STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235248	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village	1400 N Drake Rd Kalamazoo, MI 49006

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review the facility failed to provide a dignified dining experience for 2 (Resident #14 and #21) of 2 residents reviewed for dignity resulting in the potential for feelings of diminished self-worth, sadness, and frustration. Findings include: Resident #14 Review of Resident #14's Admission Record revealed Resident #14 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression. Review of Minimum Data Set (MDS) assessment for Resident #14, with a reference date of 10/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated Resident #14 was severely cognitively impaired. Review of Resident #14's Care Plan revealed, (Resident #14) is at nutritional risk due to receiving hospice care, needs assistance at meals-primarily dependent on staff . Resident #21 Review of Resident #21's Admission Record revealed Resident #21 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression and anxiety. Review of Minimum Data Set (MDS) assessment for Resident #21, with a reference date of 11/7/24 revealed a Brief Interview for Mental Status (BIMS) score of 1/15 which indicated Resident #21 was severely cognitively impaired. Review of Resident #21's Care Plan revealed, (Resident #21) is nutritionally at risk r/t (related to) . primarily totally dependent on staff at meals . (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an dining observation on 1/22/25 at 8:52 AM, Resident #14 and #21 sat at a table together and were assisted with eating their meal by Certified Nursing Assistant (CNA) X. CNA X was talking loudly to Dietary Staff (DS) KK about her plans for when she got out of work. CNA X was overheard by this writer stating, I am so ready to go home, I don't want to be here all day, I don't really want to be here at all today. DS KK and CNA X continued to carry on a personal conversation with each other for several minutes. It was noted that CNA X and DS KK did not interact with Resident #14 or Resident #21 at all during the meal. In an dining observation on 1/22/25 at 12:32 PM, Resident #21 was being assisted with eating by CNA X. CNA X was sitting at the table next to Resident #21 and CNA W. It was noted that CNA X had turned her back to Resident #21 and would only turn towards Resident #21 when she was assisting her with bites of food. It was also noted that CNA X was having a personal conversation with CNA W, and would only stop to offer Resident #21 bites of food when CNA W would begin interacting with the resident that he was assisting to eat. In an interview on 1/21/25 at 9:52 AM, Family Member (FM) N reported that they felt like the staff could improve on how they assist residents with eating in the dining room. FM N reported that they felt like the staff rushed residents, and did not take the time to interact with the residents when they were assisting them to eat. In an interview on 1/23/25 at 11:15 AM, Food Service Manager (FSM) LL reported that she supervised the dining area and would observe meal times frequently. FSM LL reported that she had previously voiced concerns with management about the way that staff behaved and interacted with and in front of the residents as they were eating in the dining room. FSM LL reported that she had witnessed staff using their phones, wearing ear buds, and ignoring residents they were assisting frequently in the dining room. FSM LL reported that she had voiced her concerns to management and they had posted signs about not using phones in the dining room, but she felt that improvement was still needed on how staff interacted with the residents as they were eating. FSM LL confirmed that CNA X was a staff member that she had observed ignoring the residents as she assisted them to eat on multiple occasions. In an interview on 1/23/25 at 12:18 PM, Health Care Manager (HC-M) E' reported that she had been made aware of staff using phones in the dining room while assisting residents in the past, but she was not aware that there were still concerns with the way that staff were interacting with residents in the dining room during meals. Using the reasonable person concept, though Resident #14 and Resident #21 had decreased ability to verbally express their own thoughts due to medical diagnoses, any reasonable person would likely feel a decreased sense of self-worth and frustration in the situations observed. Review of the facility's Dignity Policy last revised February 2021 revealed, Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Policy Interpretation and Implementation: 1. Residents are treated with dignity and respect at all times .5. When assisting with care, residents are supported in exercising their rights. For example, residents are: .e. provided with a dignified dining experience .

