STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235719	A. Building B. Wing	08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Manor Nursing and Rehabilitation Center	13990 Lakeside Circle Sterling Heights, MI 48313

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This citation pertains to Intake: MI00120674 and MI100120166 Based on interview and record review the facility failed to ensure family was notified of a change in condition for one sampled Resident (R910) of one reviewed for a change in condition resulting in the family being unaware of the resident's weight loss. Findings include: On 8/16/21 at 10:39 AM, Confidential Witness explained that R910 was a resident of the nursing home for over three years and had no idea that the resident had lost weight until the idea of a feeding tube was discussed. A review of R910's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Parkinson's Disease, Schizophrenia and Pervasive Developmental Delay. A review of the Minimum Data Set assessment dated [DATE] revealed that the resident had a Brief Interview for Mental Status score of 8/15 indicating moderately impaired cognition, and required extensive assistance for bathing, bed mobility and transfer. Further review of R910's medical record revealed that R910 had a significant weight loss of 13.39% between December 2020 and April 2021. 04/28/2021 Weight: 94.4 lbs 04/28/2021 Weight: 91 lbs 04/19/2021 Weight: 96.4 lbs 04/14/2021 Weight: 96.2 lbs 04/06/2021 Weight: 98.4 lbs 03/04/2021 Weight: 103 lbs 02/02/2021 Weight: 105.4 lbs 01/19/2021 Weight: 102.2 lbs (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/05/2021 Weight: 101.4 lbs 12/10/2020 Weight: 109 lbs A review of R910's progress notes revealed the following: 11/30/2020. 4:33 PM .Quarterly Nutrition Progress Note: Res continues on a Regular Mech (mechanical) Soft diet with House Supplements TID (three times a day) with meals. Current diet and supplements have continued to assist with weight maint. Current weight is 103 pounds per 11/16/20 and has been stable x 30, 90 and 180 days. Res continues to remain relatively alert enough to communicate preferences and dislikes and is also able to feed self with set up . Res is at risk for poor appetite and weight loss due to dx (diagnosis) of Parkinson's disease and Schizophrenia, will continue to monitor weight, appetite and labs as available. 02/23/2021. 8:57AM .RD (registered dietician) visited res at dinnertime on 2/22/21. Noted res has difficulty scooping up foods onto her utensils, causing food to near the plate edge & go onto the tray, and [R910] also spills fluids on [themselves] frequently r/t (related to) tremors. Res may benefit from a divided plate or inner lip plate, as well as a type of no-spill cup; OT (occupational therapy) notified. Additionally, resident benefits from tray set-up assistance (opening supplements, making sure res has straw for drink, adding cream to coffee, etc.) r/t Parkinson's dx (diagnosis), as well as cueing, supervision, & encouragement is recommended to maximize nutritional intake. Note that res takes longer than typical res to finish meals, will notify LPNs (licensed practical nurses) & dietary to allow res to keep tray additional time until [R910] is finished with [their] meal in order to maximize nutritional intake. 04/22/2021. 9:40pm Internal Medicine Progress Note .Following this patient after a note the patient was noted with weight loss .Oropharygeal dysphagia, Decreased p.o. (oral) intake, decreased appetite . spoke with [guardian] on the phone today 4/22, refused appetite stimulant at this time, would like to know TSH (thyroid stimulating hormone) level first. Made aware if patient will not improved, PEG (feeding tube) placement might be an option, refused PEG placement at this time . 04/28/2021. 3:04PM RD (registered dietician) participated in conference call with [guardian]. There were c/o (complaints of) resident's guardians not being aware of resident weight loss and believing she still weighed ~120# (pounds). Writer explained that res has not weighed 120# since January 2019 . On 8/19/2021 at 2:30PM, a request was made to speak with the dietician however, it was explained that the current dietician was not available, and the previous dietician was no longer working for the company. On 8/19/2021 at 3:55PM, the Director of Nursing was interviewed and asked about R910 and their weight loss, and she explained that she was not familiar with the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Change in a Resident ' s Condition or Status policy revealed the following, Highlights Policy Statement: [Nursing Home] will promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident ' s medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) .Protocol for Notifying Resident ' s Family or Sponsor When There is a Change in the Resident's Medical/Mental Condition: 3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident ' s family or representative (sponsor) when: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source or under investigation.b. There is a significant change in the resident ' s physical, mental, or psychosocial status; c. There is a need to change the resident ' s room assignment; d. A decision has been made to discharge the resident from the facility; and/or e. It is necessary to transfer the resident to a hospital/treatment center .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39918 This citation pertains to intake MI00120850. Based on interview and record review, the facility failed to thoroughly and completely follow-up and bring resolution to a concern/grievance for one sampled resident (R911) out of a total sample of 22 residents, resulting in resident/family dissatisfaction and an unresolved claim of missing personal items. Findings include: A review of intake MI00120850 revealed an allegation that the facility failed to return personal belongings (the resident's work-issued laptop), to R911/R911's family after the resident's discharge. The complaint had been filed towards the end of June 2021. On 8/16/21 at 2:00 PM, Confidential Witness S was interviewed via phone regarding R911's stay at the facility. Witness S confirmed the allegation details of the complaint and indicated that R911's work-issued laptop (and charger cord) had still not been returned by the facility. Witness S explained that R911's place of work was aware of the situation and a police report had been filed. Witness S stated that R911's family did eventually receive the resident's tablet, walker, and wheelchair from the facility but has never received the work-issued laptop. A review of R911's medical record indicated that the resident was initially admitted into the facility on [DATE], readmitted on [DATE], and discharged on [DATE]. Further review revealed the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15/15. On 8/16/21 at 4:17 PM, the current Nursing Home Administrator (NHA) and current Director of Nursing (DON) provided one concern form for R911 that had been filled out by the former NHA. The form addressed the missing laptop claim and was dated 6/21/21. The form indicated that the laptop (and cord) were found and that the police and individual who raised the concern had been notified on 7/14/21 by the former NHA. The form did not indicate that the computer/charging cord had been given to R911 or the resident's family and was not updated past 7/14/21. On 8/17/21 at 10:56 AM, when asked about the concern form for R911 dated 6/21/21 and the police report that was filed, the current DON made an attempt to contact the former NHA via phone. The former NHA did not answer the phone call. The current DON indicated she was unable to speak to the concern other than what was written. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/17/21 at 1:24 PM, the detective handling the reported missing laptop for R911, Detective T, was interviewed via phone. Detective T stated, The case is still open. The facility said they found the laptop and it turned out to be the wrong laptop. [R911/R911's family] still haven't gotten it back. The facility called the family and said they found it. They went to pick it up and it was the wrong one. That's where it's at right now. Detective T revealed that the former NHA (who filled out the concern form) was Not easy to work with, and would not get back with the detective. Detective T indicated that when they called the facility they were unable to reach anyone to talk to and left messages. Detective T also indicated that they asked to review camera footage in the facility but was told they could not. Detective T stated, [Former NHA] eventually got back to me and I asked about the cameras, she said she would review them, she never got back with me on that. She then called me to say the laptop was found. The family called me and told me it wasn't the right one and I have not heard from the [Former NHA] again. The laptop actually belongs to [R911's workplace] .the family tried to pick up the resident's belongings multiple times with no success. The current NHA was asked on 8/17/21 at 1:34 PM if it were possible to review facility camera footage from June 15th, 2021. The current NHA replied at 1:52 PM that, The camera footage turns over after 72 hours. On 8/19/21 at 3:51 PM, the current NHA and current DON were interviewed and when queried regarding the claims that the laptop, the former NHA stated was found was actually the incorrect item, the current NHA and current DON indicated they could not speak as to why the former NHA did not update the concern form and continue to follow-up on the issue. The current DON stated that the former NHA left on July 23rd, 2021. The current DON stated, I kind of remember someone saying they had found a laptop for [R911] but it was the wrong one, I'm not sure. A review of the facility's policy/procedure titled, Grievances/Complaints, dated 10/1/2016, revealed, Facility staff will help residents, their representatives, other interested family members, or resident advocates file grievances or complaints when such requests are made .1. Any resident, his or her representative, family member, or appointed advocate may may file a grievance or complaint concerning treatment, medical care, behavior of other residents, staff members, theft of property, etc. without fear of threat or reprisal in any form . 8. The Administrator has designated a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility .issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations .9. Upon receipt of a grievance and/or complaint, the Grievance Official will investigate the allegation(s) and submit a written report of such findings to the Administrator within(5) working days of receiving the grievance and/or complaint .13. All written grievance decisions will be communicated in writing to the resident within 7 business days and will include: a. the date the grievance was received, b. a summary statement of the resident's grievance, c. the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), d. a statement as to whether the grievance was confirmed or not confirmed, e. any corrective action taken or to be taken by the facility as a results of the grievance, f. the date the written decision was issued .

