d of this policy for list of exemptions). k. In situations where the facility has decided to discharge the resident while the resident is still hospitalized , the facility will send a notice of discharge to the resident and resident representative before the discharge, and must also send a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. Notice to the Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative, even though, at the time of initial emergency transfer, sending a copy of the transfer notice to the Ombudsman only needed to occur as soon as practicable. l. The resident has the right to return to the facility pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the facility. The facility will document the danger that the failure to transfer or discharge would pose .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intakes M100133539, M100131917, and M100135028. Based on interview and record review, the facility failed to acknowledge, identify, and provide adequate supervision to prevent an elopement and ensure the safety of 1 of 7 residents (Resident #111) at risk for wandering, resulting in an Immediate Jeopardy on 11/24/22 at approximately 10:00 PM, when R111 eloped from the facility unbeknownst to staff. R111 was found outside the facility after a citizen call to the police at 10:13 PM. R111 gave her [NAME] name to police who contacted the facility who did not recognize R111 was missing. Police then drove R111 to a gas station approximately 15 miles away. R111 was not discovered missing by facility staff until 12:45 AM (nearly 3 hours later). At 1:35 AM facility staff called the police who knew the last location of R111 and returned R111 to the facility at approximately 2:00 AM. Findings include: Resident #111 (R111) Review of a Face Sheet revealed R111 originally admitted to the facility on [DATE] with pertinent diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbances, unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence. Review of the Minimum Data Set (MDS) dated [DATE] revealed R111 had a Brief Interview for Mental Status (BIMS) indicating she was cognitively intact with no behaviors and independent with cares. Review of the MDS dated [DATE] revealed R111 had a Staff Assessment for Mental Status indicating she was independently and consistently able to make decisions. She rejected care with no other behaviors and independent with cares. In an interview on 2/22/23 at 12:40 PM, Complainant C1 reported R111 has Alzheimer's disease and dementia. Prior to admission to the facility, the resident was found wandering in a field with all her money that she withdrew from the bank in her sock. R111 went to the hospital and the Power of Attorney (POA) was activated in 6/2022. It is unclear if the resident eloped from the facility because the facility did not communicate that with the POA. In an interview on 2/23/23 at 11:04 AM, Licensed Practical Nurse (LPN) D reported R111's moods would go back and forth depending on the time of day and can be loud and short tempered. The day the resident left the facility, she chose to leave and called for transportation herself. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 2/24/23 at 9:53 AM, Family Member FM1 who is R111s daughter and emergency appointed guardian, that was her original appointed advocate in 2021, reported that the resident had been a Certified Nurses Aide for [AGE] years in nursing homes and knows a lot. FM1 reported several incidents prior to admission to the facility about the resident unsafely and uncharacteristically wandering in the city and had other behaviors that were not safe and poor decision making. Prior to admission to the facility, R111 had her POA activated in June 2022 at the hospital. R111 signed the Five Wishes in 2021 that made FM1 her patient advocate. R111 is giving the facility a hard time because of her background history of being a CNA for so many years. FM1 reported R111 escaped from the facility in either October or November and heard she went to one of the residential houses and told them to call the police and gave them her [NAME] name. When the police came, they took her to the police station and somehow found her somewhere else in the middle of the night. FM1 reported she received a voicemail sometime during that night that her mother eloped and thinks it may have happened on the night of Thanksgiving. In an interview on 2/24/23 at 11:00PM, the Nursing Home Administrator (NHA) reported R111 did leave the building on 11/24/22 but she did not elope because she was her own person and just wanted to get some potato chips and a pop. So, she called the police to come pick her up. She did not report the incident to the State Agency because it was not an elopement. The resident failed to sign herself out on the Leave of Absence (LOA) book. When asked if there was an incident report for this incident, the NHA