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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** 47955 Based on observation, interview, and record review the facility failed to implement care plan interventions for 2 (Resident #30 and Resident #21) of 12 residents reviewed for care plan implementation, resulting in the potential for skin breakdown for Resident #30 who's heel protectors (a padded cushion for a heel to rest in to prevent pressure caused from a heel resting directly on a mattress) not being consistently applied while in bed and Geri sleeves (sleeves worn to protect fragile skin from tearing) not being consistently applied for Resident #21 and Resident #30, and Resident #21 not consistently receiving a straw in her drinks at meals. Findings include: Resident #30 Review of an Admission Record revealed Resident #30 had pertinent diagnoses which included: Alzheimer's disease, restlessness and agitation, and repeated falls. Review of Order Summary for Resident #30 revealed Geri-sleeves to bilateral upper extremities (both arms) ON in AM and OFF in PM two times a day for fragile skin ordered on 9/5/2024. Review of Care Plan for Resident #30 revealed problem: is at risk for impaired skin integrity related to impaired mobility .intervention/task-heel protectors on when resident is in bed and float heels off of bed initiated 7/03/24 .Geri-sleeves to bilateral upper extremities ON in AM and OFF in PM initiated 9/4/24. During an observation on 1/21/25 at 9:04 AM., Resident #30 was in bed, her feet were uncovered. Resident #30's left foot was bare, with a noted scab on the top of the second toe, and her right foot had a non-skid sock in place. Neither foot had a heel protector on, and both heels were resting directly on the mattress. Resident #30's heel protectors were observed in the tan recliner on the other side of the room. At this same time, Resident #30's tan geri sleeves were observed balled together on top of the end table beside the soft brown recliner chair in her room. In an interview on 1/21/25 at 12:11 PM., Certified Nurse Assistant (CNA) V reported Resident #30 should wear heel protectors when in bed and they were not on Resident #30's feet when she got her ready today. In an observation on 1/21/25 at 12:12 PM., Resident #30's Geri sleeves were observed balled together on top of the end table beside the soft brown recliner chair that Resident #30 was sitting in, in her room. Resident #30's geri sleeves were in the same position they had been in earlier this day. During an observation on 1/22/25 at 8:08 AM., Resident #30 was in bed, sleeping, and her heel protectors were observed in the soft brown recliner in her room and not on her feet. In an interview on 1/22/25 at 12:11 PM., CNA CC reported Resident #30 should wear heel protectors while in bed and geri-sleeves when she is up. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 1/22/25 at 12:14 PM., Resident #30 was in her soft brown recliner chair in her room and her geri sleeves were noted on the end table next to her. In an observation and interview on 1/23/25 at 9:27 AM., Resident #30 was sitting at a table in the dining room waiting for breakfast to be served. Resident #30 did not have her Geri sleeves on. This surveyor asked Resident #30 about her geri sleeves and Resident #30 stated I guess we forgot them today. In an interview on 1/23/25 at 9:45 AM., CNA Y reported that Resident #30 should wear heel protectors when in bed and geri sleeves when she gets up. CNA Y reported that Resident #30 was assisted this morning by a hospice aide and CNA Y confirmed that Resident #30 was not wearing her geri sleeves. CNA Y obtained a new pair and applied Resident #30's geri sleeves. In an interview on 1/23/25 at 10:43 AM., Health Center Manager (HCM) E reported her expectations were that the care plan interventions and physician orders were followed, and that Resident #30 should have heel protectors on when in bed and geri sleeves on when up. HCM E reported Resident #30 does refuse to wear heel protectors and geri sleeves at times. HCM E reported that refusal to wear should be documented. Review of Treatment Administration Record for Resident #30 for the dates of 1/21/25, 1/22/25, and 1/23/25 revealed on 1/21/25 'Licensed Practical Nurse (LPN) JJ documented Resident #30 geri sleeves were on. On 1/23/25 Registered Nurse (RN) GG documented Resident #30 geri sleeves were on. On both dates, Resident #30 was observed without her geri sleeves on. In an interview on 1/23/25 at 11:51 AM Director of Nursing (DON) B reported her expectation was that the care plan interventions were followed by staff. Review of facility policy Care Plans, Comprehensive Person-Centered with a revision date of March 2022 revealed . Each resident's comprehensive person-centered care plan is consistent with resident's rights to participate in the development and implementation of his or her plan of care . receive the services and/or items included in the plan of care . 47659 Resident #21 Review of Resident #21's Admission Record revealed Resident #21 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression and anxiety. Review of Minimum Data Set (MDS) assessment for Resident #21, with a reference date of 11/7/24 revealed a Brief Interview for Mental Status (BIMS) score of 1/15 which indicated Resident #21 was severely cognitively impaired. Review of Resident #21s Care Plan revealed, (Resident #21) is nutritionally at risk . Interventions: Per families request, please provide a straw with every meal. Start date: 9/18/23 . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #21's Care Plan revealed, (Resident #21) is at risk for alteration in skin integrity . Interventions: . Geri Sleeves (Skin protectors that can be worn on the arms and legs to protect against skin tears and friction) to bilateral upper extremities, ON in the AM and OFF in the PM. Date initiated: 6/13/23 . In an dining observation on 1/22/25 at 12:32 PM, Resident #21 was being assisted by Certified Nursing Assistant (CNA) X. CNA X held a cup of juice for Resident #21 and gave her sips in between bites of food. It was noted that Resident #21's cup did not have a straw. In an observation on 1/22/25 at 1:00 PM, Resident #21 was sitting in her wheelchair in the dining room. It was noted that Resident #21 was not wearing geri sleeves on either of her arms. In an observation on 1/23/25 at 10:01 AM, Resident #21 was sitting in her wheelchair in her room. It was noted that that Resident #21 was not wearing geri sleeves on either of her arms. In an interview on 1/23/25 at 10:10 AM, CNA BB reported that she did not think that Resident #21 had ordered for geri sleeves. CNA BB reported that Resident #21 was supposed to have a straw with her drinks at meals, because her daughter had noticed that she drinks more fluids when she has a straw. In an interview on 1/23/25 at 11:15 AM, Food Service Manager (FSM) LL reported that Resident #21's Care Plan noted that she required a straw with her drinks per her daughter's request, and that the expectation was that staff would provide a straw for all drinks at every meal for Resident #21. In an interview on 1/23/25 at 12:12 PM, Registered Nurse (RN) GG reported that she did not think that Resident #21 needed to wear geri sleeves if she had a long sleeve shirt on. In an interview on 1/23/25 at 12:18 PM, Health Care Manager (HC-M) E reported that Resident #21's care plan indicated that she required geri sleeves to be worn every day, and that she also required a straw with drinks at meals. HC-M E reported that Resident #21's care plan did not indicate that she could wear long sleeve shirts instead of geri sleeves. HC-M E reported that it was her expectation that staff would be applying the geri sleeves every day for Resident #21 and providing straws with all of Resident #21's drinks.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on interview and record review, the facility failed to revise the nutrition care plan of one resident (Resident #344) of 12 residents reviewed for comprehensive care plans resulting in confusion regarding the diet and fluid restriction. Findings include: Resident #344(R344) Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R344 admitted to the facility on [DATE] with diagnoses including Stage 4 chronic kidney disease (kidney failure) and congestive heart failure (condition where the heart doesn't pump blood as it should). Brief Interview for Mental Status (BIMS) reflected a score of 13 out of 15 which indicated R344 was cognitively intact (13 to 15 cognitively intact). During an interview on 1/21/2025 at 10:23 AM, R344 reported that she had fluid retention in her legs which is an ongoing problem and she wishes it would go away. R344 also stated that she went to the hospital shortly after admission at the facility for fluid retention from congestive heart failure and renal disease. Review of R344's physician orders revealed 2 different nutrition orders. The first nutrition order revealed No concentrated sweets diet, Regular level 7 texture, regular/thin liquids (level 0) consistency. Under directions No added salt, 2000 ml (milliliter) fluid restriction qd (every day). The second order revealed No concentrated sweets diet, Regular level 7 texture, regular/thin liquids (level 0) consistency, fluid restriction 2000 ml/day. Dietary 1500 ml/day and nursing 500 ml/day. Under directions two times a day 2000 ml fluid restriction qd (every day). Review of the Dietary/Nutrition Evaluation-V 2.0 dated 1/10/2025 revealed Diet orders/Types specific to this resident: No added salt, NCS (no concentrated sweets) fluid restriction: yes, nursing fluid allowed per day (cc-cubic centimeter in volume; same as ml): 360, dietary fluid allowed per day (cc) :1140 6. Interventions fluid restriction 1500 ml qd no water at bedside. Review of R344's nutrition care plan revealed encourage fluids fluid Restriction: 2000ml per day, no water at bedside. Review of R344's individual service plan (ISP) that the certified nursing assistants (CNAs) have access to revealed Diet as ordered, honor food preferences as able. NCS diet, Regular texture, and regular/thin consistency liquids, Encourage fluid intake Fluid Restriction 2000 ml per day, no water pitcher at bedside, may have ice chips at bedside. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nutrition Note on 1/15/2025 completed by Food Service Manager (FSM) LL who was also the Certified Dietary Manager (CDM) revealed Per nursing/therapy: (R344) diet was upgraded to NAS/NCS (No added salt/No concentrated sweets) diet, regular texture and regular/thin consistency liquids Fluid restrictions was upgraded from 1500ml QD to 2000ml QD. Orders, care plan, Kardex have been updated. CDM will continue to monitor weights, labs, and FARS (food acceptance records). CDM will consult with IDT (interdisciplinary team) and RD (registered dietitian) as necessary. During an interview on 1/22/2025 at 1:04 PM, FSM LL stated that R344 should be on a NAS, NCS diet and 2000ml fluid restriction per day. FSM LL agreed that the care plan was confusing since it stated, encourage fluids and then has 2000 ml fluid restriction and stated she would talk to the Registered Dietitian. FSM LL agreed that on R344's ISP, NAS was missing on the diet since it wasn't on the care plan and didn't carry over. She also stated that she usually divides up fluid restriction between nursing and dietary and forgot to update it on the care plan which would show up on the ISP. FSM LL reported that nursing should get 360 ml of fluid a day and dietary should have 480 ml with each meal which leaves 200 ml for any other fluid during the day such as soups. During the interview, FSM LL updated the care plan and ISP to indicate she was on a NAS diet and fluid restriction divided between nursing and dietary and took out encourage fluids. During an interview on 1/23/2025 at 8:58 AM, Rehab Nurse Manager (RNM) F stated that she agreed that the care plan and ISP were confusing indicating to encourage fluids and then she was on a fluid restriction. RNM F reported that nursing was giving different amounts of fluid than what FSM LL had noted. RNM F stated she would talk to the FSM LL and the Registered Dietitian and make sure the care plan and ISP are updated to reflect the correct diet and fluid restriction. Review of the Care Plans, Comprehensive Person-Centered Policy with a revision date of March 2022 revealed Policy Interpretation and Implementation 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to provide assistance with eating for 1 (Resident #5) of 12 residents reviewed for activities of daily living (ADL) care resulting in the potential for avoidable negative physical outcomes for resident's who are dependent on staff for assistance. Findings include: Resident #5 Review of Resident #5's Admission Record revealed Resident #5 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia. Review of Resident #5's Care Plan revealed, (Resident #5) is at nutritional risk r/t (related to) receiving hospice care, gradual weight loss over past year, continued gradual weight loss in past 30 days, physical debility/decreased muscle mass . date revised on 10/26/24. Interventions: Offer set-up assist and verbal cues and encouragement q (every) meal. Date initiated: 6/14/23 Review of Resident #5's LCS Dietary/Nutrition Profile Note dated 10/25/24 revealed, .H. Oral Status. 2. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. E. Substantial/maximal assistance. 3. Adaptive Equipment: needing up to total assistance in the past 7 days . K. Nutritional Risk . 2. At risk for unintentional weight loss: yes. 3. If yes, please explain: Receiving Hospice care and showing gradual weight losses . Needing increased assistance at meals . In a interview on 1/21/25 at 9:52 AM, Family Member (FM) N reported that they had concerns with the facility's process for assisting residents in the dining room. FM N reported that they had frequently noticed residents in the dining room that needed more assistance with their meals than the facility provided. FM N reported concerns that the facility did not have enough staff in the dining room to monitor and assist residents when they ate. In an interview on 1/21/25 at 12:45 PM, CNA V reported that Resident #5 only needed verbal reminders from staff to eat. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an dining observation on 1/21/25 at 12:53 PM: Resident #5 was sitting at a table with her lunch plate in front of her untouched. It was noted that Resident #5 was closing her eyes. Certified Nursing Assistant (CNA) V approached Resident #5 and offered and assisted Resident #5 to take a spoonful of her meal. Resident #5 ate the spoonful of food that CNA V offered her. After Resident #5 ate the spoonful of food, CNA V left Resident #5's table to assist another resident out of the dining room. It was noted that after CNA V left Resident #5, she did not continue to eat and sat looking at her plate of food. Resident #5 was noted to attempt to take a drink of water from her cup, but her hands were too shaky for her to hold the cup, and she was unable to bring the cup to her mouth. At 12:57 PM, CNA V returned to Resident #5 and offered her a spoonful of her lunch which Resident #5 accepted. After CNA V offered and assisted Resident #5 with one spoonful of food, she left to assist another resident. It was noted that once CNA V left Resident #5, she did not continue to eat, and stared at her plate of food again. In an observation on 1/22/25 at 12:11 PM, CNA EE reported that she was unable to identify all the residents that required assistance with eating. CNA EE reported that most of the residents required assistance and that staff did the best they could to assist everyone that needed help. In an interview on 1/22/25 at 12:15 PM, CNA AA reported that Resident #5 did not require assistance with eating. In an observation on 1/22/25 at 12:17 PM, Resident #5 was sitting at the dining room table with a full plate of food in front of her that included mashed potatoes, vegetables, turkey, stuffing. Resident #5 also had a parfait dessert in a plastic cup. Resident #5 was sitting at the table staring at her plate with her food untouched. Resident #5 grabbed a fork and attempted to gather some of the turkey and mashed potatoes onto her fork, but was not able to. Resident #5 tried to maneuver her fork to get food onto it for a few minutes