STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235201	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munson Healthcare Crawford Continuing Care Center	1100 Michigan Ave Grayling, MI 49738

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on interview and record review, the facility failed to implement the abuse policy and investigate allegations of abuse for one Resident (R8) of two residents reviewed for abuse, resulting in the potential for continued abuse, fear, anger, and mental anguish. Findings include: R8 was admitted on [DATE] with diagnoses including stroke, dementia, and right-side hemiparesis (weakness). Review of R8's Minimum Data Set (MDS) assessment, dated 3/19/2024, revealed R8 had severe cognitive impairment. Review of R8's Electronic Medical Record (EMR) revealed the following: 5/4/2024 1701 [5:01 p.m.]. Health Status Note. Staff alerted to dining room ([R8] yelling) staff noted a peer close to [R8] within her [sic] personal space (very close). Staff intervened and removed peer from area. No physical contact made by either resident. 4/16/2024 19:00 [7:00 p.m.] Behavior Note .resident was in the dining room after dinner listening to music per his preference. CNA [Certified Nurse Aide] heard yelling and observed [R8] and another resident from East Hall with their fists up, but no physical contact was made. [R8] reported that the other resident said that he was going to hit his genitals, although no contact was made. Both residents were separated without any further issues. will continue to monitor. On 7/02/2024 at 10:23 a.m., the Director of Nursing (DON) reported no investigations into the referenced incidents were conducted because no physical contact was made between the two residents. Review of the facility policy titled Abuse, Neglect, Mistreatment & Misappropriation of Resident Property, last revised 7/06/2023, revealed the following, in part: It is the policy of [the facility] to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse . Definitions . Verbal Abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident Regardless of their age, ability to comprehend or disability. Examples of verbal abuse include, but are not limited to: threats of harm, saying things that frighten a resident . Investigation . It is the policy of this [facility] that reports of abuse are promptly and thoroughly investigated . The investigation will include . Who was involved. Resident statements . Involved staff and witness statements of events . a description of the resident's behavior and environment at the time of the incident . injuries present including a resident assessment, observation of resident and staff behaviors during the investigation . environmental considerations .

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	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** 34568 Based on interview and record review, the facility failed to notify the resident in writing with the reason for a transfer out of the facility for three Residents (R82, R186, R27) of three residents reviewed for transfers. Findings include: Resident #82 (R82) A review of the facility census revealed R82 was sent to an acute care hospital with primary diagnosis of acute anemia from 6/10/24-6/21/24. R82 was again sent to an acute care hospital with primary diagnosis of acute blood loss anemia from 6/24/24-6/28/24. A review of R82's progress notes revealed the following: 1. 6/10/24: Guest SpO2 (oxygen saturation) in mid to high 70's on 3 L (liters) while at rest .MD (Medical Director) updated via page .order received to send to ED (Emergency Department) for eval (evaluation) and treat . 2. 6/21/24 Admission Details: arrived by ambulance. 3. 6/24/24: .Guest requested pain medication for 7/10 pain, something for nausea and dizziness. Approx (Approximately) 15 min (minutes) later CNA (Certified Nurse Aide) approached nurse stating (R82) is reporting she can't breathe. SpO2 taken 82% on 4 L via high flow tubing .order received to transport to ED . CNA and (R82) left unit via gurney . 4. 6/28/24: Admission Details: Arrived by ambulance. Review of the EMR for R82 revealed no written transfer notice. 49302 Resident #186 (R186): A review of the facility census revealed R186 was sent to an acute care hospital with the primary diagnosis of acute respiratory failure with hypoxemia (low blood oxygen levels) from 6/15/23 - 6/23/24. A review of R186's progress notes revealed the following: 1. 6/18/24: CNA [certified nursing assistant] wheeled resident out of dining room, verbalizing that she sounds course. Upon assessment VS [vital signs] were Sp02 [oxygen saturation] 55% on RA [room air], 110 pulse, 98.3 T [temperature], BP [blood pressure] 106/73, lungs course, resident unable to verbalize if she had SOB [shortness of breath] due to dementia .paged hospitalist .arrived to floor, assessed and ordered to send to ED [emergency department] . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. 6/24/24 [late entry]: Admission summary . Reported that Res [resident] arrived at the facility 1800 hrs [hours] . Review of the Electronic Medical Record (EMR) for R186 revealed no written transfer notice. Resident #27 (R27): A review of the facility census revealed R27 was sent to an acute care hospital with primary diagnosis of leukocytosis and severe hypokalemia from 5/19/24 - 6/6/24. A review of R27's progress notes revealed the following: 1. 5/19/24, Transfer to Hospital Summary: Notified on-call provider .of [R27]'s worsening decline with visual hallucinations .Her BMP [basic metabolic panel] resulted with a critically low potassium .received verbal orders to send to emergency room for evaluation and treatment 2. 6/6/24, Clinical Admission: .Arrive by ambulance .readmit from hospital . Review of the EMR for R27 revealed no written transfer notice. On 7/3/24 at 2:04 PM, an interview was conducted with Business Officer Manager (BOM) P who verified residents and/or resident's representatives were not issued a notification in writing upon transfer or discharge. BOM P stated, I've never completed a transfer agreement .I wasn't trained to do so. A facility-initiated transfer policy was not provided by the time of survey exit.

