STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235399	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Portage	7855 Currier Dr Portage, MI 49002

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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. 41424 Based on observation, interview, and record review, the facility failed to provide an environment that promoted and enhanced resident dignity for 1 resident (Resident #6) of 3 reviewed for dignity, resulting in the potential of feelings of embarrassment, loss of self-worth, and decreased quality of life. Findings include: Resident #6: Review of an Admission Record revealed Resident #6 was a male with pertinent diagnoses which included dementia, dysphagia (difficulty swallowing foods or liquids), stroke, muscle weakness, diabetes, nutritional anemia (the body does not get enough iron or a few other nutrients from their diet), contracture of left hand, acute subdural hemorrhage (traumatic head injury, such as a blow to the head or a fall), idiopathic orofacial dystonia (involuntary, spasmodic movements of the muscles of the orofacial (mouth and face), masticatory (chewing muscles), and lingual (tongue) region and torticollis (rare condition which the neck muscles contract, causing the head to twist to one side). Review of current Care Plan for Resident #6, revised on 9/9/23, revealed the focus, .Resident has an ADL self care performance deficit related to: Adult failure to thrive, tardive dyskinesia, to thrive, chronic pain, T2DM, prostate CA, schizophrenia, left hand contracture, muscle cramps, BPH (enlarged prostate gland), restless leg syndrome, incontinence, traumatic subdural hemorrhage, anxiety, anemia, GERD, IBS, vascular dementia, dysphasia . with the interventions .EATING: Feeds self with set up assistance .DRESSING: 1 person assist . During an observation on 2/28/24 at 3:20 PM, Resident #6 was observed seated in his wheelchair by the nurse's station between the station and the wall heading towards the hallway entrance. He was observed leaning to the left side, moving his feet but was not self-propelling or ambulating anywhere. Resident #6 was observed to have 5-6 whole peas on the left chest area of his shirt with various dried food and liquids spilled on the left chest area of his shirt running down the front of his shirt. Resident #6's shorts were observed to have dried food scattered all over the front of his shorts, in his lap, and down the legs of the short. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/28/24 at 3:26 PM, Certified Nursing Assistant (CNA) AA walked passed him and did not speak to him, offer assistance to propel him to his destination or make note of his soiled shirt and shorts and offer to get him cleaned up. CNA X walked passed him as well and did not greet him, offer assistance to propel him in his wheelchair, or make note of his dirty shirt and shorts and offer to get him cleaned up. During an observation on 2/29/24 at 9:26 AM, Resident #6 was observed in his room seated in his wheelchair with his tray table and breakfast in front of him. He had the spoon in his right hand and was holding it in a bowl of oatmeal, he held the spoon in the bowl for a few moments and slowly brought it up to his mouth with his hand shaking and large pieces of oatmeal were falling of the spoon. It appeared his right hand was twisted to the inside of his wrist. Resident #6 leaned to the left while sitting in his wheelchair, head tilted forward appearing as if his left side of his jaw and chin were resting on his left shoulder/chest area. Resident #6 did not drool out the side of his mouth. During an observation on 2/29/24 at 09:28 AM, Resident #6 lifted the spoon slowly bringing it to his mouth with his hand shaking and spilled some on his pant leg on the left side. In an interview on 2/29/24 at 9:29 AM, Licensed Practical Nurse (LPN) CC reported he normally eats in the dining room but he woke up late today. LPN CC reported the staff don't bring clothing protectors to the rooms. They only have them in the dining room. Usually they would grab a towel and cover the resident. LPN CC reported if Resident #6 soiled his clothing while eating the staff would change his clothes. During an observation on 2/29/24 at 9:33 AM, Resident #6 had chunks of oatmeal down the left side of his shirt into his vest down into the chest area. During an observation on at 2/29/24 at 12:22 PM, Resident #6 was sitting in his room in his wheelchair with oatmeal down the left front of the vest he was wearing. As he leans to the left, his clothing gathers on that side creating a concave space where food gathers. In an interview on 2/29/24 at 10:40 AM, CNA E reported she would assist the resident with ambulation if they wanted, remove the larger food items on their clothing. In an interview on 2/29/24 at 10:53 AM, CNA O reported she would assist the resident with ambulation if they needed assistance; she would not just leave them in the middle of the hallway. CNA O reported she would offer to clean the resident up and change their shirt if it had food on it or food dried on it. In an interview on 2/29/24 at 2:30 PM, Director of Nursing (DON) B reported she would expect the facility staff to assist the resident with ambulation if they were struggling and needed assistance. She reported she would have expected the staff, if the