provided a summary that was in her soft file in her office. Review of the Summary provided by the NHA regarding R111 leaving the facility revealed R111 was not in the facility on 11/25/22 when staff went into her room around 12:00 AM. The nurse last saw R111 around 11:00 PM (11/24/22) and around 11:30 PM the nurse received a phone call from the police asking if she had a resident with the same first name but a different last name. The nurse told the police they did not have a resident by that name. The police informed the nurse that someone called and said they needed to be picked up in front of the building because they had been thrown out of a vehicle and wanted to make sure this was not their resident. Around 11:45 PM, the nurse locked the front door and saw EMS (emergency medical services) outside and did not think anything about it. The summary concluded R111 did not sign herself out and at an unknown time, the nurse realized the resident was not in her room and searched outside. At approximately 12:45 AM the Director of Nursing (DON) was notified that R111 was not in the building and the police were notified. The police identified the person they picked up in front of the facility was R111 and would be in route to bring her back after she got her coffee and snacks. When R111 arrived at the facility, the NHA educated the resident about signing out on the LOA book and initiated 15-minute checks due to her noncompliance with care and they would know if she left the building without signing out again. No interviews from staff provided, no camera footage available, and no sensical detailed timeline provided. In an interview on 3/1/23 at 9:46 AM, Social Worker (SW) O reported she no longer works at the facility as of 12/28/22. SW O reported R111 would walk around in the parking lot at the facility alone because she was her own person, she did not need supervision and has that right. She would stay outside the building and staff would peek through the windows to check on her. The night of the elopement, R111 wanted some snacks so she called the police to take her to get some snacks. When queried if she knew a resident was walking around at night in the cold and the dark, would you let them? SW O said No, but she was her own person and could go outside because she has that right. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 3/3/23 at 9:13 AM, the Director of Nursing (DON) was queried about R111 leaving the facility and if she thought that she eloped and the DON replied, I plead the 5th! The DON was read the excerpt in the State Operations Manual (SOM) the definition of an elopement A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts. The DON reported she was looking at R111's situation from a capacity view and could understand that by that definition it would be considered an elopement. When queried about a reasonable person's concept for wandering outside alone on a cold dark night, the DON agreed that a reasonable person would not go outside alone at 10:00 PM for chips and a pop. The DON felt that R111 did not spend time with her family on Thanksgiving Day and eat dinner with them which may have triggered her anger and desire to leave the facility. In an interview on 3/9/23 at 4:33 PM, the Fire Chief (FC) P reported he was informed R111 called 911 herself and when they arrived on the scene, he was informed she was kicked out of a car. She was on the ground on the corner not far from the facility (about 100 yards) and had her cane and thinks she had some of her belongings. He called the nursing facility who denied a resident with the last name he gave them that was given by the resident, and then asked the facility if they were missing a resident, and the facility denied missing a resident. His first impression of R111 when he arrived was that she would answer things very well, but none of the information she gave made sense even though it was consistent. It made no sense why she was there. She had no complaints of injury. The police arrived on the scene and was aware they were going to take her to the County Sheriff headquarters. In an interview on 3/9/23 at 5:08 PM, Certified Nursing Assistant (CNA) Q verified she worked the night of 11/24/23 when R111 left the facility. CNA Q reported they were short staffed that night and did not recall seeing R111 near the front doors that night or acting suspicious. CNA Q reported she has never personally seen R111 leave her room. CNA Q thinks R111 got out of the building when another resident came back to facility around 11:00 PM from visiting family. That resident was a 2 person assist back to bed and needed to be changed but that only took about 5 minutes. CNA Q and the nurse that was working that unit were the only ones on that side who assisted the resident to bed and changed him. The other 2 staff were on the memory care unit and the front doors were not