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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** 41978 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan to address safety concerns for one Resident (R3) of 12 residents reviewed for care planning, resulting in the potential for unmet safety needs. Findings include: Review of R3's Minimum Data Set (MDS) assessment, dated 5/29/2024, revealed R3 was admitted on [DATE] and had a primary diagnosis of dementia. Further review of R3's MDS revealed a Staff Assessment for Mental Status indicating R3 had short- and long-term memory problems and had severely impaired cognitive skills for daily decision-making. An observation on 7/2/2024 at 8:41 a.m., revealed R3 in her room, seated in a reclining wheelchair. Further observation revealed a metal pan-type call light positioned on the seat of R3's chair near her left knee. There were no staff present in R3's room at the time of the observation. Review of R3's Electronic Medical Record (EMR) revealed the following clinical progress note: 2/27/2024 5:57 [a.m.]. At 0500 [5:00 a.m.] CNA [Certified Nurse Aide] staff alerted this nurse to [R3] wrapping the call light cord around her neck. [R3] fought with CNA staff as they were removing it. No marks or skin issues were observed. Call button was removed from reach and bell placed on her bedside table to use for calling for assistance. During a telephone interview on 7/8/2024 at 1:03 p.m., CNA O confirmed she found R3 on 2/27/24 in bed with the call light cord around her neck. CNA O stated she worked with R3 often and R3 was impulsive at times and was not aware of her own safety. CNA O stated R3 needed to be checked on frequently to ensure her safety. During an interview on 7/8/2024 at 12:22 p.m., RN M reported R3 was unaware of her own safety needs and exhibited impulsive behaviors. RN M stated staff performed frequent safety checks on R3, including keeping R3 near the nurses' station during waking hours, to ensure her safety. Review of R3's care plans provided on 7/3/2024 at 4:49 p.m., revealed no focus area to include R3's behavior of wrapping the call light around her neck and no interventions were developed related to R3's need for frequent safety checks or keeping R3 in sight during waking hours.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 safely provide assistance with wheelchair mobility for three Residents (R6, R14, R186) and failed to investigate the root cause of self-injurious behavior for one Resident (R3) of four residents reviewed for accidents and supervision. This deficient practice resulted in the potential for injury related to unsafe wheelchair mobility assistance and the potential for continued self-injurious behavior. Findings include: Resident #6 (R6) On 7/2/24 at approximately 12:30 p.m. during an observation of the lunch meal service in the main dining room, R6 was observed being provided assistance by Certified Nurse Aide (CNA) S to a table while sitting in his wheelchair. R6's wheelchair did not have foot pedals in place, and R6's feet were noted to be scraping on the ground as he was being pushed by CNA S. R6 was noted to be wearing socks with grippers on the bottom. Resident #14 (R14) On 7/2/24 at approximately 12:30 p.m. during an observation of the lunch meal service in the main dining room, R14 was observed to be assisted by CNA T to a table while sitting in her wheelchair. R14's wheelchair did not have foot pedals in place, and R14 was attempting to move her feet while being assisted to a table. R14 was noted to be wearing socks with grippers on the bottom. 41978 R186 An observation on 7/3/2024 at 8:10 a.m., revealed R186 in a wheelchair, self-propelling toward the nurses' station on the East Hall. R186 stopping at the nurses' station and spoke with RN G, who advised R186 to continue down to the dining room for breakfast. R186 asked where the dining room was located at which time RN G called down the hall to an unidentified staff member to assist R186 to the dining room. The unidentified staff member was observed pushing R186 down the hall in her wheelchair with R186 holding her feet up approximately two inches off the floor. It was noted there were no foot pedals attached to the wheelchair for R186 to place her feet on. During an interview immediately following the observation, RN G stated staff rarely used foot pedals for residents that could self-propel. When asked the reason why foot pedals were not