STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235088	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Traverse Pavilions	1000 Pavilions Circle Traverse City, MI 49684

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on interview and record review, the facility failed to notify the Resident and/or Resident Representative in writing, the reason for transfer of four Residents (R1, R56, R149, R621) of five residents reviewed for facility initiated transfers. Findings include: Resident #56 (R56) During an interview on 9/16/24 at 12:20 PM, R56 stated he had been sent to the hospital during his stay at the facility. The Electronic Medical Record (EMR) for R56 revealed a transfer to the hospital on 6/24/24 with a readmission on 6/29/24. No evidence of written notification for the transfer provided to R56 or their representative could be located in the medical record. During an interview on 9/19/24 at 11:17 AM, the Director of Nursing (DON) stated she did not believe a system was in place to send written transfer notifications to the resident and resident representative. She said, It looks like an opportunity for improvement. She further recommended checking with the social worker. During an interview on 9/19/24 at 11:25 AM, Social Worker (Staff D) stated she was unaware of this process. 49310 Resident #1 (R1) The medical record documented R1 was transferred to the hospital on 6/26/24. R1 was readmitted to the facility on [DATE]. There was no documentation in the EMR indicating R1 or the resident representative was provided with written notification of the transfer. During an interview on 9/18/24 at 12:27 p.m., Staff D said there was no written notification of transfer provided when R1 was transferred to the hospital. (continued on next page)

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

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49302 Resident #621 (R621) Review of R621's EMR revealed the following physician communication on 7/11/24 at 4:22 PM: .Send to [acute care hospital] for evaluation . Review of the facility census report confirmed R621 was hospitalized on [DATE]. On 9/19/24 at 11:17 AM, an interview was conducted with the DON who stated written transfer notifications were not completed by the facility. On 9/19/24 at 11:31 AM, an interview was conducted with Staff D who verified a written transfer notification was not issued to R621 upon transfer to the hospital on 7/11/24. Resident #149 (R149) Review of the EMR revealed R149 was hospitalized from 6/19/24 - 6/30/24. The EMR did not indicate a written notification of transfer was issued to R149. On 9/19/24 at 11:31 AM, an interview was conducted with Assistant Director of Nursing (ADON) F who verified a written transfer of notification was not given to R149 upon transfer to the hospital. Review of facility policy titled, Discharge and Transfer Procedure, dated 6/20/22, read, in part: . [Facility Name] strives to provide a discharge plan that will assure a continuum of care and proper completion of medical records . Review of facility policy titled, Resident Care Policies, dated 3/20/24, read, in part: .Before the transfer or discharge, the Organization will . Involve the resident and/or legal representative in discharge planning to the extent feasible including reasons for the move in writing and in a language and manner they understand .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to provide written notification of the facility bed hold policy for two Residents and/or Resident Representatives (#621 and #149) of five residents reviewed for notice of bed hold policy. Findings include: Resident #621 (R621) Review of the R621's Electronic Medical Record (EMR) revealed the following physician communication on 7/11/24 at 4:22 PM: .Send to [acute care hospital] for evaluation . Review of the facility census report confirmed R621 was hospitalized on [DATE]. On 9/19/24 at 11:17 AM, an interview was conducted with the Director of Nursing (DON) who stated she was unaware if a bed hold policy was issued to R621 upon transfer. On 9/19/24 at 11:31 AM, an interview was conducted with Social Worker (Staff D) who verified a R621 was not issued a bed hold policy. Resident #149 (R149) Review of the EMR revealed R149 was hospitalized from 6/19/24 - 6/30/24. The EMR did not indicate a bed hold policy was issued to R149. On 9/19/24 at 11:31 AM, an interview was conducted with Assistant Director of Nursing (ADON) F who verified a bed hold policy was not given to R149 upon transfer to the hospital. Review of facility policy titled, Discharge and Transfer Procedure, dated 6/20/22, read, in part: .upon actual transfer with admission to another Health Care institution, contact will be made with the responsible party to inform them of the right to hold a bed . if the resident/responsible party holds the bed or declines to hold the bed, Bed Hold Form will be activated by the person making the contact and forwarded to the Financial office .for completion .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 41978 Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for the use of psychotropic medications for one Resident (#136) of five residents reviewed for unnecessary medications, resulting in the potential for unnecessary use of mood-altering drugs and decreased quality of life. Findings include: Resident #136 (R136) Review of R136's Minimum Data Set (MDS) assessment, dated 7/23/2024, revealed admission to the facility on [DATE] with diagnoses including dementia with psychotic disturbance, depression and anxiety disorder. R136 was rated as having severely impaired cognition. Review of R136's electronic medical record (EMR) revealed the following orders: Lorazepam (a controlled substance anti-anxiety medication) Oral Tablet 0.5 MG (milligram). Give 0.5 mg by mouth every 6 hours as needed for anxiety . Review of R136's care plan revealed the following: Focus: The resident uses psychotropic medications [related to] end of life, comfort measures . Date initiated: 4/25/2024. Goal: The resident will be/remain free of psychotropic drug related complications . Date Initiated: 4/25/2024. Interventions: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness . Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Date Initiated: 4/25/2024. It was noted the care plan did not include specific targeted behaviors, indication of use (diagnosis), or person-centered, non-pharmacological interventions to be used prior to administration of the medication. During an interview on 9/19/2024 at 8:31 a.m., Assistant Director of Nursing (ADON) G reported targeted behaviors and/or indications of use should be documented for each administration of as needed psychotropic medications, including lorazepam, to ensure appropriate use of the medications. During review of R136's care plan at the time of the interview, ADON G confirmed no focus area to include triggers for behavior or non-pharmacological interventions were listed related to the use of as needed anti-anxiety medication. Review of the facility policy titled, Care Planning, dated 10/09/2023, revealed the following, in part: The organization will develop a comprehensive care plan for each resident to meet a resident' clinical and psychosocial needs and to maintain the resident's highest practicable physical, mental, and psychosocial well-being The written plan of care shall be available to all individuals involved in the care of the resident and shall document all of the following: The resident's problems and needs. Goals and objectives of care. Interventions.