before she put the fork down and continued to stare at her plate. At 12:32 PM, CNA AA approached Resident #5 and verbally reminded Resident #5 to eat and then left Resident #5 seated at the table unassisted. Resident #5 continued to stare at her plate of food. At 12:51 PM, CNA W approached Resident #5 and verbally reminded Resident #5 to eat and asked if she was not hungry. Resident #5 told CNA W that she needed more time. CNA W left Resident # 5 and she continued to stare at her plate. At 12:59 PM, CNA AA approached Resident #5 and verbally reminded her to eat and offered to assist her. It was noted that with the assistance of CNA AA, Resident #5 began to take spoonfuls of her dessert parfait. After Resident #5 began to take spoonfuls of her parfait, CNA AA left Resident #5. Resident #5 continued to attempt to eat her parfait. It was noted that Resident #5 struggled to get the spoonfuls of food to her mouth, and spilled a lot of the food onto her lap and the floor. At 1:09 PM, CNA AA returned to Resident #5 and asked if she was ready to go back to her room. Resident # 5 agreed and left the dining room. It was noted that her plate of mashed potatoes, vegetables, turkey and stuffing remained untouched. In an interview on 1/23/25 at 10:10 AM, CNA BB reported that Resident #5 needed frequent verbal reminders to eat during meals because she would just sit there until she falls asleep. CNA BB did not think that staff needed to assist resident with eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/23/25 at 11:15 AM, Food Service Manager (FSM) LL reported that she did not think that Resident #5 required assistance with eating. FSM LL reported that staff needed to provide verbal reminders to Resident #5 because she would sometimes fall asleep at the table. When this writer queried about Resident #5's most recent LCS Dietary/Nutrition Profile Note dated 10/25/24 which indicated that Resident #5 had required up to total assistance, FSM LL was unable to report why Resident #5 had not been receiving more assistance at meals based on that note. FSM LL was unable to report what the expectation was for how often staff should be observing and reminding Resident #5 to eat. FSM LL confirmed that she had noticed that when Resident #5 was more lethargic, she did require more assistance. FSM LL reported that it was challenging for the facility to meet the needs of all of the residents in the dining room that required assistance with eating. FSM LL reported that she had voiced her concerns about this challenge to management, but that she was told that they had adequate staff in the facility to assist with dining. In an interview on 1/23/25 at 12:18 PM, Health Care Manager (HC-M) E reported that she did frequently observe dining, but she had not observed Resident #5 recently, and was unaware that Resident #5 required assistance with eating.

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Friendship Village	1400 N Drake Rd Kalamazoo, MI 49006

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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** 48637 Based on observation, interview and record review, the facility failed to ensure gait belt (a strap with a buckle that helps residents who have trouble walking or standing. Gait belts are used to support patients and help them move safely) use while ambulating one resident (Resident #343) of two residents reviewed for falls resulting in a fall and potential for injury. Findings include: Resident #343(R343) Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R343 admitted to the facility on [DATE] with diagnoses including tibia fracture (shinbone fracture), left patellar fracture (broken kneecap) and nondisplaced bilateral S4 fracture (sacral fracture, a triangular shaped bone at the base of the spine that hasn't moved out of place). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R343 was cognitively intact (13 to 15 cognitively intact). During an interview on 1/21/2025 at 10:49 AM, R343 stated that she fell and had fractures prior to coming to the facility and then she fell 2 times after she was admitted to the facility. R343 stated that a gait belt wasn't used for one of the falls when she was walking with her walker to the bathroom with a Certified Nursing Assistant (CNA). She said the CNA tried catching her and she fell to the ground. Review of the fall report dated 1/12/2025 revealed Resident SBA (stand by assist) with walker to bathroom per therapy, resident walking with CENA, resident fell backwards, staff member lowered her to the ground. upon assessment resident sitting on the floor in front of bathroom door with walker and CNA, Resident ASSESSED NO INJURY v/s (vital signs) WNL (within normal limits). Current Status: (R343) requires up to the following staff assist: Substantial/maximum level of assist x1 for bed mobility, dressing, toilet use, personal hygiene and bathing, Substantial/maximum level of assist x1 for transfers and ambulation using gait belt/ Wheelchair. Use of a gait belt wasn't indicated on the fall report. Review of the post fall evaluation dated 1/12/2025 revealed walking unsteady gait, increased weakness and inability to sustain balance while walking, resident also stated she likes to hurry and has to remind herself to slow down. Review of R343's fall risk evaluation dated 1/12/2025 revealed Fall Risk: History of falls (past 3 months): 1-2 falls in past 3 months . Notes: FALL WITH FRACTURES Gait / balance: Balance problem