locked. CNA Q reported she remembered when they were getting ready to lock the front doors, she saw the EMS outside of the assisted living center next door. CNA Q confirmed R111 got out of the building, and they did not even know it. When they finally realized she was missing, they called the administrator first and then they called the police. When the police brought the resident back to the facility, they put her on 15-minute checks, and she was not happy about it. R111 was on the memory care unit in the past but she did not like being there and would get aggressive, so she went back to the other unit where she is now. R111 would also refuse the wander guard in the past. Since the surveyors have been in the building, she has a wander guard now but does not like it to be checked. CNA Q reported she was told that the resident in the past was in a facility in Muskegon when R111 left and walked an hour away. When queried if R111 answers questions appropriately, CNA Q reported she answers basic questions appropriately. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Police Report with a dispatch date of 11/24/22 at 10:13 PM, arrival time of 10:31 PM, and a clear time of 2:39 AM for a suspicious situation involving R111 revealed: On 11/24/2022 at approximately (10:13 PM), I (Deputy) was dispatched to the intersection of S. Park St./ W. [NAME] St. for a medical complaint. Dispatch advised a woman was thrown from a vehicle and needed assistance. Prior to my arrival, (the Fire Department) arrived on scene and made contact with the woman. (The Fire Department) state, the woman does not appear to have been thrown from a vehicle and is sitting in someone's yard without injuries. The resident reported she was dropped off by her daughter and another male and gave the officer a different last name and date of birth. The officers then took her to a gas station in Ithaca at 11:08 PM per the resident's request. At approximately 1:35 AM, Dispatch received a call from (Nursing Facility) stating one of their patients ran away from the facility. The officer then returned to the gas station in Ithaca and confirmed the resident was the missing person from the facility and brought her back. Review of a map revealed Highway 57 is approximately a half a mile away from the facility. The police officers drove her approximately 15 miles away to a gas station in Ithaca where the resident was there unsupervised for approximately 2 1/2 to 3 hours before being transported back to the facility. Review of the weather report for [NAME], Michigan on 11/24/22 revealed a high of 55 degrees and a low of 28 degrees. Review of a Wandering Risk Scale assessment for R111 with an effective date of 7/28/22 and an admitted [DATE] at 3:00 AM revealed she was rated as a High Risk to Wander. Another Wandering Risk Scale assessment with an effective date of 7/28/22 and an admitted [DATE] at 11:49 AM revealed R111 was At Risk to Wander. Review of a Wandering Risk Scale assessment for R111 with an effective date of 8/15/22 and an admitted [DATE] revealed the resident was a High Risk to wander. Review of a Wandering Risk Scale assessment for R111 with an effective date of 9/15/22 and an admitted [DATE] revealed she was a Low Risk for elopement. Section E. History of Wandering was marked as not having a history of wandering, making this assessment inaccurate. Review of an Elopement Evaluation dated 12/14/22 for R111 upon readmission to the facility revealed the resident was ambulatory and had risk factors marked for Resident is cognitive impaired, poor decision-making skills, and/or pertinent diagnosis (Example, dementia, Organic Brain syndrome, Alzheimer's, delusions, hallucinations, anxiety disorder, depression, manic depression, and schizophrenia). The boxes marked for the resident having a history of wandering into unsafe areas and making statements that they are leaving were marked. The Elopement Care Plan not initiated was marked and to see comments - Own responsible person. Review of a Resident Elopement Assessment for R111 dated 2/28/23 revealed the resident is At Risk for an elopement. Review of an email correspondence dated 3/13/23 from the NHA revealed R111 did not have a LOA safety assessment to leave the facility by herself or any education provided to her or her representative. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Care Plan for R111 revealed no indication she was a previous CNA at a Nursing Home Facility or being at risk for wandering/elopements. On 8/3/22 revealed a focus for Behavioral Symptoms due to her diagnoses of Dementia with behavioral disturbances. On 9/1/22 another focus for Behavioral Symptoms due to the resident using psychotropic medications. The care plan overall is not a person focused care plan. On 2/28/23 at 1:00 PM, the Nursing Home Administrator NHA was notified of an Immediate Jeopardy that began on 11/24/22 when Resident #111, who was identified as an elopement risk, eloped from the facility unbeknownst to facility staff. On 3/1/23, this surveyor verified the facility completed the following to remove the Immediate Jeopardy: 1. On 2/28/23 a new elopement assessment was added to the observation task in Matrix by Corporate Social Worker. The DON and Admin were educated on the process of this assessment. Elopement policy was reviewed and deemed appropriate at this time. 2. On 2/28/23, Nurse 1 and 2 were educated by DON on new elopement assessment and scoring system. 