utilized, RN G reported staff would have to travel back to the resident's rooms to obtain the foot pedals and time did not allow for that. When asked if there was concern not using foot pedals could cause injury or accidents, RN G stated she understood the concerns and there was a potential for resident's to not understand the need to hold their feet off the floor resulting in injury or falls. R3 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R3's Minimum Data Set (MDS) assessment, dated 5/29/2024, revealed R3 was admitted on [DATE] with a primary diagnosis of dementia. Further review of R3's MDS assessment revealed a Staff Assessment for Mental Status indicating R3 had short- and long-term memory problems and severely impaired cognitive skills for daily decision-making. An observation on 7/2/2024 at 8:41 a.m., revealed R3 in her room, seated in a reclining wheelchair. R3 appeared restless and was observed moving her legs side to side while seated in the chair. A pan-type motion detection device was positioned on the footrest of the chair, near R3's left knee. Review of R3's Electronic Medical Record (EMR) revealed the following clinical progress note: 2/27/2024 5:57 [a.m.]. At 0500 [5:00 a.m.] CNA [Certified Nurse Aide] staff alerted this nurse to [R3] wrapping the call light cord around her neck. [R3] fought with CNA staff as they were removing it. No marks or skin issues were observed. Call button was removed from reach and bell placed on her bedside table to use for calling for assistance. The note was entered by Licensed Practical Nurse (LPN) N. Review of R3's Occurrence History documentation provided by the Director of Nursing (DON) revealed no report related to the incident on 2/27/2024 when R3 was found wrapping the call light cord around her neck. On 7/3/2024 at 11:39 a.m., the DON reported she was unaware of an incident involving R3 being found wrapping a call light around her neck. The DON confirmed there was no investigation initiated by the facility related to the incident. The DON was shown by this Surveyor, the entry in the progress notes dated 2/27/2024 at 5:57 a.m. The DON stated the incident should have been taken more seriously and reported to administration to allow for investigation into the root cause of the behavior to determine if R3 had thoughts of self-harm or other behavior posing a threat to her safety. The DON stated she was concerned the incident was not reported to her. The DON reported she would follow-up on the incident. A call was place to LPN N on 7/3/2024 at 1:29 p.m. and a message was left for a return call to discuss the survey. No call back was received by the end of the survey. During an interview on 7/8/2024 at 12:22 p.m., RN M reported the DON asked her about the incident involving R3 being found wrapping the call light cord around her neck on 2/27/2024. RN M stated she was unaware of the incident prior to the DON's inquiry on 7/3/2024. RN M stated she spoke to LPN N after being alerted to the incident but had no further information to offer. RN M reported R3 could not purposely use a call light and no longer had a call light within her sight but used a motion detection device placed near her thigh to alert staff of her movements. During a telephone interview on 7/8/2024 at 1:03 p.m., CNA O confirmed she found R3 on 2/27/24 in bed with the call light cord around her neck. CNA O stated she worked with R3 often and R3 was impulsive at times and not aware of her own safety. CNA O stated R3 needed to be checked on frequently to ensure her safety and after the incident they placed the call light cord out of R3's reach. CNA O was unsure why R3 wrapped the cord around her neck. CNA O reported R3 was not observed exhibiting self-harmful behaviors since the incident and the incident seemed to be isolated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/8/2024 at 12:27 p.m., the DON reported no investigation into the incident was initiated after alerting her to the incident on 7/3/2024 at 11:39 a.m. The DON stated she did not know more information was required by the survey team regarding the incident therefore did not feel the need to investigate at that time. A query was made as to whether the DON spoke with RN N or CNA O regarding the incident to which she answered she did not. The facility policy related to resident supervision and safety was requested from the DON on 7/3/2024 at 2:45 p.m. No policy was received by the end of the survey on 7/8/2024.