while walking. Gait / balance: Decreased muscular coordination. Gait / balance: Change in gait pattern when walking through doorway. Gait / balance: Jerking or unstable when making turns. Gait / balance: Requires use of assistive devices (i.e. cane, wheelchair, walker, furniture). Gait / balance: Balance problem while standing . Fall Risk Score: 18.0 which indicates she was a high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R343's fall risk evaluation dated 1/9/2025 revealed Fall Risk: History of falls (past 3 months): 1-2 falls in past 3 months . Gait / balance: Requires use of assistive devices (i.e. cane, wheelchair, walker, furniture). Gait / balance: Balance problem while standing . Fall Risk Score: 12.0 which indicated she was a high risk for falls. During an interview on 1/23/2025 at 9:46 AM, CNA Z reported that she was the CNA with R343 when she fell on [DATE]. CNA Z stated that she was taking R343 out of the bathroom and R343 was using her walker and she was walking by her side with the wheelchair and she didn't use a gait belt. CNA Z said she received gait belt training but she doesn't think about using a gait belt with residents and is used to transferring residents without one. During an interview on 1/23/2025 at 11:09 AM, Director of Nursing B and Health Center Nurse Manager (HCNM) E stated that that they don't have a gait belt policy but gait belts should be used with all transfers. During an interview on 1/23/2025 at 11:17 AM, Rehab Director (RD) Q stated that a gait belt should be used with transfers when a resident needs assistance from a staff member. During an interview on 1/23/2025 at 11:27 AM, Occupational Therapist (OT) M stated that a gait belt should always be used when a resident is a 1-person assistance with staff. OT M stated that R343 needed assistance so a gait belt should always be used with her. OT M also said that R343 told her that staff wasn't using a gait belt when she fell on [DATE]. During an interview on 1/23/2025 at 12:15 PM, CNA T stated that a gait belt should always be used for transfers or when ambulating a resident when they need assistance. During an interview on 01/23/2025 at 12:29 PM CNA BB reported that a gait belt should always be used for transfers or when ambulating a resident when they need assistance. Review of CNA Z's Skills Fair Required Learning Stations on 1/7/2025 revealed 7. Lift and Gait Belt Training: demonstrate proper use of a sit to stand lift and hoyer lift. Demonstrate proper gait belt placement and transfer technique. The box was checked to show it was completed. Review of CNA Z's Transfer Training and Ergo (Ergonomics) quiz dated 11/19/2024 revealed that CNA Z answered the questions appropriately regarding use of a gait belt 3. True: use a gait belt with all transfers unless contraindicated. Review of CNA Z s new hire paperwork revealed transfers and gait belts skills were completed on 10/29/2024. During another interview on 1/23/2025 at 12:28 PM, DON B stated she wasn't aware that a gait belt wasn't used with R343's fall on 1/12/2025. 47955 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 12:45 PM., Certified Nurse Assistant (CNA) AA was observed walking with Resident #13 from the dining room down hall 1. CNA AA was holding on to left sleeve of Resident #13's fleece jacket, while Resident #13 used a front wheeled walker to ambulate. Resident #13 was not wearing a gait belt.

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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. 47955 Based on observation, interview, and record review the facility failed to ensure accurate oxygen administration via nasal cannula (a tube with prongs into the nostrils of the nose to deliver additional oxygen to a body's blood) to 1 (Resident #4) of 1 reviewed for respiratory care, resulting in the resident not consistently receiving her oxygen at the level ordered. Findings include: Resident #4 Review of an Admission Record revealed Resident #4 had pertinent diagnoses which included: acute respiratory failure with hypoxia (caused when lungs cannot deliver enough oxygen or remove enough carbon dioxide from the body's blood). Review of Order Summary for Resident #4 revealed PRN (as needed), shortness of breath, wheezing O2 (oxygen) @ (at) 3L (liters) via nasal cannula, high flow cannula .as needed for hypoxia . started 8/27/2024 . Titrate Oxygen to keep O2 sat (blood oxygenation readings) @ 2-3 L via nasal cannula .< (greater than) 90% (percent). two times a day . started 7/23/2024. Review of Care Plan for Resident #4 revealed problem, oxygen therapy r/t (related to) Hypoxia . intervention/tasks . administer oxygen as ordered. On 1/21/25 at 10:43 AM., Resident #4 was observed sitting in her wheelchair, in her room, with a nasal cannula on her face and connected to the oxygen concentrator (machine that delivers oxygen) with the setting of 2L for oxygen delivery. On 1/22/25 at 8:40 AM., Resident #4 was observed lying in her bed in her room with a nasal cannula on her face and connected to the oxygen concentrator with the settings of 1.5L for oxygen delivery. On 1/22/25 at 12:07 PM., Resident #4 was observed sitting in her wheelchair in the dining room with a portable tank of oxygen present on the back of her wheelchair, with a nasal cannula connected to the tank and on the resident's face, with the setting on the tank of 1.5L for oxygen delivery. A tag was noted on the oxygen tank that revealed Resident #4's oxygen delivery settings were 1.5L. In an interview on 1/22/25 at 12:31 PM., Certified Nurse Assistant (CNA) X reported Resident #4's oxygen settings was 1L. CNA X reported that the oxygen settings were written on the tag present on the oxygen tank on the Resident's wheelchair. CNA X reported the tag was the only place she knew to get the oxygen settings for a resident. CNA R was present during this interview, and when CNA X reported Resident #4's oxygen settings were 1L CNA R asked CNA X Are you sure? and then CNA R stated I don't think so as her response to Resident #4's oxygen settings being 1L. CNA R reported she would have to confirm with the nurse what Resident #4's oxygen setting should be. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/23/25 at 8:24 AM., CNA T reported Resident #4's oxygen settings was 1L, and that was what was written on the tag on the oxygen tank on the back of Resident #4's wheelchair. CNA T reported the setting on the oxygen concentrator for Resident #4 was whatever it is when you turn it on. On 1/23/25 at 8:30 AM., Resident #4's oxygen tank on the back of her wheelchair, while she was eating breakfast in the dining room revealed a tag with 1.5L written on it and the tank dial turned to 1.5L of oxygen to be delivered through her nasal cannula. In an interview on 1/23/25 at 9:50 AM., Licensed Practical Nurse (LPN) FF reported Resident #4's oxygen orders were for 2L PRN via nasal cannula. LPN FF reported that Resident #4's oxygen liter flow could be adjusted per the assessment of her oxygen sats (reading that indicated how much oxygen was in the body) that was completed and documented by the nurse. In an interview on 1/23/25 at 9:57 AM., LPN FF reviewed the oxygen orders for Resident #4 and confirmed there were two active orders, and the orders included 2L or 2-3L. LPN FF reported that the nurses could titrate (adjust the flow of oxygen up or down) Resident #4's oxygen according to her O2 sats. LPN FF confirmed with this surveyor that Resident #4's oxygen concentrator in her room was set to 1.5L and Resident #4 was wearing the nasal cannula that was connected to the concentrator. LPN FF also confirmed that the tag attached to the oxygen tank on back of Resident #4's wheelchair did indicate that the tank setting was to be 1.5L. LPN FF reported she had no idea who changed the orders. Review of Treatment Administration Record (TAR) for Resident #4 for dates 1/22/25, and 1/23/25 revealed LPN FF documented that Resident #4's oxygen was titrated to maintain O2 sats <90%. No noted documentation of Resident #4's O2 sats was in the TAR. Review of O2 Sats Summary for Resident #4 revealed no O2 Sat documentation for 1/22/25 nor 1/23/25. In an interview on 1/23/25 at 10:55 PM., Health Center Manager (HCM) E reported Resident #4's oxygen order was PRN, and there was an order to titrate her oxygen as needed. HCM E reported she was aware there was an issue with the order, and it was now cleared up with the provider. New orders were being entered. In an interview on 1/23/25 at 12:03 PM., Director of Nursing (DON) B reported her expectation was that physician orders were followed. DON B reported she discussed Resident #4's oxygen orders with the provider and the order was changed immediately. Review of facility policy Medication Order with a revision date of November 2014, revealed oxygen orders-when recording orders for oxygen, specify the rate of flow, route and rationale.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to accurately document meal intake for 2 (Resident #5 and Resident #30) of 12 residents reviewed for complete and accurate medical records resulting in an inaccurate reflection of the resident's meal intakefor Resident #5 and an inaccurate reflection of care provided for Resident #30. Findings include: Review of Resident #5's Admission Record revealed Resident #5 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia. Review of Resident #5's Care Plan revealed, (Resident #5) is at nutritional risk r/t (related to) receiving hospice care, gradual weight loss over past year, continued gradual weight loss in past 30 days, physical debility/decreased muscle mass . date revised on 10/26/24. Interventions: Monitor food consumption and offer sub (substitution) if 50% or more is uneaten, document intake of meals. Date initiated: 6/14/23 . In an observation on 1/22/25 at 12:17 PM, Resident #5 was sitting at the dining room table with a full plate of food in front of her that included mashed potatoes, vegetables, turkey, stuffing. Resident #5 also had a parfait dessert in a plastic cup. Resident #5 was sitting at the table staring at her plate with her food untouched. Resident #5 grabbed a fork and attempted to gather some of the turkey and mashed potatoes onto her fork, but was not able to. Resident #5 tried to maneuver her fork to get food onto it for a few minutes before she put the fork down and continued to stare at her plate. At 12:32 PM, CNA AA approached Resident #5 and verbally reminded Resident #5 to eat and then left Resident #5 seated at the table unassisted. Resident #5 continued to stare at her plate of food. At 12:51 PM, CNA W approached Resident #5 and verbally reminded Resident #5 to eat and asked if she was not hungry. Resident #5 told CNA W that she needed more time. CNA W left Resident # 5 and she continued to stare at her plate. At 12:59 PM, CNA AA approached Resident #5 and verbally reminded her to eat and offered to assist her. It was noted that with the assistance