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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** 41978 This citation pertains to intake MI00145621. This citation has two parts: A and B. A. Based on interview and record review, the facility failed to ensure appropriate, timely assessments and physician/provider notification for a change in condition for one Resident (#173) of three residents reviewed for death, resulting in actual harm when R173 became unresponsive and ultimately expiring in the facility. Findings include: Resident #173 (R173) R173 was admitted on [DATE] with diagnoses including congestive heart failure (CHF), atrial fibrillation (abnormal heart rhythm), coronary artery disease (CAD) S/P (status-post) heart catheterization, transient ischemic attack (ministroke) and acute kidney injury. Review of R173's Minimum Data Set (MDS) assessment, dated [DATE], revealed R173 expired in the facility on [DATE]. Review of R173's Medical Certificate of Death, revealed the Resident expired on [DATE] at 1:59 p.m., cause of death was heart failure. Review of R173's electronic medical record (EMR) revealed on [DATE] the resident was hypotensive (blood pressure below ,d+[DATE] mmHg (millimeters of Mercury, a unit of pressure) became unresponsive and expired in the facility. Further review revealed the following: [DATE] at 12:35 [p.m.], [signed by Registered Nurse (RN) V] Behavior Note: low BP [blood pressure] with a manual this morning, asymptomatic. Noted to run low following hospital discharge and among admission yesterday, [R173] had a shower and was ambulating with no complaints following lunch. Upon laying down this nurse was planning to obtain another set of vitals and other care. Wife requested for blood sugar to be checked before lunch . and requested he get short acting insulin; provider notified and ordered a sliding scale . [DATE], 15:45 [3:45 p.m.], Alert Note: Wife informed CNA [Certified Nurse Assistant] that [R173] became unresponsive. CNA alerted nursing staff . immediately responded and noted [R173] to have irregular, apneic breathing with a weak thready pulse . still assessing patient, pulse stopped and CPR [Cardiopulmonary Resuscitation] was immediately initiated. Fire arrived at 1336 [1:36 p.m.], EMS [Emergency Medical Services] arrived at 1341 [1:41 p.m.]. CPR lasted ,d+[DATE] [1:25 p.m. - 1:59 p.m.]. At that time EMS called time of death [1:59 p.m.] . Further review of R173's EMR revealed the following blood pressure readings: [DATE] at 5:57 p.m. - ,d+[DATE] mmHg (manual, right) [DATE] at 10:19 p.m. - ,d+[DATE] mmHg (machine) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] at 7:24 a.m. - ,d+[DATE] mmHg (machine) [normal blood pressure range is below ,d+[DATE] mmHg and above ,d+[DATE] mmHg] [DATE] at 8:48 a.m. - ,d+[DATE] mmHg (manual, right) [DATE] at 8:49 a.m. - ,d+[DATE] mmHg (manual, left) The following was noted in review of R173's blood pressure readings, the documented reading on [DATE] at 7:24 p.m. was 30 points lower systolic and 21 points lower diastolic than the previous reading on [DATE] at 10:19 p.m. It was also noted there were no blood pressure readings recorded from [DATE] at 7:24 a.m. until [DATE] at 8:48 a.m., a timeframe of one hour and 24 minutes after R173's blood pressure was noted to be low. It was noted in review of R173's EMR, there were no physical assessments documented prior to or in response to the Resident's low blood pressure readings on [DATE]. It was also noted there was no documentation of assessments of R173's heart rate, oxygen saturation, or respiratory rate to accompany the low blood pressure readings at 8:48 a.m. or 8:49 a.m. Review of R173's Medication Administration Record (MAR) revealed RN V withheld administration of the following scheduled morning (8:00 a.m.) medications: Bumex [medication used to remove excess fluid in the body] Oral Tablet 1 MG (milligram). Give 1 tablet by mouth two times a day for CHF. Metoprolol Tartrate [medication used to lower blood pressure and heart rate] Oral Tablet 25 MG. Give 1 tablet by mouth two times a day for HTN [hypertension]. Further review of R173's MAR revealed RN V documented the reason for withholding the medications as Vital outside of parameters for administration. It was noted, the orders for the medications included no vital sign parameters for administering or withholding the medications. Further review of R173's EMR revealed no documentation of physician/provider notification of R173's low blood pressure readings on [DATE] or of RN V withholding administration of the scheduled doses of Bumex 1mg and metoprolol tartrate 25mg. Review of physician/provider notification documentation binder for [DATE], provided by Assistant Director of Nursing (ADON) F, revealed no entry or documentation to alert the physician or advanced practice providers of R173's low blood pressures on [DATE] or of the need to withhold administration of the Resident's scheduled Bumex 1 mg or metoprolol tartrate 25mg. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 1:50 p.m., RN V confirmed she was assigned to R173's care on [DATE]. RN V reported she was aware of the Resident's low blood pressure readings and verified the blood pressure readings on [DATE] were out of normal range. RN V stated she was not concerned about R173's low blood pressure readings because the Resident was not having any symptoms of hypotension, but the Resident's blood pressure was difficult to measure due to being hard to hear when taken manually. When asked what symptoms she would expect to see a change in condition, RN V stated R173 was not having symptoms because the Resident took a shower and ate lunch without reporting any increased fatigue. RN V did not remember conducting a physical assessment of R173, including listening to R173's lung sounds in response to the low blood pressure. RN V was asked if R173 was having any difficulty with breathing or cough to which she replied he must have at some point, he was wearing oxygen. A query was made regarding withholding administration of R173's scheduled Bumex 1mg and metoprolol tartrate 25mg on the morning of [DATE]. RN V reported she held administration of the medications because she was worried the medications would lower R173's blood pressure further. RN V reported she did not notify the physician of the need to withhold administration of the medications or of R173's low blood pressure readings. When asked why her concern over R173's blood pressure dropping further did not warrant physician notification, RN V stated she did not feel a call was necessary because the resident was asymptomatic and had been running low prior to admission. Review of R173's Hospital Summary, dated [DATE] at 3:04 p.m., revealed a blood pressure reading of , d+[DATE] mmHg at discharge. During an interview on [DATE] at 4:50 p.m., the Director of Nursing (DON) confirmed R173's low blood pressure readings and RN V withholding scheduled medications on [DATE] warranted physician/provider notification and should have been considered a change in condition. The DON agreed withholding medications for complicated cardiac conditions and heart failure is not always the best option. The DON confirmed transfer to a higher level of care is at times needed for