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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 administer supplemental oxygen per physician orders for one Resident (#186) of one residents reviewed for respiratory care. Findings include: Resident #186 (R186): Review of R186's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia, dependence on supplemental oxygen, and dementia. Review of R186's admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. On 7/1/24 at 9:44 AM, R186 was observed sitting in a wheelchair in the hallway just outside her room. R186 was observed becoming frustrated with navigating the oxygen tubing and subsequently removed her supplemental oxygen. Registered Nurse (RN) G was observed walking down the corridor and noticed R186 had removed her supplemental oxygen. RN G stated, I guess we'll see how she [R186] does without it [supplemental oxygen]. On 7/2/24 at 9:28 AM, R186 was again observed sitting in a wheelchair in the hallway outside her room without supplemental oxygen donned. On 7/2/24 at 11:38 AM, R186 was observed sitting in the main dining room without supplemental oxygen donned. Review of R186's EMR revealed an order, revised 6/26/24, that read, Administer oxygen at 2L [liters] continuous and up to 6L with exertion. May need to reapply tubing as she will remove ad lib. Review of R186's Plan of Care listed a Focus, initiated on 6/17/24 which read, [R186] is at risk for completion of ADLs [activities of daily living] r/t [related to] recent fall resulting in left femur neck FX [fracture] with hemiarthroplasty, acute post op [operative] anemia, chronic respiratory failure with hypoxia and is O2 [oxygen] dependent On 6/27/24 the Focus was revised to include the following: [R186] is at risk for completion of ADLs r/t recent fall resulting .chronic respiratory failure with hypoxia and is O2 dependent, acute/chronic respiratory failure, bilateral subsegmental PEs [pulmonary embolisms], mucous plugging of bronchus, COPD [chronic obstructive pulmonary disease] with exacerbation, end stage emphysema . An intervention revised 6/27/24 read, Administer oxygen at 2L continuous and up to 6L with exertion. May need to reapply tubing as she will remove ad lib. Review of R186's transfer record revealed a hospitalization from [DATE] - 6/23/24. Review of R186's hospital discharge summary, read in part: .presents to the ER [emergency room] from [facility name] for sudden onset of rhonchi [a rattling or whistling respiratory sound during respiration] and decreased O2 after lunch . CT [computed topography scan] of the chest was done showing acute segmental subsegmental pulmonary emboli [blockage of a lung artery] .end-stage emphysema mucous plugging .home O2 evaluation at discharge showed need for 2L at rest and 6 with exertion . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/3/24 at 8:42 AM, an interview was conducted with Certified Nursing Assistant (CNA) R who was asked if R186 required supplemental oxygen. CNA R stated, She [R186] has an order for supplemental oxygen, but last time I worked she was at 97% [oxygen saturation] on room air so we've been trying without it. On 7/3/24 at 9:22 AM, an interview was conducted with RN G regarding R186's supplemental oxygen requirements. RN G stated, I was told to wean her off during the day. When asked for a physician's communication indicating an order for this action, RN G was unable to provide one. On 7/3/24 at 9:24 AM, an interview was conducted with Clinical Care Coordinator (CCC)/RN L and the Director of Nursing (DON) regarding supplemental oxygen expectations. The DON stated if a resident had an active order for continuous supplemental oxygen, it is expected to be worn at all times. CCC/RN L stated there should be a communication in R186's EMR from the physician indicating a directive to trial oxygen weaning. Review of R186's EMR did not reveal a physician order or communication to trial ceasing supplemental oxygen. Review of facility policy titled, Oxygen Delivery, revised 7/3/24, did not include expectations regarding physician orders on oxygen weaning.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on observation, interview, and record review, the facility failed to assess and manage pain for one Resident (#2) of one resident reviewed for pain management. This deficient practice resulted in untreated pain and unnecessary suffering. Findings include: Resident #2 (R2): Review of R2's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including hypomagnesemia, acute pain due to trauma, and contusion of the left hip and knee. Review of R2's most recent Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. During the initial tour of the facility on 7/1/24 at 9:50 AM, R2 was observed in her room sleeping in her wheelchair. Upon entrance into the room, R2 stated she had a terrible of night of rest due to painful cramps in her legs that had kept her awake. On 7/8/24 at 1:01 PM, an interview was conducted with R2 who stated she had continued leg cramping at night. R2 stated, I was up for almost 3 hours last night with muscle spasms. When asked if her pain was addressed by the facility, R2 replied, I haven't been seen by a physician since I got here. Review of R2 EMR revealed the following progress notes: 1. 6/17/24: [R2] is A&Ox3 [aware of self, place, and time], and is able to make her needs/wants known . Resident is c/o [complaining of] BLE [bilateral lower extremities] restlessness/cramping that kept her up all night. Applied muscle rub to both Lower extremities. Communication left for the doctor . 2. 6/18/24: .She was up at approx. [approximately] 2 AM, c/o legs jumping . 3. 6/19/24: .C/o legs jumping . 4. 6/23/24: .C/o legs jumping . 5. 6/26/24: .C/o legs jumping . Review of a communication with the subject Med [Medication] Request by R2's primary care provider on 7/2/24 read, in part: [R2's] daughter .called in and stated that patient is at [Facility Name], and is having issues with her restless leg, and they are not helping her with it. She is asking for [Primary Care Physician] to call and advise them what can be done for her leg. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an addenda communication with the subject Med [Medication] Request to R2's primary care provider on 7/2/24 read, in part: I called [R2's daughter] .and explained while [R2] is at [Facility Name] she is under the care of the attending provider there . I did suggest [R2's daughter] advocate for her mom with the clinical team that cares for her mom to have her restless legs addressed. Review of R2's EMR revealed no physician communication or follow-up regarding her repeated complaints of leg pain. On 7/8/24 at 12:20 PM, an interview was conducted with Clinical Care Coordinator (CCC)/Registered Nurse (RN) L regarding pain management and interdisciplinary communication. CCC/RN L stated the usual process is for the floor nursing staff to complete a physician communication form for the provider to review and address. CCC/RN L verified R2's complains of muscle spasms were never addressed by a physician, despite a physician communication documented in a progress note on 6/17/24. CCC/RN L stated, It seems like it [the communication form] was lost in translation or it was some type of transcription error. Review of facility policy titled, Pain Management reviewed 7/3/24 read, in part: .At [Facility Name], aggressive pain prevention and control are organizational clinical goals. A holistic and interdisciplinary approach to pain management will be the standard of care for all patients experiencing acute or chronic pain . Patients have the right to appropriate assessment and management of pain . the patient's self-report of pain in the single most reliable indicator of pain .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on interview and record review, the facility failed to appropriately conduct a gradual dose reduction (GDR) for a psychotropic medication for one Resident (R23) of five residents reviewed for unnecessary medications. This deficient practice resulted in the potential for adverse medication side effects. Findings include: Resident #23 (R23) Review of R23's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including: dementia with behavioral disturbances and delusional disorders. Review of her 4/17/24 Brief Interview for Mental Status (BIMS) score on her Minimum Data Set (MDS) assessment revealed an 8/15, indicating moderately impaired cognition. Review of the Consultant Pharmacist's Medication Regimen Review for 5/1/24 through 5/31/24 read, in part, . (23) Resident is currently due for a GDR evaluation on her olanzapine (antipsychotic medication Zyprexa) 2. 5 mg (milligram) qd (every day). Please evaluate (R23) to determine if she is ready for a reduction at this time. If you feel that no GDR should be attempted, please document your reasoning for clinical contraindication at the bottom of this form or in your next progress note .Note written to physician . Review of the facility's Psychotropic & Sedative/Hypnotic Utilization by Resident between 6/1/24 through 6/26/24 read, in part, (R23) .Medication Class: Antipsychotic .Medication: Olanzapine .Dose and Directions: 2.5 mg qd .Ordered: 5/12/23 .Last GDR: (blank) .Next Eval (Evaluation): 5/25 . An interview was conducted with the Nursing Home Administrator (NHA) on 7/2/24 at 1:03 p.m. The NHA stated that the facility was made aware of the recommendations for R23's GDR but indicated the facility was having issues with the medical providers who oversee the facility and their understanding of GDR attempts per the regulations. The NHA further stated that the Medical Director was to be overseeing all GDR recommendations soon. Review of R23's Physician Orders on 7/3/24 revealed she was still receiving Olanzapine 2.5 mg every day. There was nothing in the EMR indicating the facility was addressing the original pharmacist recommendation for GDR or rationale for not performing a GDR of R23's psychotropic medication. Review of the facility's Gradual Dose Reduction of Psychotropic Drugs policy effective 9/19/23 read, in part, . Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs .Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated .GDR consideration will be documented in the clinical record .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 41978 Based on observation, interview and record review, the facility failed to ensure a medication administration error rate of less than five percent, with two errors identified out of 31 opportunities, affecting one Resident (R182) of four residents observed for medication administration, resulting in a medication error rate of 6.45 percent. Findings include: On 7/3/2024 at 7:59 a.m., Registered Nurse (RN) G was observed removing R182's morning medications from the automatic medication dispensing cabinet. RN G reported R182 was scheduled to receive one dose of gabapentin 800 milligrams with his morning medications, but the medication was not available. RN G reported the last dose must have been administered when last scheduled and was not yet restocked. After removing R182's available medications from the automatic dispensing cabinet, RN G reconciled the medications with R182's medication orders in the Medication Administration Record (MAR) and again reported R182 would not be receiving the gabapentin 800 mg as scheduled as she would need to wait for the medication to be refilled. RN G then reported R182's blood sugar was tested previously with a result of 243 mg/dL (milligrams per deciliter), requiring administration of five units of insulin. RN G removed R182's Humalog KwikPen (fast-acting insulin) and a packaged pen needle from the medication cart and left to administer R182's medications. On 7/3/2024 at 8:10 a.m., RN G was observed entering R182's room to administer his morning medication. RN G handed R182 