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41423 This citation pertains to Intakes MI00122035, MI00121950, MI00121883 and MI00121928 Based on observation, interview and record review, the facility failed to monitor, supervise, and provide an environment free from sexual abuse for one Resident (R900) of two sampled residents reviewed for sexual abuse, which began on 8/8/2021 between the hours of 10:00 PM and 11:00 PM when Resident (R901) was observed on top of Resident (R900) moving up and down in a sexual motion. This deficient practice resulted in an Immediate Jeopardy (IJ) and the likelihood for serious sexual and/or psychosocial harm (based on the reasonable person), injury, impairment or death. Findings include: A review of the complaint dated 8/10/21 noted the following: (R900) is diagnosed with Dementia. (R900) has been at a rehabilitation center since May for subdural hematoma that required a craniotomy. (R900) had plans to go home back to (their family) .(R900) was sent to the ER (emergency room) by the rehab nursing home out of concern for sexual assault that potentially happened between (R900) and another resident. The facility found (R900) without any clothes on and on the floor in (R901's) room. R900 was transferred to the hospital on 8/9/21 and prior to survey exit had not returned to the facility. An attempt was made to contact the hospital social worker on 8/12/21 at 12:55 PM, a voicemail was left with callback contact number, but contact was not possible prior to survey exit. A review of the Incident Report Statement taken over the phone by the NHA from CNA A noted the following, I (CNA A), came out of another resident's room and saw the call light on for room (R901). The door was closed, when I entered, I saw two wheelchairs by the door. I moved one to be able to walk through the room. After moving the wheelchair, I saw (R901) and (R900) laying on the floor together naked. (R901) was on top of (R900). I tried to get (R901) off (R900), but (R901) was resisting. I went to get the nurse. When (Previous/suspended DON) and I got back to the room (R901) was on the bed pulling up (their) pants. (R900) was still lying on the floor naked. A review of the Incident Report Statement dated 8/9/21 with the NHA and SW M interviewed R901 noted the following: NHA: Did (R900) touch your penis? Resident (901): No (R900) didn't. NHA: Did you touch (R900's) vagina? Resident: Yea. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	SW M: What did you touch (R900) with? Resident (901): My hands. A review of the Police Department report dated 8/8/21 noted the following: Upon arrival I met with (Previous/suspended DON), who stated that tonight at approximately 2300 (11:00 PM) hours .staff member, walked in on two residents having sexual intercourse. Stated that CNA A was doing (their) rounds and observed the door . was closed. Advised that the door is never closed and (the CNA A) found that unusual. Opened the door, walked in and observed (R900) on (their) back on the floor, next to the bed, with (R901) on top of (R900). Advised that they were having sexual intercourse. Grabbed (R901) by the shoulder in attempted to pull (R901) off of (R900) but (R901) pushed (CNA A) away from . called for help to the other staff members (the CNA A called the DON) . (DON) . observed (R900) on the floor with (their) gowned undone and observed (R901) putting (their) underwear back on. Although the facility has cameras in the hallways, the NHA stated the video was only able to go back 72 hours. It was not confirmed if R900 went to R901's room on their own or if R900 was coerced to go to R901's room. A review of the conclusion/summary Investigation that was signed by the NHA on 8/12/21 at 1:21 PM noted the following: After a thorough and exhaustive investigation was completed, and with due diligence, the IDT (Interdisciplinary Team) has determined that (The Facility) cannot substantiate abuse, exploitation, and/or sexual misconduct. R901 remained in the facility and was not under supervision after the 8/8/21 incident. On 8/16/21 at 8:45 AM, Family Member B was interviewed by phone about the incident that occurred, with R900 and R90 on 8/8/21 at the nursing facility. Family Member B revealed, They (the facility) called me and said that (R900) was found on the floor naked in (R901's) room .How does something like that happen . (R900) is home now and (R900) is always crying and yelling out .I am so angry with whatever happened to (R900) .No one is telling me exactly what happened. A review of the medical record reflected R900 was admitted to the facility on [DATE] with the diagnoses of Schizophrenia, Type 2 Diabetes Mellitus, and Malignant neoplasm of brain (Cancer of the brain). R900 was readmitted to the facility on [DATE] with the diagnoses of Dementia, Repeated Falls, Traumatic Subdural Hemorrhage (a type of bleed inside the head), Craniotomy (surgical removal of part of the bone from the skull to expose the brain), and Seizures. R900 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 (severe impairment). A review of R900's Cognitive Limits care plan (start date 5/17/21) problem noted: Resident has cognitive limits r/t (related to) diagnosis of dementia; BIMS of 2. Approach Start Date: 5/17/25 Maintain safety when up and when in room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R900's ADL (Activities of Daily Living start date 5/17/21) care plan problem noted: Resident has a self care deficit rt dementia: weakness, mobility limits; is here for pt (physical therapy) ot (occupational therapy) and slp (speech language therapy), requires assist with adls. Approach Start Date: 05/17/2021 Locomotion: Wheel chair use with 1 person assist .Dressing: 1 person assist . Approach Start Date: 05/17/2021 Transfer: x1 assist . Approach Start Date: 05/17/2021 Restrict my movement to my room . Approach Start Date: 05/17/2021 Dressing: 1 person assist . Approach Start Date: 05/17/2021 Bowel Function: incontinent . Approach Start Date: 05/17/2021 Bladder Function: incontinent. A review of R900's progress notes and care plan did not note any documentation of sexual behaviors. A review of the medical record reflected R901 was admitted to the facility on [DATE] with the diagnoses of Schizophrenia, Type 2 Diabetes Mellitus, and Malignant neoplasm of brain (Cancer of the brain). The BIMS score document provided by the Interim DON (Director Of Nursing) on 8/17/21, reflected R900 had a BIMS score of 11 out of 15 (moderate impairment) dated 8/9/21. A review of R901's Falls care plan (start date 11/10/20) noted the following: Approach Start Date: 11/24/2020 Nursing frequent visual checks when (901) is up to (their) wheelchair . A review of R901's Psychotropic Drug Use care plan (start date 10/17/20) noted the following: Approach Start Date: 01/06/2021 monitor (R901) when he is in the activity room for phone use; expect call back from 911 when he calls to ensure his safety. R901's care plan interventions before 8/8/21 that addressed any issues related to sexual misconduct A review of R901's Behavioral Symptoms care plan (start date 08/08/21) noted the following: Approach Start Date: 08/08/2021, Discourage resident from acting on feelings and impulses . Approach Start Date: 08/08/2021, Respect resident's needs for privacy and space. Avoid unnecessary touching. R901's Behavioral Symptoms care plan was noted to reflect a new approached implemented on 8/18/21 during the survey that reflected: Resident currently on 1:1 to monitor behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/16/21 at 10:08 AM, R901 was observed in the hallway in a wheelchair, alone, outside of the kitchen area asking for coffee. R901 was asked if they could talk and R901 said, What do you want .I know what you want to talk about so you can ask me right here (in the hallway). R901 was asked to have a discussion in their room agreed. On 8/16/21 at around 10:08 AM, R901 was interviewed in their room, that was located at the far end of the hall, away from the nurses' station and queried about the incident with R900. R901 stated, (R901) came to my room and asked for sex so I said yes of course. R901 was asked if R900 touched their private area and R901 said, No. I touched (R900's) vagina .(R900) did not touch my penis .we took our clothes off. On 8/17/21 at 9:43 AM, Social Worker (SW) M revealed The Administrator (NHA: Nursing Home Administrator) and I went and talked to (R901) .(R901) said that (R900) asked if (they) wanted sex and (R901) said (they) were not going to say no .were alone for about ten minutes .(R901) said that there was no penetration and (901) only touched (R900's) hips and butt .(R901's) memory is good some days and bad other .(R900) was showing some signs of sexual behavior .(R900) was very touchy. On 8/17/21 at 9:52 AM, the NHA, Interim DON, and the Clinical Corporate Operations were queried about the incident with R900 and R901. The NHA said, They were found in (R901's) room on the floor next to each other without clothing .(R900) was interviewed by the police but had no memory of what happened. The DON was asked the BIMS for R901 and stated, Around 10. The DON left the room and returned with a BIMS assessment for R901 dated 8/9/21 with a score of 11 out of 15 (moderate impairment). The Interim DON stated, (R900) went to (R901's) room, how is it (R901's) fault? On 8/17/21 at 11:46 AM, CNA A was interviewed via phone about the incident with R900 and R901. CNA A stated, I was exiting another resident's room and noticed the call light was on. I tried to open the door and noticed the wheelchairs were blocking the door . (R901) was on top of (R900) moving in a sexual motion like they were having sex. I tried to pull (R901) off (R900) and (R901) pushed me away. I ran out the room and called the DON. We ran back to the room and (R901) was getting off (R900) and pulling up (901) shorts. (R900) was laying on the floor with (their) legs open. On 8/17/21 at 3:38 PM, Nurse N was interviewed via phone about the incident with R900 and R901. Nurse N stated, I was outside on a break when this happened. I came back inside and saw the DON in the room (R901). The DON told me what happened, and I had never heard anything or dealt with this type of issue. The CNA, (CNA A) was looking after the fall residents. We were challenged that night with staffing. (R901) was acting up earlier yelling saying (their) head was hurting .The rest of the night (R901) was ok. On 8/17/21 at 4:10 PM, the NHA was interviewed and queried about their statement of R900 and R901 being found on the floor naked. The NHA stated, (CNA A) was the first witness and told me during the interview that (R900 and R901) were on the floor next to each other. The NHA was asked about the discrepancy about R901 being on top of R900, versus only being found on the floor next to each other. The NHA said, (R901) was on top on (R900), but (CNA A) did not say it was sexual. A review of the facility's Resident Abuse/Neglect policy with a revision date of 1/30/19 noted the following: The facility will not condone any form of resident abuse or neglect .An ongoing review and analysis of abuse incidents .The implementation of changes to prevent future occurrences of abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy (IJ) started on 8/8/2021, was identified on 8/18/2021 and the Administrator was notified of the Immediate Jeopardy on 8/18/2021 and was asked for a plan to remove the immediacy. The IJ was removed on 8/19/2021, based on the facility's implementation of the removal plan as verified onsite on 8/19/2021. The facility provided the following removal plan: Removal Plan 1. Female number #900 does not reside at the facility anymore. She was assessed by the charge nurse and was sent to the hospital to be evaluated. Resident # 901 was placed on a 1:1 until outside placement is found, starting 8/18/21. Resident # 901 was assessed by the charge nurse and physician at the hospital. No noted injuries or adverse reaction was documented. Resident # 901 care plan and care guide was reviewed and updated. Both resident's legal guardian and physician were notified on August 9, 2021 at 12:30am. 2. All residents are at risk for this deficient practice. All alert residents were interviewed if they were sexually abused or know if any patients were abused. All residents responded no to not being sexually abused and no to knowing anyone else was sexually abused. 3. Due to residents being cognitively impaired and unable to effectively communicate sexual trauma, the residents will be followed by nursing to evaluate any changes in behavior, emotional distress, and changes in baseline. Cognitively impaired residents will be evaluated by psych services during the next psych visit on 8/20/2021 to rule out any sexual abuse. If sexual abuse is suspected by psych services, a medical exam will be ordered immediately. 