continuous monitoring while providing the necessary medications. During a telephone interview on [DATE] at 10:47 a.m., Physician Assistant (PA) W reported being the provider on-call on [DATE]. PA W reported she was not notified of R173's low blood pressure readings or the withholding of the Resident's scheduled Bumex 1mg or metoprolol tartrate 25mg on [DATE] until after the Resident expired. PA W stated she did remember being called by RN V for R173's insulin order on [DATE] but no mention of the Resident being hypotensive or requiring supplemental oxygen was made. PA W confirmed physician notification should be made for a change in condition to allow for changes in the plan of care or transfer to a higher care setting. Review of the facility policy titled, Change in Condition, dated [DATE], revealed the following, in part: To assist facility staff with identifying individuals at risk for acute changes in condition . Procedure: Assess the resident's symptoms, mental status and physical function . Use SBAR to notify the physician and proceed as instructed, complete clinical note . Vital Signs . Blood pressure 20 mmHg lower or higher than normal. 49302 B. Based on observation, interview, and record review, the facility failed to adhere to physician treatment orders for rehabilitation services and fluid administration for one Resident (#621) out of 32 residents reviewed for quality of care. This deficient practice resulted in delayed treatment for respiratory illness, hospitalization , sepsis, and death. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Findings include: Resident #621 (R621) Review of R621's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including dementia and fracture of the left femur (leg). Review of R621's MDS, dated [DATE], revealed a score of 3 on the Brief Interview for Mental Status (BIMS) assessment, indicative of severe cognitive impairment. Review of R621's EMR revealed the following progress notes: 1. [DATE] at 17:22 (5:22 PM): Res [resident] continues to be lethargic and refuse[s] to get out of bed or eat meals. Oral intake is poor. output is minimal. Low grade temp [temperature] continues at 99.7 [degrees Fahrenheit]. 2. [DATE] at 12:31 PM: Pt [patient] heard with barky, productive cough. Thick clear mucus noted on tissue. Pt also has thick, clear mucus noted from nose. Lungs clear in upper lobes, clear in right lower, slight crackles heard in left lower lobe . 3. [DATE] at 15:55 (3:55 PM): Writer contacted on-call provider . New orders: Peripheral IV [intravenous] placement; 500 cc [cubic centimeters] NS [normal saline] IV fluid [NAME] [sic] followed by 100 cc/hr [cubic centimeters per hour] x 10 hours . 4. [DATE] at 22:50 (10:50 PM): At approximately 2130 [9:30 PM] resident noted to be in bed shivering. Temperature 100.5 [degrees Fahrenheit] . Resident lethargic, responding minimally .This nurse sat with resident and provided emotional support and comfort for approximately one hour. Temp is now 101.5 [degrees Fahrenheit] . 5. [DATE] at 16:22 (4:22 PM): Positive sepsis screen . send to [acute care hospital] for evaluation . 6. [DATE] at 9:55 AM: Per [acute care documentation], resident passed away [DATE]. On [DATE] at 2:49 PM, an interview was conducted with Licensed Practical Nurse (LPN) O who verified she was the nurse on duty who received orders on [DATE] for IV fluid. LPN O stated she gathered the necessary supplies to hang the prescribed IV fluids and asked Registered Nurse (RN)/Staff Educator P for assistance hanging fluids as it was outside her scope of practice. LPN O stated, She didn't help me . she told me to start the fluids at 8:00 PM so the next shift could deal with it .I think we received orders [from the physician] between 12:00 PM and 4:00 PM. On [DATE] at 3:29 PM, an interview was conducted with LPN Q who verified she worked the night of [DATE] alongside LPN O. LPN Q verified RN/Staff Educator P said to delay hanging the IV fluids until the night shift arrived after LPN O asked for assistance. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:19 PM, an interview was conducted with Assistant Director of Nursing (ADON) I who verified she was aware R621 was being monitored for a possible infection. ADON I stated, When I came into work that night, I poked my head in to check on her [R621]. I noticed the fluids weren't hung, so I personally hung them around 11:00 PM. ADON I verified the orders for IV fluids were given around 4:00 PM on [DATE]. When asked the acceptable timeframe between physician orders and administration, ADON I stated, My expectation is it should be done right away. ADON I replied, Yes when asked if this would be considered a delay in treatment. On [DATE] at 3:36 PM, an interview was conducted with the DON regarding the lapse in time between physician orders and administration of IV fluids to R621. The DON stated, That is not an acceptable timeframe and does not meet my expectation. Review of 2023 Update on Sepsis and Septic Shock in Adult Patients, published by the Journal of Clinical Medicine in [DATE] (https://doi.org/10.3390/ jcm12093188), read, in part: .Sepsis is a life-threatening and time-dependent condition that is still accompanied by an overall poor prognosis . Nonetheless, a well-orchestrated treatment based on selected antimicrobics, fluids, oxygen, and, if necessary, vasoactive agents can improve patients' outcomes .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on observation, interview, and record review, the facility failed to apply orthopedic braces per physician orders for two Residents (#104 and #155) out of five Residents reviewed for range of motion, positioning, and mobility. This deficient practice resulted in the potential for a reduction in range of motion and/or complications following cervical [neck] surgery. Findings include: Resident #155 (R155) Review of R155's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including surgical aftercare following surgery on the nervous system, inflammatory reaction due to internal fixation device of the spine, and quadriplegia (paralysis of all four limbs due to spinal cord damage). Review of R155's Minimum Data Set (MDS), dated [DATE], revealed a score of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicative of intact cognition. Review of a Neurosurgery Progress Note, dated 9/4/24, read, in part: .Cervical collar to be worn at all times . Review of R155's EMR revealed an order, initiated 9/5/24, which read, Wear cervical collar at all times. Review of R155's Plan of Care read, C-Collar to be worn at ALL times. On 9/16/24 at 3:44 PM, R155 was observed lying in bed without a cervical collar. The neck brace was observed resting on top of a chair across the room, out of reach of R155. On 9/17/24 at 8:23 AM, R155 was again observed lying in bed without the prescribed cervical collar. On 9/17/24 at 1:35 PM, an interview was conducted with Certified Nursing Assistant (CNA) K regarding expectations surrounding R155's cervical brace. CNA K stated, I believe he's [R155] able to have it off in bed. But if he's up and moving around, he should have it on. When asked if R155 could apply and remove the cervical collar independently, CNA K replied, I don't think so. On 9/17/24 at 1:39 PM, CNA L was observed exiting R155's private room after providing care. R155 was observed sitting upright in his wheelchair without a cervical collar. When CNA L was asked if R155 had a physician order for an orthotic, she responded, I don't know, I'm usually not down here [on the unit]. I'm just covering for the day. On 9/17/24 at 1:41 PM, an interview was conducted with Occupational Therapist (OT) M who verified R155 had orders to always wear a cervical collar. OT M stated R155 had never refused to wear the prescribed orthotic during her treatment sessions. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 3:12 PM, R155 was observed lying in bed without a cervical collar. When asked if he could apply and remove the collar himself, R155 replied, No, I need help. On 9/18/24 at 3:13 PM, an interview was conducted with Assistant Director of Nursing (ADON) F who stated R155 had surgery on his neck prior to admitting to the facility. ADON F stated, As far as I'm aware, he's [R155] supposed to be wearing it [cervical collar] at all times .He can't put it on himself . ADON F stated direct-care staff had access to R155's care plan which stated to ensure the cervical collar was always applied. ADON F stated R155 was prescribed a cervical collar to protect recent surgery on his spine and verbalized the importance of following orders to avoid compromise of the surgical site. 40383 Resident #104 (R104) On 9/18/24 at 2:05 PM, R104 was observed in the Birch Dining Room and was not wearing ordered lamb's wool palm shield/protectors. R104's hands were noted to be contracted with overlapping fingers. CNA R was assisting R104 and stated, I don't have him, but some splints are 2 hours on 2 off. CNA R was unsure of when R104 should have these orthotic devices on. During an interview on 9/18/24 at 2:20 PM, LPN T stated the plan was for R104 to wear his palm shield/protectors alternating one protector on during the day and one on the other hand during the night. LPN T observed with this Surveyor, R104 was in his room and confirmed he was not wearing any palm shield/protectors. On 9/18/24 at 2:24 PM, CNA S was with R104 in their room. When asked why R104 was not wearing palm shield/protectors, CNA S replied, He wears them at night. I take it off in the morning. I was unaware he was to have them on during the day. On 9/18/24 at 2:44 PM, R104 was transferred into bed by CNA S and was observed not wearing palm protectors. On 9/18/24 at 5:02 PM, R104 was observed in bed and was not wearing palm protectors. During an interview on 9/19/24 at 9:56 AM, RN U discussed the absence of the care planned palm protectors. RN U stated the staff needed re-education on this issue. The EMR for R104 revealed no physician order for palm shield/protectors. During an interview on 9/18/24 at 4:50 PM, Physical Therapist (PT) N stated they did not always get an order for orthotics such as palm protectors. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EMR for R104 contained a progress note dated 6/18/2024 at 14:18 (2:18 PM) titled: Therapy Communication to Nursing which read in part: Note Text: Please discontinue palm shield/protector with finger separators for L hand. Update: (R104) has been issued BUE (Bilateral Upper Extremity) (name brand) palm protectors for contracture management. Recommend RUE (Right Upper Extremity) palm protector be worn during sleeping hours; LUE (Left Upper Extremity) palm protector to be worn during waking hours, as tolerates . caution with opening hand due to h/o (history of) joint pain; may need to provide gentle ROM (Range of Motion) to hand prior to donning. A second set of palm protectors will be ordered and delivered upon arrival. (Pair to wear while the other is being washed). Notify OT of any questions or concerns. The EMR for R104 contained a care plan which read in part: (R104) has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) Disease Process (progressive decline in mobility); increased weakness. The interventions for this care plan included: I am issued BUE (name brand) palm protectors for contracture management. Recommend RUE palm protector be worn during sleeping hours; LUE palm protector to be worn during waking hours, as tolerates. Recommend warm towel or blanket wrap to hand prior to application; caution with opening hand due to h/o joint pain; may need to provide gentle ROM to hand prior to donning. On 9/18/24 at 11:15 AM, an undated facility document titled Resident brace, orthotic, and assistive device policy was received and read in part: Each resident will have an individualized care plan documented to reflect any and all applicable devices being used for positioning, bracing, or ambulation. 1. Braces and/or splints will have written orders for type and wearing frequency. 2. Braces and/or splints will have care plan documented for wearing frequency as applicable. 3. Refusals to wear said device will be documented in daily notes. 4. Poor fitting braces, splits, prosthetics, orthotics will be documented and referred to appropriate skilled therapy services and/or prosthetics/orthotics company for re-assessment of fit and modification. 5. Each resident will have their own assistive device as deemed necessary and appropriate for their condition for safe ambulation and transfers. 6. Each resident will have their mobility and ambulation status and programs as appropriate, documented in care plan. Refusals of ambulation programs will be documented weekly. On 9/18/24 at 8:37 AM the Resident Care Policies dated 3/20/24 were presented. The Quality of Care policy embedded in this set of policies read in part: Based on the comprehensive assessment of the resident, the Organization will strive to ensure that: 1. A resident who is admitted without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that reduction of range of motion was unavoidable. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for 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** 34568 Based on observation, interview and record review, the facility failed to implement appropriate interventions to prevent unsafe wandering and elopement for three Residents (R132, R156, & R221) of three residents reviewed for elopement. This deficient practice resulted in continued unsafe supervision and an elopement from the locked memory care unit. Findings include: R132 Review of R132's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnosis including dementia. R132's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated severe cognitive impairment. R132 was also noted on the 11/3/23 Elopement Evaluation to be at risk for elopement due to wandering. On 9/15/24 at 11:55 a.m., R132 was observed participating in an activity prior to lunch. R132 was observed in a seated position with no walker or wheelchair present near him. R132 ambulated to the lunchroom after the activity had concluded. Review of 132's Progress Note dated 8/13/24 read, in part, CNA (Certified Nurse Aide) staff reported to this nurse that Resident had eloped off the unit without triggering the alarm system. Resident was off the floor for only minutes before CNA staff escorted resident back to the unit. Resident does not express any irritability or negative behaviors. This nurse asked resident where he was trying to go, resident stated well I saw that guy going over there, so I thought that was the way to go. And then I got all turned around and now here I am . A phone interview was conducted with Registered Nurse (RN) X on 9/18/24 at 2:27 p.m. RN X stated that R132 had eloped off the locked memory care unit on 8/13/24 after being mistaken for a visitor by a dietary aide who let him off the unit. There was no further information or incident/accident report for R132's elopement on 8/13/24. Review of R132's Care Plans read, in part, The resident is an elopement risk/wanderer r/t (relate to) disoriented to place, resident wanders aimlessly .Interventions: Monitor location frequently. Document wandering behavior and attempted diversional interventions in behavior log. Date initiated: 11/24/23 R156 Review of R156's EMR revealed admission to the facility on [DATE] with diagnosis including dementia. R156's Admission MDS assessment dated [DATE] revealed severe cognitive impairment. The 7/31/24 MDS indicated R156 had 1 to 3 days of wandering behavior. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/24 at 11:25 a.m. R156 was observed wandering on the locked memory care unit. During this time R156 was observed entering into another resident's room, pulled the curtain, and sat on the bed. R156 stayed in this room for approximately 25 minutes before an unidentified staff member began asking if anyone knew where R156 was last seen. Shortly after this, staff member began to check rooms in the other hallways before finding R156 on 9/16/24 at 11:49 a.m. On 9/16/24 at 11:53 a.m., R156 was observed wandering into other resident rooms that were occupied. R156 then walked down to the dining room and attempted to elope out the fire exit door sounding the alarm. Staff were observed responding to the alarms, but no staff were present with R156 at the time. On 9/17/24 at 9:15 a.m., R156 was observed in the dining room for her breakfast meal. R156 would continue to leave the dining room and wander into other residents' rooms down the hall before coming back to take a small bite of food. Staff were unable to redirect R156 to stay for her breakfast. On 9/18/24 at approximately 11:30 a.m., R156 was observed sitting on the bed of a male resident while the male resident was sitting in his wheelchair. Review of R156's Care Plan read, in part, The resident is an elopement risk r/t Disoriented to place, History of attempts to leave facility unattended, impaired safety awareness. Resident wanders aimlessly . Interventions: Distract resident from wandering by offering pleasant diversion structured activities, food, conversation, television, book; Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Date initiated: 7/24/24 . R221 Review of R221's EMR revealed admission to the facility on [DATE] with diagnoses including Alzheimer's disease, restlessness, agitation, and anxiety. R221 was noted upon admission to the facility to have severe impaired cognition. On 9/16/24 at 1:37 p.m., R221 was observed wandering through the hallways of the locked memory care unit. During this observation, R221 would enter other residents' rooms, grab various items in the bathroom or bedroom and move or take items that did not belong to her. During this approximately 15-minute observation, staff did not know where R221 was located or intervene with her touching other resident's property. On 9/17/24 at 9:15 a.m., R221 was observed wandering out of the dining room, down the hallway to open a fire exit door. Staff were unable to redirect resident back to the dining room to finish her meal. Review of R221's care plan read, in part, The resident is an elopement risk/wanderer d/t Disoriented to place, impaired safety awareness. Resident wanders aimlessly .Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Date initiated: 9/6/24 . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Assistant Director of Nursing (ADON) G on 9/18/24 at approximately 11:15 a.m. The ADON stated, staff attempt to redirect and supervise all residents on the locked memory care unit, but that it was difficult to keep track of all the residents and tasks. An interview was conducted with the Director of Nursing (DON) on 9/18/24 at 2:21 p.m. The DON confirmed that residents should not be allowed to wander into other residents' rooms. The DON stated staffing continues to be a top priority for the memory care unit. Review of the facility's policy Elopements undated read, in part, .When a departing individual returns to the Organization, nurse/designee shall: examine the resident for injuries; Notify the Attending Physician; Notify the resident's legal representative (sponsor) of the incident; Complete and file an incident report; and Document the event in the resident's medical record .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on observation, interview, and record review, the facility failed to provide oxygen services per standards of practice for one Resident (#83) out of two residents reviewed for respiratory care. This deficient practice resulted in the potential for hypoxia (oxygen deficiency), respiratory complications, and the potential for re-hospitalization . Findings include: Resident #83 (R83) Review of R83's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including pneumonia, shortness of breath, and sleep apnea (a sleep disorder in which breathing repeatedly stops and starts). Review of R83's Minimum Data Set (MDS), dated [DATE], revealed a score of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicative of intact cognition. On 9/16/24 at 2:08 PM, R83 was observed sitting in a recliner in her room with an oxygen concentrator to her left. R83 did not have supplemental oxygen applied. When R83 was asked about her care satisfaction level, R83 stated, I would like to know what's going on. Am I getting oxygen or not? On 9/17/24 at 8:01 AM, R83 was observed rolling into the dining room with an oxygen canister secured to the back of her wheelchair. R83 had oxygen applied via nasal cannula (NC). On 9/17/24 at 12:42 PM, R83 was observed in dining room, eating the lunch time meal. R83 did not have supplemental oxygen applied, nor oxygen tubing connected to the oxygen canister. Review of the EMR revealed the following active physician's orders for R83: 1. Continuous Oxygen 2 L [Liters] via NC, initiated 8/21/24. 2. Wean O2 [oxygen] as able, initiated 9/4/24. On 9/17/24 at 1:20 PM, R83 was observed sitting in her recliner without oxygen applied. R83 acknowledged feeling, a little short of breath. On 9/17/24 at 1:28 PM, an interview was conducted with Registered Nurse (RN) H who stated he had just reapplied R83's supplemental oxygen because her oxygen saturation was 88%. When asked what the acceptable range of oxygen saturation was for R83, RN H stated there were not specific parameters in the physician order, but he personally liked to maintain the oxygen saturation at 92% or above. On 9/18/24 at 3:20 PM, an interview was conducted with Assistant Director of Nursing (ADON) F who agreed physician orders for both continuous oxygen and to wean oxygen as able were contradictory and confusing for clinical staff. ADON F verified supplemental oxygen orders should have defined oxygen saturation parameters to better direct floor staff. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 3:36 PM, an interview was conducted with the Director of Nursing (DON) who verified orders to wean oxygen should include oxygen saturation parameters. Review of facility policy titled, Oxygen Therapy, dated 2/2/23, read, in part: .Administer oxygen via the nasal cannula/prongs or face mask as ordered by the physician . observe . if PRN [as needed] monitor lung sounds and O2 sat [saturation] BID [twice per day] .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 Based on interview and record review, the facility failed to ensure Medication Regimen Reviews (MRRs) were addressed by the physician and maintained in the clinical records for two Residents (R61 and R91) of five residents reviewed for MRR. Findings include: Resident #61 (R61) Medication orders for R61 included three different antianxiety medications and an order for melatonin, a medication used for insomnia. The pharmacist MRR on 4/21/24 recommended the physician evaluate R61 to determine if the dosages of the antianxiety medications could be reduced. The report to the physician read, in part: .If you feel that no GDR (Gradual Dose Reduction) should be attempted, please document your reasoning for clinical contraindication at the bottom of this form or in your next progress note . The portion of the report for the physician's written response to the recommendation was blank, unsigned, and undated. Physician visit notes documented a visit on 5/10/24. The physician documentation did not include reasoning for declining the pharmacist's recommendation for GDR. The pharmacist MRR report to the physician on 7/25/24 recommended a reduction of R61's melatonin dosage. The portion of the report for the physician's written response to the recommendation was blank, unsigned, and undated. The Director of Nursing (DON) was interviewed on 9/18/24 at 4:03 p.m. The DON said there was no documented physician follow-up on the pharmacist's MRR recommendations. The DON said she could not confirm the physician had been provided the pharmacist's recommendations and was not able to provide the documented clinical rationale by the physician for declining the recommendations of the pharmacist. 40383 Resident #91 (R91) The Electronic Medical Record (EMR) for R91 revealed an original admitted [DATE] and recent admission of 1/9/2024 with a primary diagnoses of Lewy body dementia (a type of dementia which affects thinking, memory and movement). The MDS (Minimum Data Set) assessment included a BIMS (Brief Interview for Mental Status) score of 3 of 15 indicating R91 had severe cognitive impairment. The DON provided the pharmacist recommendations (MRRs) for R91 which read in part: For Recommendations Created Between 4/1/2024 and 4/30/2024 . Could a current AIMS (Abnormal Involuntary Movement Scale) assessment be done to monitor? For Recommendations Created Between 5/1/2024 and 6/30/2024 . Could a current AIMS assessment be done to monitor? (Two months of recommendations were included in this document.) (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EMR did not contain an AIMS following the recommendations above. During an interview on 9/18/24 at 11:25 AM, the DON reviewed the EMR and noted AIMS assessments had been completed for R91 on 11/28/23, 01/2024, 7/11/24 and 8/8/24. No AIMS assessment had been completed after the April pharmacist recommendations and one had not been done until 7/11/24. The DON said, I was under the impression when pharmacy put the recs (recommendations) in, he did not just say 'see report' (in the EMR), but he also sent them to us . There was not a follow up (to his recommendations for R91). It is an opportunity for process improvement. The Pharmacy Consultant Reports Policy was received on 9/18/24. The document was dated 7/3/2019. It read in part: Every month, the pharmacist will share the consulting recommendations with the DON. The DON will print the reports and share them . Additionally, they will provide the ADON with a copy. The provider (physician) is responsible for reviewing the recommendations and either agreeing, disagreeing, or writing an alternate response. Nursing staff is responsible for noting these orders and filing the recommendations in the chart under the orders tab. If there is an order, the nurses will need to co-note the order. The ADON will follow-up after one week and ensure all the recommendations have been addressed and filed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41978 Based on interview and record review, the facility failed to ensure documentation of targeted behaviors and use of non-pharmacological interventions prior to administration of as needed anti-anxiety medication for one Resident (#136) of five residents reviewed for unnecessary medications, resulting in the potential for over-medication and decreased quality of life. Findings include: Resident #136 (R136) Review of R136's Minimum Data Set (MDS) assessment, dated 7/23/2024, revealed admission on 4/23/2024 with diagnoses including dementia with psychotic disturbance, depression and anxiety disorder. Further review of the MDS revealed R136 has severely impaired cognition. Review of R136's June 2024 through September 2024 Medication Administration Records (MARs) revealed the following order: Lorazepam (a controlled anti-anxiety medication) Oral Tablet 0.5 MG (milligram). Give 0.5 mg by mouth every 6 hours as needed for anxiety . Further review of the MARs revealed R136 was administered as needed doses of lorazepam 0.5 mg on the following dates and times: 6/15/2024 at 8:24 a.m. 6/17/2024 at 9:29 a.m. 6/22/2024 at 6:10 a.m. 7/14/2024 at 10:15 p.m. 7/15/2024 at 2:23 p.m. 7/19/2024 at 4:31 p.m. 7/23/2024 at 12:19 p.m. Review of R136's EMR revealed no documentation of the reason for administration for the referenced doses of as needed lorazepam 0.5 mg. No behaviors or symptoms targeted by administration of the medication were observed documented. No use of non-pharmacological interventions prior to administration of the medication were observed documented. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/19/2024 at 8:31 a.m., Assistant Director of Nursing (ADON) G reported targeted behaviors and/or indications for use should be documented for each administration of as needed psychotropic medications, including lorazepam. ADON G stated use of non-pharmacological interventions should be used prior to the use of any as needed psychotropic medication. During review of R136's EMR, including progress notes, evaluations and point of care documentation at the time of the interview, ADON G confirmed no documentation of the behaviors targeted by the administration of as needed lorazepam 0.5 mg or use of non-pharmacological interventions on the referenced dates. Review of the facility policy titled, Psychoactive Medication Use, dated 7/20/2022, revealed the following, in part: Quality of Life Team will regularly review each resident for possible symptoms of mood and/or behavior changes, with the goal of determining underlying causes. Symptoms will be recorded by staff . When prn [as needed] psychoactive medication is prescribed, the following steps must be taken . Prior to administration of prn medication, non-pharmacological interventions must be attempted and proven ineffective .