the medication cup containing the medications. R182 looked into the cup and RN G told R182 the medications were his gabapentin and all that. After the administration of R182's oral medications, RN G prepared the Humalog KwikPen by attaching the needle and was observed dialing the pen to deliver five units of insulin. RN G then administered the insulin into the back of R182's left arm without priming the pen. RN G then returned to the medication cart and recorded the administration of the medications. During an interview immediately following the observations, RN G was asked if the Humalog KwikPen required priming prior to dialing up the dosage to be administered. RN G reported she was unsure but would check. RN G acknowledged she did not prime the pen prior to dialing up the dose and administering the insulin to R182. On 7/3/2024 at 8:57 a.m., RN G reported she researched the instructions for the Humalog KwikPen and determined the pen should have been primed with two units of insulin prior to dialing up the dose to be administered to ensure R182 received the full dosage required. On 7/8/2024 at 11:10 a.m., review of R182's MAR with RN L, revealed the following order: Gabapentin 800 mg, oral, cap, QID (four times daily), Start 6/23/2024 (7:00 p.m.), Routine. Further review of R182's MAR revealed a documented date and time of administration of the gabapentin 800 mg on 7/3/2024 at 8:31 a.m. RN L reported when medications are unavailable in the medication cart or the automatic dispensing cabinet, staff are to send a message or call the pharmacy to alert to the need for a refill. RN L reported there was no record of a message being sent to the pharmacy on 7/3/2024 regarding the need to refill R182's gabapentin 800 mg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Medication Administration, last revised 3/25/2024, revealed the following, in part: . When medication eligible for a scheduled dosing time are not administered within the defined time period: Document the reason the dose was missed or delayed . reschedule missed or delay doses . medication errors that are the result of missed or delayed doses must be reported to the attending provider . Review of the manufacturer's instructions for use of the Humalog KwikPen, accessed on 7/8/2024, revealed the following, in part: Priming your Pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin .

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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 26 residents. Findings include: On 7/2/24 at approximately 8:00 AM the morning meal was observed being served in the dining room. Included was a large pan of fresh cut cantalope melon. The temperature of the melon was measured using a Super fast Thermapen digital thermometer and found to vary between 45 F and 48 F. At this time an interview was conducted with Dietary Aide (DA) E related to the preparation of the melon. DA E stated They use some special wash. On 7/2/24 at approximately 8:30 AM an interview was conducted with prep cook (PC) F related to the preparation of the melon. PC F stated the kitchen no longer used any cleaner for the exterior of the melons prior to slicing. An interview with the Certified Dietary Manager (CDM) A confirmed there was no process to ensure thorough cleaning of the exterior of the melon, that the facility had discontinued the use of a fruit and vegetable wash a year prior. CDM A stated a fruit and vegetable wash product would be ordered immediately. The 2017 FDA Food Code states: 3-302.15 Washing Fruits and Vegetables. (A) Except as specified in (B) of this section and except for whole, raw fruits and vegetables that are intended for washing by the CONSUMER before consumption, raw fruits and vegetables shall be thoroughly washed in water to remove soil and other contaminants before being cut, combined with other ingredients, cooked, served, or offered for human consumption in READY-TO EAT form. On 07/02/24 at approximately 12:02 PM observations of the noon meal were made including a pan identified as mechanical chicken by DA E. DA E stated the temperatures of the foods had been taken and were ready for service. The temperature of the mechanical chicken was measured using a Super Fast thermapen and found to be between 119-131 F. the FDA Food Code 2017 states: 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401. 11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54 C (130 F) or above

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 49302 Based on interview and record review, the facility failed to report Payroll Based Journal (PBJ) information to CMS (Centers for Medicare and Medicaid). This deficient practice resulted in inaccurate reporting of staffing levels with the potential to affect all 26 residents. Findings include: Review of the CMS PBJ Staffing Data Report FY (fiscal year) Quarter 2 2024 (January 1- March 31) revealed the metric Failed to have Licensed Nursing Coverage 24 Hours/Day and No RN Hours Triggered with daily infractions from 1/1/24 to 3/31/24. On 7/8/24 at 8:55 AM, an interview was conducted with the Business Office Manager (BOM) P who verified she was responsible for submitting PBJ information to CMS. BOM P was unable to produce confirmation emails from CMS from Quarter 2 2024 indicating the required information had been successfully submitted. Review of PBJ XML Submission Process found at https://www.cms.gov/medicare/quality/nursing-home-improvement/staffing-data-submission read, in part: .XML Submission Process: After your submitted PBJ data file is successfully received by the CASPER Reporting and PBJ systems, the PBJ system validates the file structure and data content. Within 24 hours of a successful submission, a system-generated Final Validation Report is created in the CASPER Reporting system. This report provides a detailed account of any errors found during the validation of the records in the PBJ submission file .