3. Beginning on 2/28/23, Nurse 1 and 2 began all elopement assessments for residents to be completed by 3/1/23. 4. Beginning on 2/28/23 all residents will that were determined at risk will have an assessment, anyone at risk for exit seeking or wandering will have a wander guard placed if not on the memory care unit. Residents on the memory care unit do not require wander guards due to it being a secured unit. Care plans updated and revised as appropriate. 5. Beginning on 3/1/23, residents that are their own responsible parties and not at risk for elopement or are approved by responsible parties to go on LOAs will be reviewed to be following policy. 6. Beginning on 2/28/23, re-education will be provided by the regional corporate compliance nurse/Designee to the administrator regarding definition of an elopement. All staff will be re-educated on elopements and residents at risk and how to report concerns. 7. On 3/1/23 Elopement books placed on units for resident identification of elopement risk with face sheet and elopement assessment. The Social worker will be responsible for upkeep. 8. On 2/28/23, Resident #1 (R111) was notified of the concern. 9. On 2/28/23, the Medical Director was informed of the concern and agrees with the plan. Although the immediate jeopardy was removed on 3/1/23, the facility remained out of compliance at a scope of isolated and no harm that is not an Immediate Jeopardy due to the fact that sustained compliance had not yet been verified by the State Agency, all education had not yet been completed regarding elopements.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 29073 Based on interview and record review, the facility failed to ensure a staff member had the required certification and competency evaluation to work as Certified Nurse Aide, resulting in the potential for substandard quality of care for all residents living at the facility. Findings: Review of a facility Job Description for Certified Nursing Assistant dated 12/14/2020 reflected The certified nursing assistant position provides quality nursing care to residents; implements specific procedures and programs; coordinates work within the department, as well as with other departments; reports pertinent information to the immediate supervisor; responds to inquiries or requests for information; and assists the immediate supervisor with tasks to support department operations. Minimum Qualifications for the role included: Must hold a current Nurse Aide Certification in the State of Michigan. Review of a list of employees that included date of hire, department, credentials and contact information revealed staff member JJ was listed as a Certified Nurse Aide (CNA). Review of staff member JJ's employee file revealed that she applied for a full time Waiver Care Aide position on 4/29/2022. Staff JJ was hired and started working at the facility on 5/5/2022. Review of a Waiver Care Aide Agreement signed by staff member JJ on 7/10/2022 (two months after being hired) reflected I am currently working as a Waiver Care Aide for (name of facility) with the agreement that (the facility) will pay for and send me to get certified thru the State of Michigan. I agree to maintain full-time employment with (name of facility) for 1 year beginning the day after I receive my license. If I end employment by any means, resign, abandon my job or get fired prior to the 1 year, (name of facility) will keep my last check, up to $800, as reimbursement for fees paid to get me certified. Further review of the staff member JJ's employee file revealed a Waiver Care Aide Training Reimbursement Agreement signed by JJ on 8/22/2022 but was not signed as Approved by Employer. Another form Exhibit 1 Training Costs was signed by JJ on 8/22/2022 but did not list out any fees or total training costs. An Application, Contract, and Background Check Consent form signed by JJ on 7/10/22 for a nurse aide training program was found in JJ's file, however, no evidence the training was obtained was found. Review of the State of Michigan Nurse Aide Registry did not reflect that staff JJ had a current CNA certification. Review of (Name of Facility) Daily Schedules from 12/01/2022-3/15/2023 reflected that on the days staff JJ worked she was counted as a CNA. During an interview on 3/16/2023 at 3:05 PM the manager of Human Resources (HR) KK confirmed that staff JJ was not a CNA.