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 49310 Based on interview and record review, the facility failed to ensure timely dental services were provided for three Residents (R49, R61, and R56) of three residents reviewed for dental services. Findings include: Resident #49 (R49) During an interview on 9/16/24 at 3:14 p.m., R49 said, I broke my tooth last month. R49 opened her mouth and pointed to the left upper part of the front of her mouth revealing what appeared to be a tooth fragment in the gum line. R49 said she did not know when she would be able to see the dentist. R49 admitted to a history of issues with dentition and said she has went to dental appointments with a dentist in the community but was waiting to see the dentist in the facility. A progress note in the medical record dated 8/16/24 documented, in part: .Resident had a tooth fall out today .Son has denied consent for inhouse services. Resident is still her own person and would like to consent for those services . A form Consent for Services that included dental services was signed by R49's son on 7/31/24 with a checkmark next to the box that read I wish to use the services. The social worker (Staff D) was interviewed on 9/18/24 at 11:02 a.m. Staff D said R49 had not been deemed incompetent to make her own decisions and did not have an activated Power of Attorney (POA). Staff D said R49 was on the list to be seen by the contracted provider of dental services. When asked the date of the next scheduled visit by the contracted dental provider, Staff D said she did not know when the dentist was scheduled. Staff D said, she's on the list, but I don't know a date for the next dental visit. Staff D was asked if a community dentist was considered. Staff D said she did not schedule an appointment for R49 with a dentist in the community and suggested the nursing department may have made an outside appointment. Staff D reviewed documentation and said, I don't think there was any follow up for an outside appointment. There's none documented. Staff D confirmed she was the staff member who usually scheduled dental appointments. Resident #61 (R61) During an interview on 9/17/24 at 1:15 p.m., R61said he had a tooth that was causing him a lot of pain. R61 said staff was aware of the toothache and he has been waiting to see the dentist. On 9/18/24 at 2:51 p.m., R61's family member said R61 had been asking to see the dentist for over two weeks because of a tooth that has been causing pain. The family member said, I've asked but nobody in the building knows when the dental clinic is coming to see him. (continued on next page)

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	235088	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at approximately 7:30 a.m., the Assistant Director of Nursing (ADON) I confirmed R61 had not been seen by the dentist. ADON I was asked for the list of residents waiting to see the dentist. ADON I said someone else had the information and she would obtain the requested information. ADON I admitted she did not know the frequency of dental visits or the date of the last dental visit or when the dentist was next due to visit the facility. The staff Scheduler (Staff J) provided a dental clinic list documented as updated on 9/19/24 at 12:05 p.m. R49, R61, and Resident #56 (R56) were on the list. The list was stamped Tentative and had a date of 10/17/24 as the next scheduled visit by the dentist. 40383 Resident #56 (R56) On 9/16/24 at 12:17 PM, R56 was observed and was not wearing his dentures. R56 stated he had lost about 60 pounds and his dentures did not fit. He said the food was hard to chew and he was eating breakfast food like eggs and hashbrowns every meal. R56 said he could chew those. R56 said he recently found out a dentist did come into the building, but he had not seen one. He also said he just found out he could see his own dentist. He said he was going to call his dentist. During an interview on 9/18/24 at 12:33 PM, ADON U stated there had been an issue with consents with the contracted provider of dental services. ADON U stated R56 needed to have his dentures realigned and he had not been wearing his dentures for quite some time. ADON U stated, Back in July we reached out to (the contracted provider of dental services). ADON U said she had received an email dated 7/17/24 from social services. The email revealed social services was working with R56 on filling out the needed dental paperwork. However, the social services personnel had changed, and an appointment was not set up. ADON U said the dental clinic comes into the building, but R56 was not seen. The medical record included a care plan for R56 which read in part: Increased Nutrition and Hydration risk r/t (related to) dx (diagnoses) . AEB (as evidenced by) significant weight loss, edentulous (dentures do not fit), hx (history) of refusing weights/skin assessments, variable meal intake, and risk for further weight/fluid/skin changes. There was a further related care plan which read in part: ORAL CARE: (R56) has upper/lower dentures. (R56) requires oral inspection daily Report changes to the Nurse. The medical record included Registered Dietitian (RD) progress notes which read in part: - 4/10/24 RD High Risk review . triggering for significant weight loss x 1 month and x 3 months Weights:12/24/23 220# (pounds) .3/15/24 183.8# .4/9/24 174# . - 5/31/24 RD Quarterly/High Risk . Continues to show sig (significant) weight loss from admission weights, but stable 165=169# over the past month Weights: 3/15/24 admission 183.8# .4/26/24 173# . 5/31/24 166.6# . - 8/15/2024 Note Text: .met with resident this afternoon to follow-up on any further food concerns. Resident requesting to have cheese omelets with ham and mushrooms (well done) with hashbrowns for all meals in addition to his scheduled boosts (supplement). Plan: RD updated preferences and meal to ticket with requested items. RD continues to follow resident monthly r/t high risk . (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Care Policies dated 3/20/24 were presented. The Dental Services policy embedded in this set of policies read in part: A. The Organization will assist residents in obtaining routine and twenty-four (24) hour emergency dental care. B. Residents are encouraged to use good dental hygiene. Nursing employees provide routine oral hygiene to those residents who are unable to do so. C. An Organization designee will assist residents with transportation arrangements to and from the dentist's office. D. The Organization has arrangements for emergency dental services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 13791 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among any and all 164 residents of the facility. Findings include: On 9/16/24 at approximately 11:10 AM, kitchen staff were observed in the kitchen, near the dish washing area removing trays containing soiled dishes, utensils and uneaten food from wheeled Cambro insulated transport carts. These carts were returned to the kitchen with trays removed from residents' eating areas. Once the soiled trays, utensils and uneaten food were removed