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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 performance indicators, identification of quality issues, and the conducting of distinct performance improvement projects to correct quality deficiencies and maintain sustained compliance. This failure had the potential to affect all 26 residents in the facility. Findings include: On the 7/8/24 at 12:41 PM, an interview was conducted with the Director of Nursing (DON) who verified she was in charge of leading the QAPI process. When asked about a current Performance Improvement Project (PIP), the DON was unable to provide a formal record of a PIP and stated, That's not a concept I was aware of, I guess. The DON could not present evidence of regular review or data analysis collected under the QAPI program including tracking and measuring performance, establishing goals and thresholds for performance improvements, nor monitoring and evaluating the effectiveness of corrective actions. The DON stated, I've struggled with what I had and what I needed to have [in reference to the QAPI program]. I didn't have a lot of orientation for this job. Review of facility policy titled, Quality Assurance and Performance Improvement, revised 7/12/23 read, in part: .The QAPI plan will address the following elements: .Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: a. Tracking and measuring performance. b. Establishing goals and thresholds for performance improvements. c. Identifying and prioritizing quality deficiencies. d. Systematically analyzing underlying causes of systemic quality deficiencies. e. Developing and implementing corrective action or performance improvement activities. f. Monitoring and evaluating the effectiveness of corrective action/ performance improvement activities and revising as needed . .The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to: 1. The written QAPI plan. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events. 3. Data collection and analysis at regular intervals. 4. Documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities . .The plan and supporting documentation will be presented to the State Survey Agency or Federal surveyor at each annual recertification survey and upon request .

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49302 Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) attended the Quality Assurance and Performance Improvement (QAPI) meetings on a quarterly basis. This deficient practice resulted in the potential for ineffective interdisciplinary communications regarding facility process with the potential to affect all 26 residents residing in the facility. Findings include: On the 7/8/24 at 12:41 PM, an interview was conducted with the Director of Nursing (DON) regarding the QAPI process. Attendance documents from the previous 3 quarterly meetings were reviewed with the DON which revealed the IP was not in attendance. The DON confirmed the IP does not attend the QAPI meetings and instead, acts as a resource and is stationed in the acute-care portion of the facility. Review of facility policy titled, Quality Assurance and Performance Improvement, revised 7/12/23 read, in part: .The QAA Committee shall be interdisciplinary and shall: 1. Consist at a minimum of: a. The Director of Nursing (DON) Services; b. The Medical Director or his/her designee; c. At least three other members of the facility's staff, at least one of which must be the administrator, owner, a board member, or other individual in a leadership role; and d. The Infection Preventionist .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41978 This citation will have two deficient practice statements: A and B A. Based on interview and record review the facility failed to implement a system for recording and tracking communicable disease during an outbreak of respiratory illness (Covid-19), resulting in the potential for further spread of the virus to 23 un-infected residents. Findings include: During review of the facility's infection surveillance documents on 7/8/2024 at 10:31 a.m., the Director of Nursing (DON) reported the facility had an outbreak of Covid-19 in March 2024. The DON reported she was the acting facility Infection Preventionist. A request was made to review the outbreak investigation and surveillance. The DON stated she did not have a written summary of the outbreak but did have a record she used to present at the facility QAPI (Quality Assurance and Performance Improvement) meetings. Review of the Infection Control Monthly Report, dated 3/2024 and provided by the DON, revealed the following, in part: Covid positive, no hospitalization s, minor symptoms. No further positive after 3/5 [3/05/2024] . There were five resident names listed as being Covid-19 positive with the date 3/5/24 written next to each name. The DON reported 3/5/24 was the day testing was completed in the facility in response to a staff member becoming ill and subsequently testing positive for Covid-19. The DON could not provide information on the listed Covid-19 positive resident's symptoms, including what the symptoms were, when symptoms began or when the symptoms resolved. The DON stated all residents and staff were found to be negative through testing conducted on 3/06/24 and 3/08/24. The DON reported she did not systematically track infections which did not require antibiotic use. When asked if all communicable disease required antibiotic use, the DON stated no and that she understood the concern. The DON reported all residents with signs and symptoms of infectious disease were discussed with staff in a daily morning meeting, so staff were aware, but no official record of onset or resolution of illness was kept unless the resident was prescribed an antibiotic. Review of the facility policy titled Infection Control Surveillance and Outbreak Policy, last revised on 6/27/2024, revealed the following, in part: The purpose of the surveillance program is to determine the incidence and prevalence of nosocomial infections [facility-acquired infections] in order to implement strategies designed to prevent disease transmission . after the outbreak a Root Cause Analysis (RCA) will be done to identify and address performance improvement opportunities . On 7/8/2024 at 1:00 p.m., a request was made for all infection surveillance documents related to the March 2024 Covid-19 outbreak. A review of the documents revealed no RCA to identify what the facility did to mitigate the risk of spread of Covid-19, if the actions were effective, or if improvement was needed to mitigate the risk if another outbreak of respiratory illness should occur. 