4. The facility policy on abuse was reviewed and deemed appropriate. All staff was in-serviced on the different types of abuse and supervision to ensure all patients are safe and free from abuse. The staff that was not present was in-serviced over the phone on Wednesday, August 18, 2021. The following was text and discussed via phone with staff: Abuse types: Sexual, emotional, physical, neglect, verbal, mental, involuntary seclusion, misappropriation of belongings Any allegations of abuse MUST be reported to the Administrator immediately (Administrator phone number listed) A hard copy of the abuse policy will be attached to paychecks. 5. The facility will audit 20% of the current resident population, twice a week for 4 weeks then monthly/PRN, to ensure residents are free from abuse and safety is in place. Results will be reviewed in QA meeting monthly x3. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date of compliance 8/19/2021. Administrator will maintain compliance. Although the immediacy was removed the facility's deficient practice was not corrected and remained isolated with actual harm that is not immediate jeopardy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on interview and record review the facility failed to implement and update care plan interventions for one sampled resident (R910) of one reviewed for care plans resulting in targeted interventions and goals for weight loss not being implemented. Findings include: A review of R910's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Parkinson's Disease, Schizophrenia and Pervasive Developmental Delay. A review of the Minimum Data Set assessment dated [DATE] revealed that the resident had a Brief Interview for Mental Status score of 8/15 indicating moderately impaired cognition, and required extensive assistance for bathing, bed mobility and transfer. Further review of R910's medical record revealed that R910 had a significant weight loss of 13.39% between December 2020 and April 2021. 04/28/2021 Weight: 94.4 lbs 04/28/2021 Weight: 91 lbs 04/19/2021 Weight: 96.4 lbs 04/14/2021 Weight: 96.2 lbs 04/06/2021 Weight: 98.4 lbs 03/04/2021 Weight: 103 lbs 02/02/2021 Weight: 105.4 lbs 01/19/2021 Weight: 102.2 lbs 01/05/2021 Weight: 101.4 lbs 12/10/2020 Weight: 109 lbs A review of R910's care plan revealed the following: Problem: Category: Nutritional Status: Resident has potential alteration in nutritional status R/T PMH (past medical history) of: Parkinson's dx. Res has difficulty scooping up foods onto [their] utensils, causing food to near the plate edge & go onto the tray, and [they] also spills fluids on [themselves] frequently r/t tremors. It also takes res long periods of time to eat [their] meals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Approach Start Date: 02/23/2021 House Supplement TID with all meals Approach Start Date: 02/23/2021. LPNs & dietary will allow res to keep tray additional time until [R901] finished with [their] meal in order to maximize nutritional intake. Approach Start Date: 02/23/2021 Provide tray set-up assistance (opening supplements, making sure res has straw for drink, adding cream to coffee, etc.) r/t Parkinson's dx, as well as cueing, supervision, & encouragement PRN (as needed) . Further review of R901's care plan revealed that prior to the 2/23/21, there were no interventions in place from the date of admission (8/30/18 to 2/23/21) and included the following: Approach: Diet: regular mech soft w/ thin liquids. Offer HS (nightly) Snack. Provide divided plate & insulated mugs w/ tumbler lids (weighted or nonweighted), as well as using weighted utensils. Provide the resident with as much control as possible in routines, food preferences, etc . A review of R910's progress notes revealed the following: 11/30/2020. 4:33PM .Quarterly Nutrition Progress Note: Res (resident) continues on a Regular Mech (mechanical) Soft diet with House Supplements TID (three times a day) with meals. Current diet and supplements have continued to assist with weight maint (maintenance). Current weight is 103 pounds per 11/16/20 and has been stable x 30, 90 and 180 days. Res continues to remain relatively alert enough to communicate preferences and dislikes and is also able to feed self with set up . Res is at risk for poor appetite and weight loss due to dx (diagnosis) of Parkinson's disease and Schizophrenia, will continue to monitor weight, appetite and labs as available. 02/23/2021. 8:57AM .RD (registered dietician) visited res at dinnertime on 2/22/21. Noted res has difficulty scooping up foods onto her utensils, causing food to near the plate edge & go onto the tray, and [R910] also spills fluids on [themselves] frequently r/t (related to) tremors. Res may benefit from a divided plate or inner lip plate, as well as a type of no-spill cup; OT (occupational therapy) notified. Additionally, resident benefits from tray set-up assistance (opening supplements, making sure res has straw for drink, adding cream to coffee, etc.) r/t Parkinson's dx (diagnosis), as well as cueing, supervision, & encouragement is recommended to maximize nutritional intake. Note that res takes longer than typical res to finish meals, will notify LPNs (licensed practical nurses) & dietary to allow res to keep tray additional time until [R910] is finished with [their] meal in order to maximize nutritional intake. Let it be noted, there were no other Dietician progress notes located in the medical record, dating back to June 2020. On 8/19/2021 at 2:30 PM, a request was made to speak with the dietician however, it was explained that the current dietician was not available, and the previous dietician was no longer working for the facility. On 8/19/2021 at 3:55PM, the Director of Nursing was asked about R910 and their weight loss, and she explained that she was not familiar with the resident. A review of the facility's Care Planning Process/Physician Role policy did not address Interdisciplinary members updating and implementing individualized care plans.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 This citation pertains to Intakes: MI00118285, MI00118887 and MI00120850. Based on observation, interview, and record review, the facility failed to answer call lights in a timely manner for one sampled resident (903) out of three reviewed for quality of life resulting in decrease in self-worth, frustration, and feelings of shame. Findings include: On 8/17/2021 at 9:08 AM an interview was conducted with R903 regarding the care in the facility. R903 stated that they must wait for a long time to be helped. R903 stated that they were currently attempting to have a bowel movement and needed to be turned on their side to help facilitate it. R903 stated they were going to turn on their call light for assistance. The same day at 9:11 AM, R903 proceeded to press their call light for assistance. At 9:16 AM, R903 call light was still activated. The NHA (Nursing Home Administrator), Kitchen personal and a nurse were observed walking past the call light. At 9:22 AM the call light was still activated and the NHA and nurse were observed walking past the light. At 9:29 AM the light was still activated and R903 stated no one had been in to address their call light being on. At 9:34 AM, R903 call light was still activated and the NHA and Nurse were observed in the hallway. At 9:35 AM a CNA (Certified Nursing Assistant) came out of another room and walked into R903 room to address the call light and render care. R903 was interviewed after receiving care, as to how long they waited. R903 stated that waiting that long was not an unusual occurrence and they often have to wait longer for assistance. R903 stated that it makes them feel like they are not important when they must wait a long time for assistance and worthless. A review of R903's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Muscular Dystrophy, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, and Heart Failure. A review of the Minimum Data Set (MDS) assessment set dated 7/27/2021 revealed that the resident was cognitively intact and required total dependence for toilet use, transfers, and mobility. On 8/18/2021 at 3:56 PM, an interview was conducted with the NHA (Nursing Home Administrator). The NHA was queried about what their expectation for call lights and who should address them. The NHA stated that their expectation is that everyone answers call lights and addresses the issue or find someone who can. The NHA was queried as to what was an excessive time for a call light to be on and they replied, 20 minutes is definitely excessive. A review of the policy titled; Nurse Call dated 02/01/2018 stated, 3. All staff members have responsibility to respond to nurse call alerts. 2. Resident calls must be addressed immediately. Any staff person can address a resident's call. Call lights must be answered quickly.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 This citation pertains to intakes MI00118887, MI00118285, MI00117913, MI00120674, MI00120166, MI00120850. Based on observation, interview, and record review, the facility failed to provide showers per care plan and resident preference, and failed to provide assistance with activities of daily living including responding timely to requests for assistance for six sampled residents (R902, R903, R904, R906, R910, R917 and R918) reviewed for activities of daily living (ADLs), resulting in resident dissatisfaction with care, and unmet care needs. Findings include: Resident # 902 On 8/16/2021 at 12:00 PM, an interview with R902 was completed about the care in the facility. R902 stated, I don't get my showers like I should, I have not had one in weeks. R902 stated that they feel the facility is too short staffed to get anything done. A review of R902's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Muscular Dystrophy, Contracture of Right Hand, and Hidradenitis Suppurative. A review of R902's Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was cognitively intact and required total dependence for bathing, toilet use, transfers, and mobility. A review of shower sheets for the last thirty days revealed R902 received showers and/or bed baths on 7/6/2021, 7/12/2021, refused on 7/13/2021,7 /14/2021, 7/16/2021, 7/20/2021, 7/30/2021, refused 8/6/2021, 8/7/2021, and 8/10/2021. A review of R902's care plan revealed the following, Problem Start Date: 9/18/2020 Category: ADL Functional/Rehabilitation Potential. Resident has a self-care deficit R/T mobility limits. R902 has a diagnosis (dx) of Muscular dystrophy; R902 is requires total assist with most Activities of Daily Living (ADLs) .Approach Start Date: 9/18/2020 Bathing: 1-2 person assist as needed. On 8/18/2021 at 11:19 AM, R902 was interviewed in their room and asked if they had received a shower on 8/17/201 since it was their scheduled shower day. R902 stated they had not received a shower, and they were not offered one. A review of progress notes and Certified nursing assistant charting showed no documentation of refusals. Resident #903 On 8/16/2021 at 12:27 PM, an interview with R903 was completed about the care in the facility. R903 stated, I never get my showers. I may get one once a month if I'm lucky and that depends on who if the good CNAs are working. R903 stated that they are supposed to get a shower twice a week and has gone weeks without one. When queried about the last time they had a shower R903 stated they had one the night before but only because she had a great CNA who felt bad for her cause it had been so long. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R903's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Muscular Dystrophy, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, and Heart Failure. A review of the Minimum Data Set (MDS) assessment set dated 7/27/2021 revealed that the resident was cognitively intact and required total dependence for toilet use, transfers, and mobility. A review of R903's shower sheets for the last thirty days showed that R903 received a bed bath on 7/15/2021 and 8/16/2021, a shower on 7/30/2021, and refused showers on 7/31/2021, 8/4/2021, and 8/7/2021. A review of R903's care plan revealed the following, Problem Start Date: 8/10/2020 Category: ADL Functional/Rehabilitation Potential. Resident has a self-care deficit R/T mobility limits. R903 has a diagnosis (dx) of Muscular dystrophy; R903 is wheelchair bound (W/C) .Approach Start Date: 8/10/2020 Bathing: 1-2 person assist as needed, twice weekly per facility schedule. On 8/19/2021 at 12:00 PM, R903 was interviewed in their room and asked if they had received a shower on 8/18/2021 since it was their scheduled shower day. R903 stated they had not, and nobody had offered them one. A review of progress notes and Certified nursing assistant charting showed no documentation of refusals. Resident #904 On 8/17/201 at 10:00 AM, an interview was completed with R904 about the care in the facility. R904 stated that they had been in the facility for about a month and had not received a shower, toothbrush, or linen changes after having asked multiple people. R904 was observed wearing a pink robe with a green gown. Both the robe and gown were visibly stained. On 8/18/2021 at 11:30 AM, CNA J was queried as to what happens when a new admission comes into the facility. CNA J stated that they usually get a welcome kit with things such as a toothbrush and toothpaste in it. CNA J was queried as to how often linens are changed and what they do if someone refuses a shower. CNA J stated that they change linen every two days and after showers. CNA J stated that if someone refuses a shower then they tell the nurse and chart it. On 8/18/2021 at 12:10 PM, R904 was queried as to whether they had received a shower yesterday being that it was their scheduled shower day and they replied, no. When asked if they had changed their clothes, they replied, no. R904 was observed wearing a pink robe and a green gown that was visibly stained. At 3:04 PM R904 was observed in their room. R904 stated they still had not received a shower. R904 was observed still wearing a pink robe and green gown. On 8/19/2021 at 9:00 AM R904 was observed in their room with a pink robe and a green gown. R904 stated that someone came in and stated they would be back to give them a shower. At 11:21 AM R904 stated they had just got out of the shower, and they felt wonderful and alive. CNA K stated that although it was not R904 scheduled shower day they looked like they needed some help and their bed looked jacked up so they changed R904 linens and gave them a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A request for R904 shower sheets was made, but never received prior to end of survey. A review of R904's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Hyperthyroidism, Hypertension, and Depressive Episodes. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was cognitively intact and required minimum assistance for toilet use, transfers, and mobility. A review of progress notes and Certified nursing assistant charting showed no documentation of refusals. Resident #906 On 8/17/2021 at 10:30 AM R906 was observed in their room sitting in their wheelchair with a white and grey shirt that was visibly stained. R906 did not have on any pants and was wearing a pull up. R906 was unable to be interviewed due to a language barrier. At 11:18 AM, 12:09 PM, and 2:25 PM, R906 was observed in the same white shirt that was visibly stained and no pants on. A review of the facility master shower schedule revealed that R906 scheduled shower days were Tuesday and Friday during the daytime. On 8/18/2021 at 11:10 AM, R906 was observed with the same white and grey shirt that was visibly stained and no pants. A review of R906's shower sheets for the last thirty days revealed that R906 received a shower on the following dates, 7/6/2021,7/9/2021, 7/15/2021, 7/16/2021, 7/30/2021 (completed by hospice), 8/3/2021, and 8/12/2021. A review of R906's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Cerebrovascular Disease, Dementia, and Osteoarthritis. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had impaired cognition and required 1 person assist with toilet use, transfers, and mobility. A review of R906's care plan revealed the following, Problem Start Date: 5/20/2021 Category: ADL Functional/Rehabilitation Potential. Resident has a self-care deficit R/T mobility limits. R906 is on hospice care; LTC; Requires Assist with ADLs .Approach Start Date: 5/20/2021 Bathing: 1-2 person assist as needed, twice weekly per facility schedule. A review of progress notes and Certified Nursing Assistant charting showed no documentation of refusals. On 8/19/2021 at 3:56 PM the Nursing Home Administrator (NHA) and Director of Nursing (DON) were interviewed. When queried as to the expectation for the number of showers a resident should receive in a week the DON stated, At least two a week. When queried as to where they document showers, the DON reported they document on the shower sheets. The DON was queried as to whether they felt there was a problem with people receiving showers in facility to which the DON replied, Yes, there is a problem with people receiving shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled Bed Bath dated 3/21/2018 did not reveal information in regards to completing baths and showers. A review of the facility policy titled Shower/Tub bath dated 3/21/2018 did not provide information on the completion of showers/baths. 39918 Resident #910 A review of intake MI00120166 received on 5/19/2021 revealed: [R910] was recently hospitalized after suffering a fall and breaking a hip. [R910] was observed with dirty clothes and food on [their] clothing. [R910's] hair was matted and [they] had dirty (sic) under [their] fingernails. A review of intake MI00120674 received on 6/15/21 revealed: It was alleged staff failed to adequately groom the resident [R910]; It was alleged staff failed to appropriately dress the resident [R910]. Intake MI00120674 included submitted attachments which were reviewed and revealed photos of six different articles of clothing visibly soiled with dried, dirty debris/food, two photos of a large matted piece of hair attached to the resident's head, and a photo of dirty fingernails. The intake information alleged the photos were taken on 5/13/21-5/14/21 after R910's arrival to an acute care facility from the nursing home. A review of R910's Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was most recently readmitted to the facility on [DATE] with medical diagnoses of Hip Fracture, Osteoporosis, Dementia, Anxiety, Depression, Bipolar Disorder, and Schizophrenia. Further review revealed the resident was moderately cognitively impaired and required extensive assistance from one to two staff members for bed mobility, transfers, dressing, eating, toileting, and personal hygiene/bathing. R910's discharge MDS assessment dated [DATE] indicated the resident required limited assistance from staff for bed mobility, transfers, dressing, toileting, and personal hygiene/bathing, and extensive assistance from staff for eating. Resident #917 On 8/16/21 at 12:05 PM, R917 was observed in a geri chair (reclined, with the leg rest elevated) near the North Unit nurse's station. R917 was heard asking aloud if someone could take them to the bathroom. Two Certified Nursing Assistants (CNAs) P and Q were observed near the nurse's station at this time, where two additional staff members were seated. On 8/16/21 at 12:09 PM, CNAs P and Q began passing lunch trays to the North Unit. On 8/16/21 at 12:18 PM, R917 was observed attempting to swing their legs out of the geri chair. R917 had on a hospital-type gown and only one non-slip yellow sock. CNAs P and Q continued to pass lunch trays but did not acknowledge R917. Licensed Practical Nurses (LPNs) D and R were seated at the nurse's station at this time. R917's legs became completely exposed as the resident continued to try to pull and sit themselves up to get out of their chair on their own. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:22 PM, LPN D came over to R917 to ask if she could cover up the resident's legs. R917 stated, No, they're hot. LPN D then walked away. R917 continued to try to unsuccessfully get up out of their chair. R917 then asked CNA P if she could lower the leg rest on the chair. CNA P told the resident she would be right back and to put their legs back in the chair. R917 replied, I don't want to be restrained. CNA P elevated the head of the chair and put the leg rest down slightly lower before walking away. On 8/16/21 at 12:30 PM, LPN D was interviewed regarding current staffing assignments and indicated that she was currently technically the only nurse for approximately 30 residents on the North Unit, as she was precepting LPN R. LPN D stated, Most patients [on the North Unit] have behaviors, it's hard. If we were fully staffed, we wouldn't have issues. On 8/16/21 at 12:35 PM, R917 remained in the hallway in their geri chair. R917 stopped this surveyor and asked this surveyor to take them to the bathroom. R917 stated, I need to pee now, dammit! And no one will take me! And I am restrained. They restrain me because I walk around at night. At 12:39 PM, CNA P indicated they would take R917 to the bathroom. R917 stated, I'm confused, everyone is eating. Upon approaching R917, CNA P indicated they were unsure if R917 could stand. R917 told CNA P they could walk. At this time, R917 was still expressing the need to urinate. CNA Q then joined CNA P, however, both indicated they were unsure as to what the resident's transfer status was. R917 told the CNAs they needed help to the bathroom and with eating. Social Worker M approached and stated, The resident will probably need 1 to 2 person assist for everything. A review of R917's medical record revealed that the resident had just been admitted to the facility on [DATE]. Minimum Data Set (MDS) assessment information was not yet present in the record at the time of the survey. Resident #918 A review of R918's Minimum Data Set (MDS) assessment dated [DATE] and medical record revealed that the resident was admitted into the facility on [DATE], and was severely cognitively impaired with medical diagnoses that included Aftercare Following Joint Replacement Surgery, Need for Assistance with Personal Care, Alzheimer's Disease, Glaucoma, Anxiety Disorder, Depression, Muscle Weakness, and Osteoporosis. Further review of the MDS revealed that Rejection of Care was coded as Behavior not exhibited. R918's care plan included: Resident has a self care deficit R/T (related to): Mobiility (sic) Limits; [R918] Had A Fall With Humerus Fx (fracture) And Had Arthroplasty .Also Has Cogntive (sic) Limits, Is Here For PT (Physical Therapy) And OT (Occupational Therapy) And Requires Assist With .ADLs . Approach Start Date: 08/04/2021, BATHING: 1-2 person assist as needed, weekly per facility schedule . Approach Start Date: 08/04/2021, Dressing: 1 Person Assist; Sling To Left Arm ; Is Non Weight Bearing To Left Arm . Approach Start Date: 08/04/2021, Hygiene/Oral Care: 1 person assist . R918's care plan did not include reference to refusals of assistance with ADL care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A search of R918's medical record for all POC (Point of Care - documentation of care provided, such as assistance with ADLs, toileting, eating, hygiene, etc. generally recorded by nursing assistants) Responses From 08/03/2021 To 08/19/2021 was conducted and returned the following response, No POC data found for the selected search criteria. R918's hard copy shower sheets were provided by the facility upon request. R918's shower sheet dated 8/6/21 was reviewed and revealed, Refused, with no corresponding progress note addressing the refusal. R918's shower sheet dated 8/13/21 was reviewed and revealed, Washed up [with] BM (bowel movement), with no additional documentation. No additional shower sheets were provided