from the wheeled transport carts, the carts were relocated to an unused dining area west and adjacent to the kitchen. No cleaning of the carts had been conducted following the removal of the soiled trays and uneaten food. At approximately 11:35 AM Food Service Worker (FSW) B was observed filling a small bucket from a disinfectant dispenser in the kitchen and going to the unwashed carts in the adjacent area. FSW B then was observed dabbing a few areas inside two carts coming in contact with less than 2% of the surface area of the internal portions of the cart. At approximately 11:38 AM, Kitchen Manager (KM) A was requested to watch FSW B conducting the activity at the carts through the window of the door between the kitchen and the carts. FSW B again dabbed a few spots on the interior of a third cart, closed the door and opened the door to a fourth cart. An interview with KM A at this time was conducted who stated that the process of cleaning the carts by FSW B was inappropriate. KM A stated he would speak to FSW B and ensure the carts were properly sanitized before being used for the transportation of the noon meal trays to residents. The FDA Food Code 2017 states: 4-603.15 Washing, Procedures for Alternative Manual Warewashing Equipment. If washing in sink compartments or a WAREWASHING machine is impractical such as when the EQUIPMENT is fixed or the UTENSILS are too large, washing shall be done by using alternative manual WAREWASHING EQUIPMENT as specified in 4-301.12(C) in accordance with the following procedures: (A) EQUIPMENT shall be disassembled as necessary to allow access of the detergent solution to all parts; (B) EQUIPMENT components and UTENSILS shall be scraped or rough cleaned to remove FOOD particle accumulation; and (C) EQUIPMENT and UTENSILS shall be washed as specified under 4-603.14(A). On 9/16/24 at approximately 12:55 PM, [NAME] C was observed washing his hands and drying with a paper towel. [NAME] C then pushed down on the swivel top trash container with his bare hands, disposed of the towel and returned to serving line. The FDA Food Code 2017 States: 2-301.14 When to Wash. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301. 12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (I) After engaging in other activities that contaminate the hands.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on interview and record review, the facility failed to ensure collaboration and communication between the facility and hospice provider for one Resident (R137) of one resident reviewed for hospice services. This deficient practice resulted in gaps in communication for coordination of care. Findings include: Review of R137's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia with behavioral disturbance, and dysphagia. Review of R137's 6/26/24 Minimum Data Set (MDS) assessment revealed he was unable to complete the Brief Interview for Mental Status (BIMS) and had severely impaired cognition. R137 was admitted to the facility on hospice services and had a Designated Power of Attorney (DPOA) for medical and financial decisions. On 9/16/24 at 1:40 p.m. an interview was conducted with R137's DPOA, who stated there is a lack of communication between R137's hospice services and the facility. The DPOA stated, I know that they are here, but I don't know what's happening. Review of R137's IDG (Interdisciplinary Group) Meeting Review written on 8/14/24 read, in part, .RN (Registered Nurse) 1x (time)/week, HHA (hospice health aide) 1x/week. Patient is a [AGE] year-old with diagnosis of Alzheimer's disease .patient is non-verbal, unable to make his needs know .dependent of 6/6 ADL's (activities of daily living) .certification period 8/5/24-10/3/24 . On 9/18/24 at 3:30 p.m. an interview was conducted with Assistant Director of Nursing (ADON) G who stated that R137's Hospice Notes would be in the [Hospice Name] binder located at the nurse's station. During observation and review of this folder, there were only two documented hospice visits in August 2024. ADON G stated hospice staff are visiting R137 and that the wife knew there was a care conference. A request was made for R137's hospice visit notes since 8/5/24. Review of R137's Hospice Notes from 8/5/24 through 9/19/24 revealed two hospice visits on 8/16/24 and 8/23/24. An interview was conducted with the Director of Nursing (DON) on 9/19/24 at 11:30 a.m. The DON confirmed there was no additional documentation from R137's hospice provider since 8/23/24. Review of the facility's [Hospice Name] Standing Nursing Home Hospice Care Agreement dated 3/16/22 read, in part, Hospice will provide and document the following information to the Facility in accordance with the Coordination of Care protocols established with the Facility to facilitate coordination of care: .a clinical summary of each nursing, social work and spiritual care visit made by Hospice staff members to each Hospice Patient, visits to each Hospice patient by Hospice aides .Facility Coordination of Care: Facility shall designate a member of the Facility's interdisciplinary team who is responsible for working with Hospice representatives to coordinate care provided to the Hospice Patient by the Facility staff and Hospice staff .the designated interdisciplinary team member is responsible for the following: Collaborating with Hospice representatives and coordinating Facility staff participation in the Hospice care planning process for Hospice Patients .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49302 Based on interview and record review, the facility failed to implement an effective Quality Assurance & Performance Improvement (QAPI) program that included development, monitoring, and evaluation of adverse events to correct quality deficiencies and maintain sustained compliance. This deficient had the potential to affect all 164 residents in the facility. Findings include: On 9/19/24 at 10:10 AM, an interview was conducted with Registered Nurse (RN)/Staff Educator P who verified she oversaw the QAPI process. When asked if adverse events such as a death in the facility, were reviewed in QAPI. RN/Staff Educator P stated these events were discussed in Interdisciplinary Team (IDT) meetings but not in QAPI. RN/Staff Educator P verified she considered an unexpected death an adverse event but, It's just something we never really discussed [in QAPI]. RN/Staff Educator P was unable to explain how medical errors or adverse resident events were identified, analyzed, corrected, or monitored to ensure desired outcomes throughout the QAPI process. Review of facility policy titled, Quality Assurance Performance Improvement Plan, reviewed 7/12/24 read, in part: . [Facility Name] has a Performance Improvement Program which systematically monitors, analyzes and improves its performance to improve resident/patient outcomes .The following data is monitored through QAPI (not limited to): .Adverse events . Daily interdisciplinary team (IDT) notes are reviewed including adverse events/complaints on a daily basis. We have a mechanism for communicating patterns, trends identified during IDT meetings to the broader QAPI Committee .