resident's clothing was soiled, to talk with the resident and change the resident's clothing. Review of policy, Resident Rights revised on 1/1/22, revealed, .11. The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to ensure a call light was accessible to two residents (R89 and R93) of 22 residents reviewed for accommodations of needs, resulting in the potential of unmeet care needs. Findings include: R89 According to the Minimum Data Set (MDS) dated [DATE], R89 scored 2/15 on her BIMS (Brief Interview Mental Status) indicating the resident was severely cognitively impaired. The resident had no impairment in her arms or legs with diagnoses that included Alzheimer's disease. Observed on 2/27/24 at 10:40 AM, R89 was in bed with her eyes closed. The bed was against the wall on the resident's right side with the call light on the floor under the bed out of sight and reach of the resident. R93 According to the Minimum Data Set (MDS) dated [DATE], R93 did not have a BIMS score indicating her cognition. Her functional abilities in Section GG reported her as having an impairment on one side of her body affecting her arm and leg. Diagnoses included a stroke with partial paralysis. During an observation on 2/27/24 at 10:45 AM, a call light was clipped to the privacy curtain behind R93's head-of-bed, out of sight and reach of the resident. During an observation and interview on 2/27/24 at 10:49 AM, Certified Nursing Assistant (CNA) W stated, (R93) has a push type call light. The CNA then turned around and looked at the call light clipped to the privacy curtain and stated, I did not see the call light there. The last time I checked on her was 8:30 this morning when I was feeding her. I did not notice the call light then either. During an interview on 2/27/24 at 1:41 PM, CNA DD stated, Call lights should be kept within reach of residents; any resident no matter if they can use it or not. During an observation and interview on 2/28/24 at 12:42 PM, while touring R93's room, Licensed Practical Nurse (LPN) TT observed with surveyor, resident's soft touch call light clipped to resident's left side below the left edge of the perimeter mattress out of sight and reach of resident. LPN stated, The call light should be available to the resident. During an interview on 2/28/24 sat 1:27 PM, Unit Manager TT stated, Call lights should be accessible to all residents when in their rooms.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview, and record review, the facility failed to accurately complete Minimum Data Set (MDS) assessments in 1 of 22 residents (Resident #80) reviewed for accuracy of assessments, resulting in an inaccurate reflection of the resident's status. Findings include: Resident #80 Review of an Admission Record revealed Resident #80 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: adult failure to thrive. Review of a MDS assessment for Resident #80, with a reference date of 12/14/23 indicated 0 unhealed pressure ulcers, 2 venous and arterial ulcers, and was checked for diabetic foot ulcers. Review of a Significant Change of Condition MDS assessment for Resident #80, with a reference date of 9/23/23 indicated 0 unhealed pressure ulcers, 0 venous and arterial ulcers, and was checked for diabetic foot ulcers. In an interview on 02/29/24 at 02:18 PM, MDS Nurse QQ reported that the information used to complete the MDS assessment was taken from actual observation of the resident's skin, nursing skin/wound assessments, treatment administration records, progress notes, medical diagnoses, and wound doctor notes. MDS Nurse QQ reported that the physician noted on 8/16/23 that Resident #80 had an unstageable pressure ulcer and the wound clinic notes indicated a Stage 3 pressure ulcer on 8/30/23. MDS Nurse QQ reported that Resident #80's Significant Change of Condition MDS assessment on 9/15/23 should have indicated a new unhealed pressure ulcer. Review of Resident #80's Physician Progress Note dated 8/16/2023 revealed, .recently treated in the hospital for aspiration pneumonia sepsis .work-up in the hospital showed old multiple pelvic fractures, she was found to have a left heel pressure ulcer unstageable .Documentation reviewed .Plan: .Unstageable left heel ulcer with discharge-continue calcium alginate dressing . Review of Resident #80's Wound Doctor Consultation Note dated 8/30/23 revealed, .Assessment/Findings: Stage 3 pressure ulcer with possible arterial insufficiency .New Orders: 1. left foot/heel xray: r/o (rule out) osteomyelitis (inflammation in the bone that is caused by a skin infection) . In an interview on 02/29/24 at 10:33 AM, Wound Nurse (WN) Y reported that Resident #80 acquired wounds on both heels while in the facility; the left heel wound was identified on 6/21/23, and the right heel wound in September 2023. WN Y reported that both wounds are located over a bony prominence, and the interventions put in place were to offload pressure to promote healing. WN Y reported that she assessed the wounds weekly and the facility provider called them diabetic wounds, therefore, that is how they were documented. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 02/29/24 at 11:04 AM, Resident #80 was sitting in her wheelchair in her room, wearing blue protective boots and her feet were laying turned outward. RN T reported that the wounds on Resident #80's heels have came a long way. Observation of Resident #80's right lateral (side) heel was an area of dark thickened skin approximately the size of a quarter. Observation of Resident #80's left lateral (side) heel was a thick dark brown scab approximately the size of a quarter. In an interview on 02/29/24 at 11:43 AM, Nurse Practitioner (NP) RR reported that Resident #80's heel wounds were classified as diabetic ulcers due to her history of diabetes, regardless of the location of the wound being over a bony prominence. NP RR reported that Resident #80 was not eating well and was not getting out of bed as much when the wounds started. NP RR reported that she does not always physically assess wounds, but she reviews the photos that the wound nurse takes, and was not able to recall when the last physical assessment was performed. NP RR reported that the bone scan and/or vascular work-up that was recommended by the wound clinic was not obtained due to the resident's general health at that time. In an interview on 02/29/24 at 01:10 PM, Unit Manager-Registered Nurse (UM-RN) Q reported that Resident #80 had developed areas of softness and redness on both heels in April of 2023, and that the facility implemented skin prep (protective skin treatment) and repositioning. UM-RN Q reported that Resident #80's left heel wound was discovered in June 2023 and then in September 2023 an additional wound was discovered on her right heel. UM-RN Q reported that Resident #80 was a diabetic and that any wound below the waist would have been diagnosed as a diabetic ulcer, and not a pressure ulcer.

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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** 46999 Based on observation, interview, and record review, the facility failed to develop person centered, comprehensive care plans for 2 residents (Resident #408 and Resident #82) of 22 sample residents reviewed for care planning, resulting in a potential for re-traumatization of a Resident with PTSD (post-traumatic stress disorder), and a potential for unmet care needs for a resident with an implanted medical device. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident 's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident 's written plan of care . Resident #408 Review of an Admission Record dated 2/25/23 revealed Resident #408 was admitted to the facility with pertinent diagnoses that included: depression. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Inventory for Mental Status (BIMS) score of 15/15 which indicated Resident #408 was cognitively intact. Review of a current Care Plan for Resident #408 dated 9/14/23 revealed the focus, .Resident is at risk for/has an impaired mood/psychiatric status related to depression .with intervention the intervention .observe for signs of mood changes or distress . Review of a Social Services Progress Review dated 11/17/23 revealed section E (Trauma Informed Care, question 1, Does resident have a diagnosis of Post-Traumatic Stress Disorder (PTSD) .the documented answer: No. Review of a Nursing Progress Note documented on 12/31/23 at 7:23pm revealed Resident #408 sought out a nurse following an encounter with his roommate and stated, I have PTSD and I've had thoughts of hurting that son of a b*tch. The nurse documented Nursing Home Administrator (NHA) A was immediately informed. (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 interview on 2/28/24 at 1:53pm, Registered Nurse (RN) L reported Resident #408 had several roommates in the past that he was not comfortable with, and that she learned the resident had PTSD (Post Traumatic Stress Disorder) from his military service when she talked with him. RN L reported Resident #408 told her that he had the urge to hit his former roommate when he awoke and saw his roommate standing over him. RN L reported the facility had several residents who received services from a governmental agency because they were disabled from military service. RN L confirmed that a resident with PTSD required person centered care to maintain their psychosocial wellness. In an interview on 2/28/24 at 3:36pm, Resident #408 sat on the edge of his bed, his eyes were directed downward throughout the interview and when asked, he confirmed was diagnosed with PTSD related to his service in the military. Resident #408 reported the roommate he had in December frequently invaded his personal space, sorted through his personal belongings, and appeared manipulative. Resident #408 reported on the evening of 12/31/23, he awoke and saw the roommate standing over him. Resident #408 stated it really upset me when I woke up and that guy was standing over me. It triggered me from my time in the service. Resident #408 reported he worried he would get another roommate that did similar things that would cause him to relapse with symptoms of PTSD. Resident #408 gestured toward his current roommate and stated I worry what kind of roommate I'll get when he leaves. I don't want to go through that situation again. In an interview on 2/29/24 at 9:34am, Care Coordinator (CC) II from the government agency that services to military veterans, reported Resident #408 should have person-centered interventions in place for his diagnosis of PTSD and without a proper care plan, the resident's psychosocial wellness may not be maintained. CC II reported it was likely Resident #408 would