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intakes MI000132840 and MI000132219 Based on interview and record review, the facility failed to ensure 1 resident (Resident #114) was free from significant medication errors resulting in an Immediate Jeopardy (IJ) when transcription errors resulted in 1. Multiple dose changes of Clozaril without adequate laboratory monitoring or clinical rational, 2. A transcription error resulted in a dose reduction of a medication used to treat hypotension without adequate blood pressure monitoring and 3. When a transcription error resulted in a dose of Cymbalta that exceeded FDA guidelines without clinical rational. This deficient practice resulted in the high likelihood for R114 to experience over sedation, medication administration without physician knowledge and over-sight and lack of side effect monitoring when administering antipsychotic, antidepressant and cardiac medication and for R114 to experience psychiatric decompensation, newly emerging psychosis, rapid onset of agitation, neutropenia, and decreased efficacy of Clozaril when the medication is titrated again. This deficient practice continues to have a high likelihood to cause serious harm, injury and or death to all residents receiving medications in the facility. Findings: Review of the manufacturer guidelines Clozapine Rems revealed, Clozapine/Clozaril is a prescription medicine to treat people with schizophrenia who have not responded to other medicines. Clozapine may also reduce the risk of suicidal behavior . Clozapine can cause a blood condition (severe neutropenia), which can lead to serious infections and death. Neutropenia occurs when you have too few of a certain type of white blood cells called neutrophils. This makes it harder for your body to fight infections . Getting your blood tested is important because a low number of neutrophils may not cause any symptoms until you have an infection. Having a blood test helps your doctor know if you are more likely to get an infection. You must have regular blood tests before you start taking clozapine and during your treatment. This test is called absolute neutrophil count (ANC). If the number of neutrophils, or ANC, is too low, you may have to stop clozapine. Your doctor will decide if or when it is safe to restart clozapine . The Clozapine REMS will keep track of your blood test results so your doctor and pharmacist know if it is safe to fill your clozapine prescription. Remember: You must get your blood tested before you can receive clozapine from your pharmacy . Midodrine works by constricting (narrowing) the blood vessels and increasing blood pressure. Midodrine is used to treat low blood pressure (hypotension) that causes severe dizziness or a light-headed feeling, like you might pass out. midodrine is for use only when low blood pressure affects daily life. Midodrine may not improve your ability to perform daily activities. (accessed from Midodrine Uses, Side Effects & Warnings - Drugs.com on 3/24/23 at 8:00 AM) Cymbalta is a selective serotonin and norepinephrine reuptake inhibitor antidepressant (SSNRI). Duloxetine affects chemicals in the brain that may be unbalanced in people with depression.Cymbalta is used to treat major depressive disorder in adults. It is also used to treat general anxiety disorder in adults and children who are at least 7 years old. Cymbalta is also used in adults to treat nerve pain caused by diabetes (diabetic neuropathy), or chronic muscle or joint pain (such as low back pain and osteoarthritis pain). Usual Adult Dose for Depression: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Initial dose: 20 mg to 30 mg orally 2 times a day Maintenance dose: 60 mg per day, given either once a day OR 30 mg orally 2 times a day Maximum dose: 120 mg/day. Overdose symptoms may include vomiting, dizziness or drowsiness, seizures, fast heartbeats, fainting, or coma. (accessed from Cymbalta Uses, Dosage, Side Effects & Warnings - Drugs.com on 3/24/2023 at 8:00 AM) Review of the Fundamentals of Nursing revealed, The National Coordinating Council for Medication Error Reporting and Prevention (2018) defines a medication error as any preventable event that may cause inappropriate medication use or jeopardize patient safety. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, administering extra doses, and/ or failing to administer a medication. Preventing medication errors is essential. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 605). Elsevier Health Sciences. Kindle Edition. Resident #114 (R114) Review of a facility Admission Record reflected R114 admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, bipolar type, idiopathic hypotension, repeated falls, muscle weakness, candidiasis, hereditary motor and sensory neuropathy, intellectual disabilities, hyperlipidemia, restless leg syndrome, open-angle glaucoma, major depressive disorder, encephalopathy, somnolence, cerebral infarction, age related osteoporosis without current pathological fracture, hypothyroidism and anxiety. Review of an OBRA Admission Minimum Data Set (MDS) assessment dated [DATE] reflected R114 admitted to the facility from the community (Assisted Living Center) on 7/22/2022. A Brief Interview for Mental Status (BIMS) assessment determined R114 was cognitively intact as evidenced by a score of 13/15. The assessment indicated R114 was independent with bed mobility, transfers and walking; needed set up help only for eating, needed supervision and set up help only for dressing and toilet use and limited assistance from one person for personal hygiene. Review of an OBRA Quarterly MDS assessment dated [DATE] (three months after the admission assessment) reflected R114 was severely cognitively impaired as evidenced by a BIMS score of 7/15. R114 required supervision and one person to physically assist for bed mobility, required extensive assistance from one person for transfers, dressing and toilet use needed one person to physically assist her with walking once or twice in the lookback period. R114 was not steady but able to stabilize with human assistance with moving from a seated to standing position, walking and turning around and facing the opposite direction while walking and when moving on an off the toilet or during surface-to-surface transfers. Review of R114's referral pre-admission Medication Orders from an Assisted Living facility reflected the following pertinent orders: 1. Clozapine 25MG ODT (Oral Disintegrating Tab) Flazco 25 MG ODT Tab Give 3 tablets (=75MG) by mouth in the morning and give 1 tablet by mouth at bedtime. 2. Clozapine 100/ODT Tab Fazaclo 100/ODT Tab Give 2 tablets (=200MG) by mouth at bedtime. The total dose of Clozapine = 300MG/day (continued on next page)

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	235532	A. Building B. Wing	03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Duloxetine HCL 30 MG Cap Cymbalta 30 MG cap Give one Capsule by mouth in the morning. 4. Duloxetine HCL 60 MG Cymbalta 60 MG Cap Give 1 capsule by mouth in the morning. The total dose of Duloxetine = 90 MG/day 5. Midodrine HCL 5MG PO Tab Take 1 tablet 3 times daily morning, mid-day & 4 hours before bedtime. The total dose of Midodrine = 15 MG/day Review of R114's Medication Administration Record (MAR) for the month of July 2022 reflected the following orders: Clozaril Tablet 25MG (cloZAPine) Give 3 tablet by mouth one time a day for schizophrenia-Start Date-7-23-2022 0700-D/C Date-08/02/2022 cloZAPine Tablet Disintegrating 25MG Give 1 tablet by mouth at bedtime related to schitzoaffective disorder bipolar type(F25.0) -Start Date-7/28/2022 1900 cloZAPine Tablet Disinegrating 25MG Give 3 tablets by mouth one time a day related to schizoaffective disorder bipolar type (F25.0_-Start Date-07/29/2022 0700 FazaClo Tablet Disinegrating 100MG (cloZAPine) Give 200MG by mouth at bedtime for schizoaffective disorder -Start Date-7/22/2022 1900 -D/C Date-7/28/2022 1623 In summary, from 7/22/2022-7/27/2022 R114 received a total of 275MG of Clozaril. On 7/28/2022 R114 was given 100MG of Clozaril. On 7/29/2022 R114 began receiving 175MG of Clozaril per day. No documentation in the clinical record accounted for the significant dose reduction or increase. No evidence there was an increase in laboratory monitoring was found. Review of R114's MAR for the month of August 2022 reflected the following orders: cloZAPine Tablet Disintegrating 25MG Give 1 tablet by mouth at bedtime related to schizoaffective disorder bipolar type (F25.0)-Start Date-7/28/2022 1900 cloZAPine Tablet Disintegrating 25MG Give 3 tablet by mouth one time a day related to schizoaffective disorder bipolar type (F25.0)-Start Date 7/29/2022 0700 cloZAPine Tablet Disintegrating Give 200MG by mouth at bedtime related to schizoaffective disorder bipolar type (F25.0)-Start Date-08/02/2022 1900-D/C Date-8/11/2022 1808 cloZAPine Tablet Disintegrating Give 25MG by mouth at bedtime for mood related to schizoaffective disorder bipolar type (F25.0)-Start Date-8/11/2022 1900: Clozaril Tablet 25MG (cloZAPine) Give 3 tablet a day for schizophrenia -Start Date-7/23/2022 0700 -D/C Date-8/02/2022 1445 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In summary: R114 received 175MG of Clozaril on 8/01/2022 then 375MG of Clozaril on 8/2/2022. R114 was hospitalized from 8/3/2022 until 8/11/2022. On 8/11/2022 R114 was given 50MG of Clozaril. Starting 8/12/2022 R114 was given a total of 125MG of Clozaril per day. No rational for the significant dose reductions and significant dose increases were found in the clinical record. No evidence R114's ANC was monitored more frequently after the significant dose increases were found. Review of R114's September 2022 MAR reflected the following