by the facility for R918 prior to survey exit. On 8/16/21 at 12:00 PM, R918 was observed calmly sitting in the hallway in front of the North Unit nurse's station. Upon inquiry, R918 did not know their own name. R918 was observed with visibly greasy/dirty hair and a sweater on with a large dried stain. On 8/16/21 at 2:40 PM, R918 was observed calmly sitting in the hallway in front of the North Unit nurse's station. R918 was observed with visibly greasy/dirty hair and a sweater on with a large dried stain. R918 was now observed with visibly soiled navy sweatpants. On 8/17/21 at 2:25 PM, R918 was observed in the hallway in front of the North Unit nurse's station. R918's hair remained visibly greasy/dirty. On 8/18/21 at 3:28 PM, R918 was observed calmly sitting in the hallway in front of the North Unit nurse's station. Dried food particles were visible on the resident's shirt. R918's hair was observed to remain disheveled, very visibly greasy/unclean. On 8/19/21 at 10:07 AM, R918 was observed calmly sitting in the hallway in their wheelchair, in front of the North Unit nurse's station. R918's hair was observed to remain disheveled, very visibly greasy/unclean. R918 was observed to be wearing the same soiled clothing as they had been wearing on 8/18/21 (jeans with a teal flowered blouse with dried, stuck-on food particles). On 8/19/21 at 1:55 PM, R918 was observed sleeping in their wheelchair in the hallway in front of the North Unit nurse's station. R918 remained in the same soiled clothing and their hair remained visibly dirty and disheveled. A review of the facility's, North Master Shower Assignments, schedule revealed that R918 was scheduled to receive a shower/bath on Tuesdays and Fridays on the afternoon shift (due to have received a shower/bath on 8/17/21, however no shower sheet provided by facility). On 8/19/21 at 3:51 PM, the Nursing Home Administrator (NHA) and current, Interim Director of Nursing (DON) were interviewed. When queried regarding POC documentation and ADL care information, the Interim DON acknowledged that she had, Identified a lack of POC documentation present in the charting, and added, It should be there for every shift for ADL care, etc. A review of the facility's policy/procedure titled, Activities of Daily Living, reviewed 12/2020, revealed, 2. The facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39918 This citation pertains to intake MI00121819 and MI00121931. Based on interview and record review, the facility failed to effectively assess/monitor a change in condition, and provide prompt acute care following noted guarding during transfer in the morning and fall the same day (in the afternoon) for one sampled resident (R914) of four reviewed for falls, resulting in delayed treatment, transfer to higher level of care, and un-addressed pain. Finding include: A review of intake MI00121819 revealed: [R914] has been receiving physical therapy at Lakeside Manor for rehabilitation .is diagnosed with dementia. On 8/5/2021 at 1:14 AM, .Lakeside Manor contacted 911 stating that [R914] broke [their] hip. No details were provided by the facility. [R914] was transported to the emergency for examination. The medical examination confirms an acute multiple part intertrochanteric left femur fracture of the left public ramus . A review of R914's Minimum Data Set (MDS) assessment dated [DATE] and medical record revealed that the resident was admitted into the facility on [DATE] (with preferred language of Arabic), and was severely cognitively impaired with medical diagnoses that included Generalized Anxiety Disorder, Adjustment Disorder With Mixed Anxiety and Depressed Mood, Metabolic Encephalopathy, Heart Failure, Vitamin D Deficiency, Unspecified Dementia with Behavioral Disturbance, and Bipolar Disorder, Current Episode Depressed, Mild. Further review of the MDS dated [DATE] revealed that the resident required limited assistance from one person for bed mobility, extensive assistance from one person for transfers, walking in room, locomotion on unit, dressing, toilet use, and personal hygiene. On 8/17/21 at 9:29 AM, the facility was asked to provide any and all incident/accident (I/A) reports for R914 for the duration of the resident's stay at the facility. The facility provided one I/A report, titled Unusual Occurrence Report, dated 8/4/21 at 3:30 PM. A review of R914's medical record and progress notes revealed the following: -Progress note dated 8/3/2021 at 7:38 AM: Resident received in bed, alert with language barrier; all needs anticipated and met. VSS (vital signs stable), resident refused all medication, resident kept hitting writer's hand away, left note in NP (Nurse Practitioner) book to f/u (follow-up). ADL (activities of daily living) care completed by nursing staff in a timely manner. Bed left in low position, call light left within reach, frequent checks. -Date/Time: 08/04/2021 09:10 AM (Created Date: 08/04/2021 02:13 PM, by NP H) .Evaluating this patient noted guarding [their] left hip during transfer. Patient was also noted with mild rash on the right ischial area. Patient has language barrier however .was noted noncooperative to care and transfer. No apparent respiratory distress .ASSESSMENT/PLANS: #Left hip pain. Will order x-ray, pain management . -Two radiology orders for R914 were reviewed and indicated that LPN D entered orders for a RT (right) Hip and a Rt Tibia/Fibula X-ray at 12:32 PM on 8/4/21. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-The radiology report from Medical Diagnostic Services, INC included, Study Description: Pelvis, RT Hip C/O (complaints of) Pain. The report also included, Performed Date: 8/4/21, Reported Date Time: 8/4/21 (at) 13:50:41 (1:50 PM and 41 seconds) . Technique: Pelvis with right hip, 3 views. Comparison: None. Findings: There is an acute complete left intertrochanteric fracture present with moderate displacement resulting in varus angulation. Left lesser trochanter fragment is mildly medially displaced. Superior and inferior pubic rami are intact. The bony mineralization is moderately decreased. Soft tissues are unremarkable. Moderate narrowing of acetabular-femoral joint spaces with subchondral sclerosis in the roof of the acetabulum. Impression: 1. Acute left intertrochanteric femoral fracture with moderate displacement with varus angulation. 2. Left lesser trochanter fragment is mildly medially displaced. 3. Moderate degree of osteopenia/osteoporosis. 4. Moderate degree of osteoarthritis. -Progress note dated 8/4/2021 at 3:28 PM by LPN D: Received Client at 7am. Client received all prescribed medications vital signs were taken .Family notified at 3:44 pm about fall from wheelchair on to [their] bottom and no physical or mental status changes. NP notified at 3:40 pm and x-ray ordered STAT. Will continue to monitor . -The facility-provided Unusual Occurrence Report, included: Incident Date: 8/4/21, Time 3:30 PM, Location: Hall. What was resident doing before incident? Sitting in w/c (wheelchair) across from nursing station. What preventative devices were in place prior to incident? [Blank]. Baseline Level of Consciousness: [Blank]. Changes? [Blank] .Describe the incident based in resident's own words or what the first responder observed: [Blank]. Nature of Occurrence: Unable to Determine. Locate location of Injury: [Right hip circled on diagram]. Resident Outcome: [Blank]. Intervention: X-Ray to Right leg; Hip. Name of MD Notified: [NP H], Time Notified: 3:40 PM .What did you do to try to prevent the incident from happening again? [Blank] . Signed by LPN D. -Pain assessment dated [DATE] at 8:51 PM by LPN D: Pain Site: Hip Pain. Character of Pain: Unable to Verbalize Pain. On a scale of 0-10, how does resident rate intensity of pain if able, or indicate based on observation: 7 - Severe Pain - Horrible/Intense. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Duration of Pain: [Blank]. Onset of Pain: [Blank]. Other Expressions of Pain: Frowning/Grimacing, Hitting/Pushing Away, Holding/Splinting/Guarding. What brings pain on or increases pain? moving. Extremity or Trunk Pain: Restricted Movement/Limited Range of Motion, Weight Bearing Limitation - Unable/unwilling to bear weight. .Does resident exhibit any of the following as a change in mental status of new onset? Agitation, Confusion. Interventions - Indicate measures taken: Relaxation Techniques/Biofeedback . Notification Guidelines: (boxes checked) Hip/Joint Pain - Associated with a fall or other trauma, Other Pain - With altered mental status, Severe/Excruciating Pain of new onset. -Licensed Practical Nurse (LPN) D administered PRN (as-needed) acetaminophen (Tylenol) capsule; 500 mg; 1 tablet at 8:41 AM on 8/4/21 due to a pain score of 2 out of 10 (mild pain). No additional pain medication administrations or orders were found for the resident on 8/4/21 upon review of the medical record. -Progress Note dated 8/4/2021 at 8:55 PM by LPN D: Received report that client has a fractured right hip from x-ray. DON and NP notified. Skin assessment and pain assessment updated. -Progress Note dated 8/5/2021 at 12:13 AM by LPN D: Per NP has requested for writer to send client out to [specific hospital]. [Transport Company] was called at 12:14 am transportation stated will be at facility in an hour. endorsed over to next nurse. -Progress Note dated 8/5/2021 at 1:04 AM: Resident transported to [different acute care hospital] @ (at) 12:45 am, via EMS accompanied by 2 EMT's r/t RT Hip FX (fracture). -The Former Director of Nursing (DON) entered in the following order for R914 on 8/5/21 at 9:45 AM: Transfer to acute care facility 2/2 (secondary to) possible fracture. On 8/19/21 at 3:16 PM, LPN D was interviewed via phone regarding caring for R914 and what occurred on 8/4/21. LPN D indicated she did not know if the fall on 8/4/21 was the only one the resident had experienced while in the facility. LPN D explained, When I came in that morning and aide was getting [R914] up, she told me she had seen a bruise on [the resident's] leg, we were trying to [get the resident to] stand up to see .NP saw the resident .asked to order an X-Ray. I was working on the floor by myself that day. Then [R914] had a fall and [their] left leg was bent, was sitting in front of [their] wheelchair. We put [R914] in [the] chair and put [the resident] to bed. I called the doctor, they hadn't come in to do the X-Ray yet, I made the [Former DON] aware .[Later I was] talking to [the Former DON] not sure what time, she checked her emails and saw it was a fracture when the results came back .The bruise had been there previously on [their] hip. The previous shift didn't tell me if [R914] had a fall. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	LPN D indicated that the resident put themselves in and out of bed frequently. LPN D was asked if she asked the resident if they had fallen, to which LPN D replied, [R914] didn't speak English at all. LPN D posed that she thought possibly R914 fell during the night and put themselves back in bed, then fell again later on during her shift, but indicated she could not be sure. LPN D stated she had, Called for transport later on after the X-Ray results .