of CNA AA, Resident #5 began to take spoonfuls of her dessert parfait. After Resident #5 began to take spoonfuls of her parfait, CNA AA left Resident #5. Resident #5 continued to attempt to eat her parfait. It was noted that Resident #5 struggled to get the spoonfuls of food to her mouth, and spilled a lot of the food onto her lap and the floor. At 1:09 PM, CNA AA returned to Resident #5 and asked if she was ready to go back to her room. Resident # 5 agreed and left the dining room. It was noted that her plate of mashed potatoes, vegetables, turkey and stuffing remained untouched. Review of Resident #5's Amount Eaten tasks revealed that on 1/22/25 staff had documented that Resident #5 had eaten 51-75% of her lunch. It was noted that this documentation occurred at 12:43 PM, but Resident # 5 had not finished eating until 1:09 PM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/23/25 at 11:15 AM, Food Service Manager (FSM) LL reported that a plate of food that was untouched and a half eaten dessert parfait would not be considered 51-75% intake of a meal. FSM LL reported that the facility did not have any guidance on how staff should determine what percentage of meal intake they should be documenting, and that they just used best judgement. FSM LL confirmed that it was her expectation that her staff were not documenting meal intake prior to the resident finishing the meal. FSM LL confirmed that the facility relied on accurate documentation of meal intake to monitor resident's nutritional needs. 47955 Resident #30 Review of an Admission Record revealed Resident #30 had pertinent diagnoses which included: Alzheimer's disease, restlessness and agitation, and repeated falls. Review of Order Summary for Resident #30 revealed Geri-sleeves to bilateral upper extremities (both arms) ON in AM and OFF in PM two times a day for fragile skin ordered on 9/5/2024. Review of Care Plan for Resident #30 revealed problem: is at risk for impaired skin integrity related to impaired mobility .intervention/task-heel protectors on when resident is in bed and float heels off of bed initiated 7/03/24 .Geri-sleeves to bilateral upper extremities ON in AM and OFF in PM initiated 9/4/24. During an observation on 1/21/25 at 9:04 AM., Resident #30 was in bed, her feet were uncovered. Resident #30's left foot was bare, with a noted scab on the top of the second toe, and her right foot had a non-skid sock in place. Neither foot had a heel protector on, and both heels were resting directly on the mattress. Resident #30's heel protectors were observed in the tan recliner on the other side of the room. At this same time, Resident #30's tan geri sleeves were observed balled together on top of the end table beside the soft brown recliner chair in her room. In an observation on 1/21/25 at 12:12 PM., Resident #30's Geri sleeves were observed balled together on top of the end table beside the soft brown recliner chair that Resident #30 was sitting in, in her room. Resident #30's geri sleeves were in the same position they had been in earlier this day. In an interview on 1/22/25 at 12:11 PM., CNA CC reported Resident #30 should have geri-sleeves on when she is up. In an observation on 1/22/25 at 12:14 PM., Resident #30 was in her soft brown recliner chair in her room and her geri sleeves were noted on the end table next to her. In an observation and interview on 1/23/25 at 9:27 AM., Resident #30 was sitting at a table in the dining room waiting for breakfast to be served. Resident #30 did not have her Geri sleeves on. This surveyor asked Resident #30 about her geri sleeves and Resident #30 stated I guess we forgot them today. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/23/25 at 9:45 AM., CNA Y reported that Resident #30 should wear geri sleeves when she gets up. CNA Y reported that Resident #30 was assisted this morning by a hospice aide and CNA Y confirmed that Resident #30 was not wearing her geri sleeves. CNA Y obtained a new pair and applied Resident #30's geri sleeves. Review of Treatment Administration Record for Resident #30 for the dates of 1/21/25, 1/22/25, and 1/23/25 revealed on 1/21/25 'Licensed Practical Nurse (LPN) JJ documented Resident #30 geri sleeves were on. On 1/23/25 Registered Nurse (RN) GG documented Resident #30 geri sleeves were on. On both dates, Resident #30 was observed without her geri sleeves on. Review of the facility's Charting and documentation policy last revised July 2017 revealed, Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional or psychosocial condition, shall be documented in the resident ' s medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident ' s condition and response to care .Policy Interpretation and Implementation .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . According to Legal and Ethical Issues in Nursing, 4th Edition, ([NAME], G, 2006), A major responsibility of all health care providers is that they keep accurate and complete medical records. From a nursing perspective, the most important purpose of documentation is communication. The standards for record keeping attempt to ensure patient identification, medical support for the selected diagnoses, justification of the medical therapies used, accurate documentation of that which has transpired, and preservation of the record for a reasonable time period. Documentation must show continuity of care, interventions used, and patient responses. Nurses' notes are to be concise, clear, timely, and complete.