orders: cloZAPine Tablet Disintegrating 25MG Give 1 Tablet by mouth at bedtime related to schizoaffective disorder, bipolar type (F25.0)-Start Date-7/28/2022 cloZAPine Tablet Disintegrating 25MG Give 3 tablet by mouth one time a day related to schizoaffective disorder, bipolar type (F25.0)-Start Date-7/29/2022 0700 cloZAPine Tablet Disintegrating Give 25MG by mouth at bedtime for mood related to schizoaffective disorder, bipolar type (F25.0)-Start Date-8/11/2022 In summary: R114 received a total of 125MG/day of Clozaril for the month of September 2022. Review of R114's October 2022 MAR from PCC reflected the following orders: cloZAPine Tablet Disintegrating 25MG Give one tablet by mouth at bedtime related to schizoaffective disorder bipolar type (F25.0) -Start date- 7/28/2022 1900 cloZAPine Tablet Disintegrating 25MG Give 3 tablet by mouth one time a day related to schizoaffective disorder bipolar type (F25.0)-Start Date- 7/29/2022 0700 cloZAPine Tablet Disintegrating 25MG by mouth at bedtime for mood related to schizoaffective disorder bipolar type (F25.0)-Start Date-8/11/2022 1900 Duloxetine HCl Capsule Delayed Release Sprinkle 30MG Give 1 capsule by mouth one time a day for major depressive disorder-Start Date-8/13/2022 0700 Duloxetine HCl Capsule Delayed Release Sprinkle 60MG Give 60MG by mouth one time a day for major depressive disorder-Start Date-7/23/2022 0700 Midodrine HCl Tablet 5MG Give 1 tablet by mouth 3 times a day for hypotension-Start Date-7/22/2022 1900 In summary: R114 was receiving 125MG/day of cloZAPine, 90MG/day of Duloxetine and 15MG/day of Midodrine. Review of R114's October 2022 MAR from the new electronic health record (EHR) reflected the following orders: clozapine tablet, disintegrating; 25MG; Amount to Administer: 75MG; oral Once a Day Start Date-End Date 10/03/2022-10/21/2022 (DC Date) (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	clozapine tablet, disintegrating; 25MG; Amount to Administer: 3 tablets; oral Once a Day StartDate-EndDate 10/21/2022-Open Ended duloxetine capsule, delayed rlease (DR/EC); 30 mg; Amount to administer: 30 MG oral Once a Day StartDate-EndDate 10/3/2022-10/21/2022 duloxetine capsule, delayed release (DR/EC); 30 MG; Amount to administer: 3 capsules; oral Once a Day StartDate-EndDate 10/21/2022-Open Ended duloxetine capsule, delayed release (DR/EC); 60 MG; Amount to Administer: 60 MG; oral at bedtime StartDate-EndDate 10/03/2022-12/13/2022 midodrine tablet; 5MG; Amount to administer: 5MG; oral Twice a Day StartDate-End Date 10/3/2022-Open Ended In Summary: R114 was being given 75MG of Clozaril a day. No rational in the clinical record was found to describe the significant dose reduction. R114 also began receiving 150MG of duloxetine, a significant dose increase of the antidepressant without clinical rational. Finally, R114 was only given 10MG of the Midodrine beginning in October with the implementation of the new electronic health record. No evidence in the clinical record was found to explain the dose reduction of the blood pressure medication. No evidence was found that facility staff were monitoring R114's blood pressures on a regular basis. Review of a consultant psychology progress note dated 12/13/2022 reflected At this time would recommend D/C (discontinuation) of 60MG QHS (at bedtime) dose of Cymbalta as maximum recommended dosage is 120MG/day. Patient had been doing well on 90MG QD (every day) previously. Review of a Community Mental Health (CMH) Psychiatry note dated 12/14/2022 reflected Patient (R114) with a history of schizophrenia, who was seen by (name of a CMH physician) in the past for medication management, apparently patient psychotropic medications was managed at a rehabilitation facility, staff (CMH staff) has concerns about medication management and brought her to me to help with her psychotropic medications. There is also concern about her physical wellbeing as well, obviously during this quick encounter I cannot corroborate if there is any neglect or physical abuse per se, but the staff have concern about that. From a psychiatric standpoint, the patient is barely oriented x3, she seemed to be pleasant, she denies any auditory hallucination, but she has major cognitive limitations. I do not know what her baseline is, but at the moment she is unable to manipulate information, her fund of knowledge is poor, but she says she feels okay, noticeable upper extremity tremor, patient uses a walker to help her with her gait, her left arm has limited movement. I got most of the information from the chart and the staff, since the patient has major cognitive limitation. Patient with a history of treatment resistant schizophrenia, apparently dosing of medications has been changed during her admission to rehabilitation. I recommend the dosing of medications that worked for her in the first place, as stated above, as of now I am not sure where patient is to get psychiatric treatment, I recommend she continue with us here to manage her psychotropic medications, on any occasion the dose of Cymbalta at 150 mg as being given to he is above the FDA (Food and Drug Administration) guidelines, and thus has to be reduced to 90 mg which was a dose that she was taking previously, Clozaril has to be titrated up to the dose that she was taking previously, see medication list. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 3/10/2023 at 9:41 AM, the Consultant Pharmacist reported that he would come to the facility for monthly reviews of resident medication regimens. The Pharmacist reported that he did not notice any issues with the Clozaril and would not pay close attention to that as it is required the prescribing physician and pharmacy must be registered in the Clozapine/REMS program. Review of documentation related to the medication transcription errors reflected the following conclusions as indicated by notes made by the Nursing Home Administrator as follows: The explanation for the Midodrine dose change from 15MG/day to 10MG/day was Matrix (EHR) change over was put in wrong by nurse order should have read 3 times a day. Clozapine was put in Matrix incorrectly by nurse order should have read 75MG AM and 25MG HS (hour of sleep) Discontinue original order at NOC (night) d/t (due to) day med (duloxetine) being at 90MG did not need NOC med at 60MG too. Review of Monitoring History required for the Clozapine/REMS program for R114 reflected that R114 did not have increased laboratory monitoring after significant dose increases. The record revealed an ANC (Absolute Neutrophil Count) was calculated and reported on 7/07/22, 8/04/22, 8/21/22, 9/29/22. An ANC was not reported in October or November 2022. The record reflected that R114 refused to have labs drawn in December 2022 with the records indicating Not reported(Patient Refused). On 3/14/2023 the Administrator was verbally notified and received written notification of the Immediate Jeopardy that was identified on 3/14/23 due to the facility's failure to ensure medications were transcribed and administered appropriately and following FDA dispensing regulations for Clozaril. A written plan for removal for the immediate jeopardy was received on 3/14/23 and the following was verified on 3/16/23: 1. All residents are at risk with this concern (transcription errors). 2. On 3/14/23 all residents on Clozaril were reviewed to ensure all labs were in place and monitored at appropriate frequency. 3. On 3/14/23 all residents on Clozaril were reviewed to ensure orders were correct. 4. On 3/14/2023 all residents on Clozaril were reviewed to ensure all orders matched the MAR. 5. On 3/14/2023 all residents on Clozaril were reviewed for any adverse effects if concerns with medications were found. 6. On 3/14/2023 all residents on Cymbalta were reviewed to ensure current monitoring orders were correct. 7. On 3/14/23 all residents on Cymbalta were reviewed to ensure orders were correct (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. On 3/14/23 all residents on Cymbalta were reviewed to ensure orders matched the MAR 9. On 3/14/23 all residents on Cymbalta were reviewed for any adverse effects if concerns with medications were found. 10. On 3/14/23 all residents on Midodrine were reviewed to ensure all blood pressure checks were in place. 11. On 3/14/23 all residents on Midodrine were reviewed to ensure orders were correct. 12. On 3/14/23 all residents on Midodrine were reviewed to ensure all orders matched the MAR 13. On 3/14/23 all residents on Midodrine were reviewed for any adverse effects if concerns with medications were found. 14. On 3/14/23 all resident orders were reviewed to ensure they matched the MAR. 15. Beginning 3/14/23 all residents that are requiring labs were reviewed to ensure labs were ordered as appropriate. 16. Beginning 3/14/23 all residents with orders were reviewed to ensure appropriate parameters/monitoring are in place for medications ordered. 17. Beginning 3/14/23 licensed nurses were educated on proper medication administration, review of narcotic dispensing, lab ordering, blood pressure monitoring, proper processing of new medication orders and the 5 rights of medication administration. 18. On 3/14/23 the Medical Director was notified of deficient practice and in agreement with plan. 19. On 3/14/23 an Ad-Hoc QA (Quality Assurance) meeting was held with the NHA (Nursing Home Administrator), DON (Director of Nursing), medical director and nurse consultant to review action steps and results to ensure compliance. Although the Immediate Jeopardy was removed on 3/14/2023, the facility remained out of compliance at a scope of pattern and severity of likelihood for harm due to the fact that not all facility staff have received education and sustained compliance has not been verified by the state agency.