[was told] it was a 3-4 hour wait .then called again and [the resident] was sent out at around midnight. LPN D was unable to recall the initial time transportation was called for R914 to be sent out to the hospital. On 8/19/21 at 3:51 PM, the Nursing Home Administrator (NHA) and current, Interim DON were interviewed. When queried regarding the expectation for diagnostic testing and timeliness of transfers after finding change in health status such as a fracture, the Interim DON responded, The routine timeframe can take up to 24 hours, STAT usually 4-5 hours. When asked if a fracture is found on a radiology report, how long should a resident be waiting to be sent out for acute care, the Interim DON stated, [Staff should] Notify the Physician or NP they will give you an order to send out, depending on if [the resident] is in lots of pain would call 911. Or notify [transportation company] and they will give an ETA. When asked if a log was kept of when the facility's transportation company was notified to come transfer a resident out, the Interim DON stated the facility did not have a log and, It would just be in the progress notes. When queried regarding the order for R914's transfer not being entered into the medical record until 8/5/21 after 9:00 AM, the NHA and Interim DON were unable to provide any further information. A review of the facility's policy/procedure titled, Incidents and Accidents/Physician Role, revised 6/1/2016, revealed, Physician will help the staff evaluate and manage clinically significant incidents or occurrences. The facility will collect and analyze information on incidents and accidents. Complications from incidents and accidents involving residents/patients, staff, and visitors will be minimized .The facility will document and manage incidents and accidents appropriately .Staff will follow the facility's protocols for managing, documenting, and notifying others of incidents and accidents. When an incident involving a resident/patient occurs, a nurse will evaluate the individual for possible injury. If there is an injury or other significant acute change of condition, a nurse will communicate promptly with the attending physician .As indicated, the physician will authorize appropriate testing and treatment or transfer of the individual for acute or emergency care .The physician will document pertinent medical information related to an assessment, or conversations with a resident/patient or family member, in the medical record. The documentation should be factual and not speculative, and should provide a basis for any medical opinions and conclusions . A review of the facility's policy/procedure titled, Falls and Fall Risk, Managing, dated 12/2020, revealed, 6. In conjunction with the Attending Physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling . The policy did not address post-fall procedures. A review of the facility's policy/procedure titled, Change in a Resident ' s Condition or Status, revised 6/1/2016, revealed, 6. The Nurse Supervisor/Charge Nurse will record in the resident ' s medical record information relative to changes in the resident ' s medical/mental condition or status .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39918 This citation pertains to intake MI00121977. Based on interview and record review, the facility failed to adequately assess/monitor, initiate/implement individualized care plan interventions for skin management, and/or prevent the new development/worsening of pressure ulcers for one sampled resident (R915) out of a total sample of 22 residents, resulting in the development of a Stage II (partial thickness loss of skin presenting as a shallow open ulcer with a red/pink wound bed or open/ruptured serum-filled blister) pressure ulcer and a Stage IV (full thickness loss of skin, extending down and presenting with exposed bone, tendon or muscle) pressure ulcer. Findings include: A review of R915's Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was admitted into the facility on [DATE] with a Brief Interview for Mental Status (BIMS) score of 00/15 indicating severely impaired cognition and medical diagnoses that included High Blood Pressure, Urinary Tract Infection (UTI) (last 30 days), Diabetes, Dementia, Anxiety, Depression, Repeated Falls, and Obesity. Further review of the 5/30/21 MDS assessment Section M - Skin Conditions revealed, Is this resident at risk of developing pressure ulcers? Yes. Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? No. A review of R915's MDS discharge assessment dated [DATE] revealed that the resident was discharged (unplanned) from the facility to an acute care hospital on 6/13/21. Further review of the discharge MDS assessment Section M revealed, Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? Yes. Current Number of Unhealed Pressure Ulcers at Each Stage: Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. 1. Number of Stage 2 pressure ulcers: 1 2. Number of these Stage 2 pressure ulcers that were present upon admission/reentry: 0. Unstageable - Slough and/or eschar (dead tissue): Known but not stageable due to coverage of wound bed by slough and/or eschar. 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar: 1 2. Number of these unstageable pressure ulcers that were present upon admission/reentry: 0. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 8/17/21 at 9:44 AM and at 11:20 AM, Confidential Witness E was interviewed via phone regarding R915's stay at the facility. Witness E explained that they were unable to see the resident due to quarantine restrictions for 14 days after R915 was admitted on [DATE]. Witness E stated they were able to talk with R915 on the phone during that time but it didn't help, due to the resident having Dementia. Witness E continued and stated, I got to see [R915] finally after 14 days (on approximately 6/8 or 6/9) and [the resident] told me that [their] butt hurt. I asked one of the staff why it hurt, they said it was probably just because [R915] was lying in bed .Three days later (Friday, 6/11/21) I saw [R915] and brought [them] some food .Then, Sunday night (6/13/21) they (facility staff) called me and told me to go to [hospital], they had to rush [R915] there. Confidential Witness E explained that once at the hospital, They (hospital staff) asked me how long the wound had been like this and we (family) said 'What wound?' Witness E explained that they saw R915's wound and said, Oh my gosh, where did that come from? It was 5 inches long, 4 inches wide and an inch deep. There was dried blood and oozing blood. [R915] was admitted to the hospital and they did a debridement to pull the dead skin away and scrape the dead skin away. Shortly after, they had to do another debridement .The doctor said it was a Stage IV pressure wound (full thickness tissue loss with exposed bone, tendon, or muscle where slough or eschar may be present) that went to the bone and I did see the wound going to the bone .I went back to the facility to get [R915's belongings]. I told [former Director of Nursing (DON)] how terrible they treated [R915] and how badly [R915] was doing and she snapped her fingers at me and walked away. When asked if they were ever contacted by or spoke in-person with a wound care nurse/team about R915 while they were at the facility, Witness E stated, Not there, we had no idea there was even anything wrong with [R915]. [R915] kept saying [their] butt hurt, so how were we supposed to know what was going on? R915's hospital documentation was obtained and reveled the following: 6/13/21 at 6:05 AM (General Surgery Consult): .Skin: .sacral decubitus ulcer (SDU) (also known as pressure ulcer) with surrounding eschar, some bleeding, and granulation tissue .Rectal exam showing sizeable SDU with some eschar . 6/13/21 at 9:28 AM (History & Physical Internal Medicine): [Family] unhappy with the care patient received at the ECF (extended care facility), patient noted to have poor oral intake, also developed multiple Pressure injuries .patient has history of dementia is AO (alert and oriented) times 1-2 with behavioral disturbance, requiring assistance with . activities of daily living, is nonambulatory .Physical Examination: .skin: Multiple pressure injuries noted over the buttock and sacral (POA) (present on admission) .Assessment/Plan: . Multiple pressure injuries -POA . 6/16/21 at 9:32 AM (Infectious Disease Consult): [R915] was seen by surgery .was noted to have a stage IV necrotic sacral decubitus ulcer .underwent a bedside debridement .Recommendations .3. Will discuss status of sacral decubitus ulcer and Adaptic with surgery and then will determine the antibiotic course . A review of R915's assessments and progress notes over the duration of their stay at the facility revealed the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Admission Nursing Comprehensive Evaluation assessment dated [DATE] at 8:00 PM included, admitted and Time: 05/24/2021 07:00 PM .Skin: .Indicate Location on the body: Pressure Ulcer .Does the resident have a Stage III IV pressure ulcer in an area affected by incontinence? Yes . [Completed by Licensed Practical Nurse (LPN) F]. No additional documentation related to a Stage III or IV pressure ulcer was found. -Admission Body Observation assessment dated [DATE] at 2:49 AM included, Pressure Sores: Yes, describe. - coccyx .Describe any additional body marks or sores: Writer unable to complete full skin observation; resident combative.[Completed by Licensed Practical Nurse (LPN) F]. -Corresponding admission progress note dated 5/25/21 at 7:06 AM completed by LPN F included, .Resident is incontinent of b&b (bowel and bladder), bedbound, per outgoing nurse, has a stage 1 (intact skin with nonblanchable redness of a localized area usually over a bony prominence) on coccyx. All needs and concerns anticipated, unable to meet due to resident's combative behavior. Staff attempted to assist resident with with ADL's (activities of daily living), VS, and skin assessment, resident hit and kicked at staff. -Weekly Skin assessment dated [DATE] at 3:07 PM included, No Identified Concerns. No additional weekly skin assessments were found. -Progress note dated 6/10/2021 at 2:52 PM by LPN G included, Resident is alert and oriented times one is an assist times two with all adl care and transfers. Resident is transferring to room [ROOM NUMBER] on south unit. Report given to receiving nurse along with medications .[Resident] has no open areas on skin . -Progress note dated 6/11/2021 at 2:35 PM included, .Unstageable pressure ulcer to the coccyx area observed. Stage 2 measuring 3 x 2 cm (centimeters) to Lt (left) hip. area cleanse with soap and water pat dry and applied [NAME]/silvadene, cover with 4 x 4 and tape in place. wound care consulted . -No nursing progress note or skilled daily charting were present in R915's record on 6/5/21 or 6/8/21, and no skilled daily charting was present in R915's record on 6/8/21, 6/9/21, or 6/10/21. The progress note on 6/9/21 did not address the resident's skin. Multiple refusals of care were noted in R915's progress notes after 5/25/21, however, upon review of R915's care plan and progress notes, revisions to R915's plan of care for skin management and/or behavioral management were not made after 5/25/21. No notification of R915's responsible party was noted in the record regarding the new observed skin areas. -Per R915's progress notes, the resident was transferred out of the facility via 911 to the hospital on 6/12/21 just after 11:00 PM. R915's care plan included the following: Problem Start Date: 05/25/2021: Risk for alteration in skin R/T (related to): mobility limits, incontinence, w/c (wheelchair) bound, weakness, multiple comorbidities, stage 1 to coccyx, braden of 13 (moderate risk for development of pressure ulcers). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Approach Start Date: 05/25/2021: Apply moisture barrier after incontinent episodes and as needed. Approach Start Date: 05/25/2021: Braden assessment per policy Approach Start Date: 05/25/2021: Dietary consult as needed Approach Start Date: 05/25/2021: Ensure cushion to w/c when up and Encourage and assist with wieght (sic) shifts Frequently when up, Float heels when in bed using pillows or Soft heel boots, Assist with turning and repositioning When in the bed. Approach Start Date: 05/25/2021: Observe skin with daily care Approach Start Date: 05/25/2021: Provide 1 person assist with toileting as needed Approach Start Date: 05/25/2021: Provide assist with repositioning at regular intervals Approach Start Date: 05/25/2021: weekly skin assessments Last Reviewed/Revised: 05/25/2021 11:22 AM. Problem Start Date: 05/25/2021, Category: Behavioral Symptoms: Resident has behaviors r/t to dx (diagnosis) of dementia; hx (history) of agitation; was found to have UTI; refusing food and care; hit and kicked staff; is on psych med. Approach Start Date: 05/25/2021: Administer medications per order Approach Start Date: 05/25/2021: Assign consistent staff member. Establish a trusting relationship with resident. Approach Start Date: 05/25/2021: Discourage resident from acting on feelings and impulses. Approach Start Date: 05/25/2021: Do not confront, argue against, or deny resident. Explore resident's underlying feelings (e.g., anxiety, fear, etc.). Approach Start Date: 05/25/2021: Encourage resident to discuss feelings, impulses, and hallucinations to validate reality. Approach Start Date: 05/25/2021: Maintain a consistent routine. Approach Start Date: 05/25/2021: Promote clear and open communication. Approach Start Date: 05/25/2021: Provide safe, quiet, low-stimuli environment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Approach Start Date: 05/25/2021: Respect resident's needs for privacy and space. Avoid unnecessary touching. Last Reviewed/Revised: 05/25/2021 11:22 AM. A search of R915's medical record for all POC (Point of Care - documentation of care provided, such as assistance with ADLs, toileting, eating, hygiene, etc. generally recorded by nursing assistants) Responses From 05/24/2021 To 06/14/2021 was conducted and returned the following response, No POC data found for the selected search criteria. A review of R915's electronic medication administration record (eMAR) and treatment administration record (TAR) for the duration of their stay at the facility revealed the following: Order: Weekly Skin Assessment, Frequency: Order Once A Day on Tuesday, Special Instructions: RECORD SKIN ASSESSMENT UNDER, OBSERVATIONS Start/End Date: 05/25/2021 - Open Ended. The order was charted off as being completed on Tuesday, 6/8/21, however, upon review of R915's documented observations, as well as the rest of R915's medical record, no skin assessment for that date was found. Order: [NAME]/silvadene 50/50 ointment; 50/50; Amount to Administer: 1 application; topical, Frequency: Once a Day, Special Instructions: Wash area with saline solution, pat dry apply to coccyx daily and PRN (as needed), Start/End Date: 06/11/2021 - Open Ended. No skin related treatment orders were noted in the record prior to this date. Order: Turn and reposition. PRN, Frequency: Every Shift, Start/End Date: 06/11/2021 - Open Ended. The facility was asked to provide any and all wound care documentation for R915 during their stay at the facility. The facility provided a copy of the progress note dated 6/11/2021 at 2:35 PM and a copy of the [NAME]/silvadene 50/50 ointment wound care order from 6/11/21 with no further information provided. The facility was asked to provide any hard copy shower sheets for R915 (that may have included any additional skin assessments) on 8/19/21 at 1:49 PM. The Nursing Home Administrator replied on 8/19/21 at 3:15 PM, We could not locate shower sheets for [R915]. On 8/19/21 at 11:07 AM, the facility's current wound care nurse, LPN C was interviewed and indicated that she has only been the facility's designated wound care nurse since July 12th. Upon questioning who was in the position prior to her, LPN C did not believe there had been a wound care nurse in the facility around the time of May-June 2021. LPN C was then asked what the facility's next steps would be for a resident admitted with a Stage 1 pressure ulcer on the coccyx. LPN C indicated that a Stage 1 would be, Up to the floor nurses to monitor and treat if needed. Wound care does Stage 2 and above. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	When queried regarding what skin management interventions she would expect floor staff to put into place for a Stage 1 pressure ulcer, LPN C stated, They would put in an order to clean the area with wound cleaner and place a dry dressing. When queried whether she would expect to see that put into the care plan and/or physician orders, LPN C stated, It would be in the physician orders on the TAR. When queried where the implementation of care plan interventions is documented in a resident's medical record if they are not found in the TAR, LPN C stated, I am just learning the care plans, there is a section in the care plan for wounds. Probably wouldn't put a Stage 1 on the care plan. When queried if nursing assistants (CNAs) document skin management interventions in the medical record, LPN C indicated she was unsure and stated, I am just getting used to [EHR software]. When queried regarding frequency of skin assessments, LPN C stated, Skin assessments are done weekly on a shower day. Upon review of R915's medical record with LPN C, LPN C acknowledged no weekly skin assessment observation in the resident's record for the week of 6/6/21 (due in the eMAR on 6/8/21). LPN C also acknowledged that two wounds were observed on R915 on 6/11/21 despite documentation on 6/10/21 that the resident had no skin issues. LPN C was unable to provide any further information. On 8/19/21 at 3:51 PM, the Interim Director of Nursing (DON) and Nursing Home Administrator (NHA) were interviewed. When queried regarding documentation of implementation of care plan interventions as well as POC documentation, the Interim DON acknowledged that she had, Identified a lack of POC documentation present in the charting, and added, It should be there for every shift for ADL care, etc. The Interim DON was asked where interventions are documented in the record as carried out, related to preventing skin breakdown, such as for a resident with no skin issues or a skin issue like a Stage 1 pressure ulcer not managed by wound care. The Interim DON replied, Usually for a Stage 1 they would initiate calmoseptine q (every) shift and normally it would be in the TAR. When asked if skin management interventions get documented in the record, to which the Interim DON replied, Under the skin care plan, not necessarily signed out but staff can view it to know it was an intervention. When queried regarding LPN G noting no skin areas on R915 on 6/10/21, and the resident being subsequently noted on 6/11/21 with an unstageable pressure ulcer and a Stage II pressure ulcer, the Interim DON replied, That would be a problem . There should have been a weekly skin assessment documented under the observation tab for that week. The NHA and Interim DON were unable to provide any additional information related to R915's pressure ulcers, as the resident had already been discharged prior to the NHA and Interim DON filling their current roles. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's policy/procedure titled, Prevention of Pressure Ulcers, revised 8/1/2016, revealed, Review the resident's care plan to assess for any special needs of the resident .The facility should have a system/procedure to assure assessment are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed .Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor. The care process should include efforts to stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate .Documentation: The following information should be recorded in the resident's medical record: 1. The type of skin care give. 2. The date and time the skin care was given. 3. The position in which the resident was placed. 4. The name and title of the individual who gave the care. 5. Any change in the resident's condition. 6. The condition of the resident's skin (i.e. the size and location of any red or tender areas). 7. How the resident tolerated the procedure or his/her ability to participate in the procedure. 9. If the resident refused the care and the reason(s) why. 10. Observations of anything unusual exhibited by the resident. 11. The signature and title of the person recording the data .Notify the supervisor if the resident refuses the procedure. 2. Report other information in accordance with facility policy and professional standards of practice.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Deficient Practice Statement #1 This citation pertains to Intake: MI00121929 Based on interview and record review, the facility failed to prevent, monitor, and supervise a male resident (R920) with a known history of inappropriate flirtatious behaviors of one sampled resident reviewed for supervision, resulting in R920 touching a female resident (R919) inappropriately on their breast, and the potential for other inappropriate behaviors towards staff and residents. Findings include: A review of MI00121929 noted the following, Summary of Occurrence On 6/24/21 at approximately 9am resident [R919] told nurse that [R920] touched [them] inappropriately on [their] left breast on 6/22/21 . A review of R919's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Encounter for other orthopedic aftercare-orif fingers, Anxiety disorder due to known physiological condition. According to R919's Minimum Data Set (MDS) assessment dated [DATE], R919 had a Brief Interview for Mental Status (BIMS) score of 10/15 indicating a moderately impaired cognition and required extensive assistance for Activities of Daily Living (ADLs). R919 left against medical advice from the facility on 7/14/21. Further review of R919's medical record revealed the following progress notes: 06/24/2021 7:09 PM. Writer was made aware by client that [they were] touched inappropriately. Writer immediately made abuse coordinator, Social Worker, Unit Manager and DON (Director of Nursing) aware of the situation. 06/24/2021 [Recorded as Late Entry on 06/29/2021 03:48 PM] 3:48 PM Alleged incident that occurred on 6/22/21, reported to abuse coordinator/administrator and social worker on 6/24/21. [R919] reported [they were] was touched inappropriately by [R920] . A review of The Facility Reported Incident revealed the following: Statements taken from residents, [R919] states I was sitting in a chair by the lamp reading a book and not paying attention to my surroundings. I felt something touch my breast it startled me and I jumped. I looked to my left and [R920] was standing there and I pointed my finger at [them], I told [them] not to ever touch me again . On 8/18/21 at 3:30 PM, R920 was asked about an incident in which they touched another resident on their breast. R920 stated, No, I didn't touch anybody. God to honest truth I didn't touch nobody. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of R920's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included, Encephalon, Parkinson's disease, and Schizophrenia. R920's MDS dated [DATE] revealed a BIMS score of 10/15 indicating a moderately impaired cognition. R902 was independent with supervision for ADLs. Further review of R920's medical record revealed the following care plan: Problem Start Date: 02/23/2021 Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by: Resident makes sexual advances and inappropriate sexual comments towards female staff members. [R920] also walks around holding [their] foley bag and will not use a leg bag and he will not leave a privacy bag on over the bag. Approach Start Date: 08/04/2021 Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Approach Start Date: 04/21/2021 assist [R920] with [their] catheter bags and encourage [them] to use a privacy bag. Approach Start Date: 02/23/2021. Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Approach Start Date: 02/23/2021 Do not engage resident in sensitive topics such as any sexual conversations; report behavior immediately. Approach Start Date: 02/23/2021 Maintain a calm environment and approach to the resident. Approach Start Date: 02/23/2021 Observe and report socially inappropriate/disruptive behaviors when around others . A review of the facility's statement provided by R920 revealed the following, [R902] did you touch a residents breast in the library? Resident stated yes. Why did you touch her there? Resident stated my mind told me to. What do you mean by your mind told you to? Resident stated I don't know it passed through my mind. What happened after you touched [R919]? Resident stated nothing Did the other resident say anything to you? Resident stated no, [R919] didn't. A review of R920's progress notes revealed the following: 02/12/2021 [Recorded as Late Entry on 02/17/2021 10:52 AM] 10:50 AM SW (social worker) spoke to resident regarding inappropriate behaviors in behavior log at nurse's station. Resident exhibited undesired sexual behavior towards staff. SW spoke to resident regarding incident and [they] stated [they] did not mean to offend anyone. Discussed appropriate vs (versus) inappropriate behaviors towards staff and other residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	02/23/2021 Nursing .7:24 AM Writer informed by female staff that resident has been saying sexually inappropriate things when they are in [their] room. Staff stated that resident stated, 'Go over in the corner, bend over and pull your pants down.' At other times, staff states that resident has been observed lying in bed naked and fondles himself when they enter into the room. Will notify DON and oncoming nurse. 