13791 Part B: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review, the facility failed to develop and implement laundry policies and procedures for residents' personal laundry, to prevent the transmission of resistant and difficult to eliminate pathogen infection. This deficient practice had the potential to affect all 26 residents. Findings include: On 7/1/24 a review of the facility's infection control policy for performing laundry services for transmission based pathogen sourced (including residents with C. diff; MRSA and Covid) laundry was reviewed. The policy was titled: Laundry Policy with an origination date of 7/11/23; Last Approved Date of 6/27/2024; and a Last Revised Date of 7/11/2023. Components of the policy stated the following: D. Laundry equipment will be used and maintained according to manufacturer's instructions. E. Laundry may be processed with low-temperature processes: 1. Low-temperature cycles: Wash with chemicals suitable for low-temperature washing at the proper concentration. 2. A 125 part per million (PPM) chlorine bleach rinse will be used to destroy microorganisms whenever possible. The section titled: Potentially contaminated laundry with Clostridium Difficile (C. Diff) stated: A. Laundry considered contaminated by C. Diff will be bagged in a red bag. Only items in red bags will be washed in the same load. B. Staff will wash the clothing with the following procedure: 1. 1/2 cup of bleach will be added once washer is full of hot water. 2. 1/2 cup of detergent then let machine agitate briefly. 3. Dump red bag into washer and run through the normal cycle. C. Bleach water should be a 1:10 bleach dilution as recommended by CDC On 7/2/24 at approximately 10:00 AM an interview was conducted with the Director of Nursing (DON) regarding the handling of potentially contaminated resident's personal clothing. The DON acknowledged the above policy was used with staff were using washing machines located on the resident unit, but stated staff no longer conducted laundry services of personal items from TBP (Transmission Based Precaution) sourced rooms. The DON stated this potentially contaminated laundry was sent down stairs and done by hospital laundry staff. The DON also acknowledged the some of the policy statements did not make sense including the use of 1:10 bleach dilution for laundry, which is generally a housekeeping and cleaning of high touch surface criteria. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/2/24 at approximately 10:30 AM, an interview was conducted with the hospital laundry manager (LM) B; Laundry staff (LS) C and maintenance supervisor (MS) D. It was learned the laundry department used yellow bags for potentially contaminated TBP sourced laundry from the long term care unit, in difference to the stated red bags. Also learned was that no added bleach or high water temperature wash cycles were used when cleaning these laundries. Upon looking behind the one washing machine used for this purpose, MS D identified the chemicals being dispensed into the machine were not connected correctly, stating that two of the buckets of chemicals were the same. Both LM B and LS C stated they were unaware of the need to utilize a chlorine disinfectant or monitor the levels of the disinfectant when used. The facility policy did not address the need to ensure that proper levels of the disinfectant were met during the washing process of the TBP sourced residents' clothing.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 41978 Based on interview and record review, the facility failed to ensure a qualified Infection Preventionist worked at least part-time at the facility and was present to properly assess, implement, and manage the Infection Prevention and Control Program resulting in the lack of outbreak surveillance and investigation and tracking of communicable diseases. Findings include: During an interview on 7/8/2024 at 10:31 p.m., the Director of Nursing reported she conducted all infection prevention and control duties for the facility. The DON reported she was in the process of completing an approved Infection Preventionist course but was having trouble finding the time. The DON stated Registered Nurse (RN) L was also in the process of completing the Infection Preventionist training, but neither the DON nor RN L had completed the courses as of 7/8/2024. The DON stated the hospital affiliate Infection Preventionist, RN Q acted as a resource for the facility Infection Prevention and Control Program. When asked how involved RN Q was in conducting infection prevention and control surveillance for the facility, the DON reported RN Q was a resource only, did perform actual oversight of the program and was not in the facility at least part-time. Review of the facility Infection Control Program with the DON at the time of the interview, revealed no outbreak investigation or symptom tracking for an outbreak of Covid-19 in March 2024. In addition, the DON reported she did not systematically track infections which did not require antibiotic use. When asked if all communicable disease required antibiotic use, the DON stated no and that she understood the concern. The DON reported all residents with signs and symptoms of infectious disease were discussed with staff in a daily morning meeting, so staff were aware, but no official record of onset or resolution of illness was kept unless the resident was prescribed an antibiotic. Review of the facility policy titled Infection Control Surveillance and Outbreak Policy, last revised 6/27/2024, and presented on 7/1/2024 at 11:31 a.m. as the facility guideline for the Infection Prevention and Control Program, revealed the policy did not include information regarding the regulatory need for a qualified Infection Preventionist to work on-site at least part-time in the facility.