02/23/2021 Social Services .10:13 AM. Per behavior log at nurses station, resident has been exhibiting sexually inappropriate behaviors towards staff. SW spoke to resident about these behaviors and we discussed appropriate behaviors. Resident admitted to behaviors and stated [R920] understands it is inappropriate and will refrain from these behaviors in the future. SW consulted psych about behaviors- waiting for order to be sent over for medication. 03/21/2021 Nursing .5:09 AM. Resident has showed aggressive behaviors towards female staff during shift. Resident stated to writer 'I would love to pull your hair.' Resident then asked writer if [they] could touch writers skin. When writer stated to resident that wasn't appropriate, resident laughed and walked away. Residents vitals stable, medication administrated as directed by MAR (medication administration record). Resident has needed constant redirection and education about inappropriate comments made to staff. Care plan interventions in place, writer will continue to monitor. 04/05/2021 Social Services .2:23 PM. SW spoke to resident following undesirable sexual behavior/comments towards staff listed in the behavior log. SW reiterated the importance of appropriate behavior to resident and [R920] stated [they understand] . 05/20/2021 Nursing .5:04 AM. Resident socially inappropriate toward writer. Resident stared at writer in hall during p.m. medpass. When asked if [they] needed anything, Resident continued to stare, looked writer up and down then stated 'You got a nice shape'. When told by writer [that they were] behaving inappropriately, Resident laughed and continued to blanky stare until writer walked away. Logged in behavior book. 06/24/2021 [Recorded as Late Entry on 06/29/2021 03:50 PM] 3:50 PM Administrator and social worker interviewed [R902]- [they] stated [that they] did touch another resident's breast. When asked why [they] touched another resident's breast, [R920] responded 'my mind told me to'. Social worker then asked what [they] meant by that and asked [R902] if [they have] been having any A/V (auditory/visual) hallucinations. [R902] stated [they have] not had any hallucinations. [R902] acknowledged that [they] will not touch another resident again. Social worker notes that [they have] not had any physically inappropriate behaviors like this prior to incident. On 8/19/21 at 9:06 AM, all Incident and Accident reports were requested from the facility and were informed that there were no reports for R920. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/19/21 at 11:08 AM, an interview was completed with Nurse C about R920's behaviors and they stated, [R920] can be very sexual, and will make sexual inappropriate comments to staff and residents and has had to be redirected out of women resident rooms. Nurse C explained that the resident has had to be moved twice because of their behaviors, and further explained that one move was due to them making inappropriate sexual behaviors as their room was in the middle of the hallway and would comment on the women walking by. The second move was due to the resident constantly looking into other women resident rooms. Nurse C explained that R920's behaviors tend to escalate after phone calls with their sister, and reports that they have heard pornography playing on the phone during R920's phone calls. On 8/19/21 at 11:23 AM, CNA L was asked about R920's behaviors and explained that their behaviors have been inappropriate to the point where their room had to be moved because they would be very loud while they self-pleasured themselves causing staff to tell them that they needed to quiet down. CNA L also explained that there was an incident in which R920 attempted to take a severely cognitively impaired resident into their room but was redirected before they entered R920's room. On 8/19/21 at 2:07 PM, and interview was completed with Social Worker M about the incident between R919 and R920 and explained that she and the previous Nursing Home Administrator (NHA) talked to both R919 and R920. Social Worker M explained that R919 reported that R920 touched their breast on the outside of their clothes, and they in turn reacted by asking R920 what they thought they were doing. Social Worker M explained that R920 stated that the voices in their head made them touch R919, and that they apologized and stated they would not do it again. Social Worker M was asked about R920's behaviors and explained that R920 would make inappropriate comments to staff, pleasure themselves while praying very loudly in the middle of the day resulting in a room change as it made their roommate uncomfortable, and their room was in the middle of the hallway. In addition, R920 would request to have their foley catheter changed and would be located lying in bed pleasuring themselves when staff arrived. Social M explained that the resident's sister explained that R920 will talk to her and other family members in an inappropriate manner and have to be told not to talk to them in such a way. A review of the facility's findings following their investigation of R919 and R920 revealed the following, After complete investigation, it is substantiated that [R920] did touch [R919] inappropriately on [their] left breast . On 9/18/21 at 3:55 PM, an interview was attempted to be completed with the DON and NHA regarding the incident between R919 and R920 however, neither were in their positions and did not investigate the incident. They were asked their expectations regarding abuse and explained that abuse is not acceptable. A review of the facility's Resident Abuse/Neglect policy outlines the following, [Nursing Home] will not condone any form of abuse or neglect . Deficient Practice Statement #2 This citation pertains to Intake: MI00121225 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to identify and prevent a skin abrasion for one sampled resident (R909) of one reviewed for accidents resulting in the resident having a 12 x 7 centimeter abrasion on their back, causing pain. Findings include: A review of Intake MI00121255 revealed the following, .[R909] resides at [Nursing Home]. [They have] a diagnosis of Dementia with behavior disturbances. On 7/2/21, at approximately 11:59 PM [R909] arrived at [Local Hospital] .[R909] has an abrasion 12 X 7 centimeters in size toward the right-hand side of [their] mid back. The abrasion is a bright pink discoloration. [R909] does not feel safe at [Nursing Home] . A review of R909's medical record revealed that the resident was admitted into the facility on [DATE] with diagnoses that included Unspecified Dementia with Behavioral Disturbance, Hypertensive Heart Disease without Heart Failure, and Altered Mental Status. A review of the resident's Minimum Data Set assessment dated [DATE] notes that the resident had a Brief Interview for Mental Status score of a 2/15 indicating a severely impaired cognition. Further review revealed that the resident was independent with supervision for Activities of Daily Living. A review of R909's progress notes revealed the following: 07/03/2021 Nursing .1:47 AM At approx 8:40 pm writer informed by nursing staff that resident punched her in the face. Resident was immediately escorted to [their] room. Nursing staff was assessed by writer. Administrator informed of situation. Ambulance called to remove resident from facilty. At 10:50pm emt (emergency medical transport) arrived . Further review of R909's medical record revealed an Admission Nursing Comprehensive Evaluation with an observation date of 07/01/2021 at 07:40pm and a completed date of 07/01/2021 at 10:51pm. Under the evaluation for skin, it indicated the following, Skin. Any s/sx (signs or symptoms) of dehydration check must be assessed and documented in the nurses notes. Contact RD (registered dietician) and or Physician is indicated, Areas identified on body must be explain (explained) in detail, in nurses notes and treatments indicated, in indicated. No identified concerns was checked off on the form. On 8/18/21 at 2:45 PM, Nurse O was interviewed regarding R909's transfer to the hospital on 7/3/21. Nurse O explained that CNA A (Certified Nurse Assistant) went to the common area to give R909 a snack, and as they were attempting to redirect R909 to their room, the resident punched CNA A in the face. Nurse O explained that CNA A was able to subdue R909 who was redirected to their room where they calmed down and eventually fell asleep. Nurse O explained that the resident was then sent to the hospital, and denies that the resident was restrained in any way. On 8/18/21 at 2:58 PM, CNA A was interviewed regarding R909's transfer to the hospital due to their combativeness. CNA A stated that R909 was combative and resistant during their shift, and was wandering into other residents' rooms. CNA A explained that they tried to prevent R909 from going into another resident's room and tried to guide them away and was punched in the face. CNA A explained that after they were punched, she informed the nurse that she needed a break and is unsure what happened after she left for her break. On 8/18/21 at 9:23 PM, all Incident and Accident reports were requested from the facility however, they reported that they did not have any. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235719	A. Building B. Wing	08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Manor Nursing and Rehabilitation Center	13990 Lakeside Circle Sterling Heights, MI 48313

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/19/21 at 2:09 PM, the emergency department transfer form was requested for R909, however it was not received by the end of the survey. A review of hospital medical records revealed the following upon R909's admit.Patient complains of pain on [their] back stating [they were] injured while staff were fighting against [them] .[They are] able to recall some of the night's events. [R909] states [they do not] want to go back to the facility .Otherwise [R909] has no complaints except for the pain to [their] back .Findings: Lesion present. No erythema or rash Comments: There is a 12 by 7 cm (centimeter) abrasion to the patient's back. Please see photos in chart. Patient states this injury occurred while [they were] scuffed pulling with staff at the nursing facility [they] transported from . An observation was made of the photo located in R909's hospital record. The abrasion was observed on the right midsection of the resident's back, pink in color and 12 x 7 cm in size. On 8/19/21 at 3:55 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were asked about R909 however, both are new their current positions. The DON was shown the photo of R909's back, in which she responded that the abrasion appeared old. It was explained to the DON that the upon admission, the resident's skin assessment had no identified concerns, and upon admission to the hospital, the resident's back had an abrasion. The DON and NHA did not offer an explanation. A review of the facility's Incidents and Accidents/Physician's Role was reviewed and did not address when incident reports should be completed and skin assessments upon discharge.