experience re-traumatization if he was placed with a roommate that exhibited the behaviors that had triggered his distress in December of 2023. In an interview on 2/29/24 at 2:01pm, Nursing Home Administrator (NHA) A confirmed she was notified that Resident #408 was upset with his roommate. NHA A reported the information the staff member reported did not clearly explain that Resident #408 was experiencing symptoms of PTSD and as a result, it was acted upon immediately or shared with social services. In an interview on 2/29/24 at 10:28am, Social Services Director (SSD) D reported she had reached out to the governmental agency involved in Resident #408's care and learned he had a diagnosis of PTSD. SSD D reported Resident #408 should have a care plan in place to outline interventions that would avoid further re-traumatization because without a care plan, Resident #408 could be assigned a roommate with the same types of behaviors that caused his distress in December. Review of an Active Problems list dated 2/28/24, generated by the governmental agency for military veterans, revealed Resident #408 had a diagnosis of chronic PTSD. 38384 R82 According to the Minimum Data Set (MDS) dated 1.17.24, R82 scored 15/15 (cognitively intact) on her BIMS (Brief Interview Mental Status) with diagnoses that included urinary tract infections within the last 30 days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/24 at 2:13 PM, R82 reported she had been seen the day prior by an urologist regarding her InterStim (InterStim therapy implantable device for overactive bladder and urinary retention). During an interview on 2/28/2023 at 1:27 PM Licensed Practical Nurse (LPN) N stated, (R82) has a bladder stimulator. She came to the facility with it. She has been seeing a urologist while here and has another appointment in April (2024). Review of R82's Hospital Summary, 10/20/23 reported bladder stimulator. Review of R82's Nursing Admission Evaluation 10/22/23 reported the resident was incontinent of bladder with no mention of a Interstim. Review of R82's Care Plan, 10/24/2023, reported the resident had impaired genitourinary status related to overactive bladder, urge incontinence, incontinence, and polyuria (abnormal large amounts of urine). The goal was to be free of altered genitourinary status. An internal bladder stimulator was not included in the resident's specific plan of care. Review of R82's Progress Note 1/3/2024 14:36 (4:36 PM) reported the resident has a bladder stimulator that per resident was non-functioning. Review of R82's Progress Note 1/4/2024 09:41 (AM), reported the facility received a phone call back from urology related to the bladder stimulator not functioning. Review of R82's 1/26/24 Urology Report reported the resident presented with urinary urgency and InterStim check that was not helping her with urinary symptoms. The resident had a prior history of InterStim stage I and II on 10/20/2018, InterStim lead removal and replacement on 9/25/2019, with InterStim battery pocket revision on 4/14/2021. Review of R82's Progress Note 1/29/2024 12:09 (PM) reported the resident went to follow up with urology; they did adjust her bladder stimulator and follow up in one month. Review of R82's Progress Note 2/28/2024 09:43 reported the resident went to follow up with urology on 2/27/24 to recheck her Interstim with talk of getting the device replaced. During an interview and record review on 2/29/24 at 10:29 PM, Director of Nursing (DON) B reviewed R82's medical record stating, There is no care plan for (R82's) InterStim in her bladder. That should be in the care plan to direct resident care. Every morning during the IDT (interdisciplinary team) meeting, if something is discussed that needs to be put in a care plan it is done then. If, outside of that meeting, something comes up any nurse can create or revise a care plan. It should be done. (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 facility policy Baseline Care Plan revised 1/1/2022, reported Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care . Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident .The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary care plan . The facility may develop a comprehensive care plan in place of the baseline care plan . Review of facility policy Comprehensive Care Plan revised 6/30/2022, reported, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment (Minimum Data Set) . Definitions: Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives . The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care . The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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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** 41424 Based on observation, interview, and record review, the facility failed to ensure assistance with activities of daily living (ADL) care was provided for 1 (Resident #6) of 2 residents reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for resident's dependent on staff for assistance. Findings include: Resident #6: Review of an Admission Record revealed Resident #6 was a male with pertinent diagnoses which included dementia, dysphagia (difficulty swallowing foods or liquids), stroke, muscle weakness, diabetes, nutritional anemia (the body does not get enough iron or a few other nutrients from their diet), contracture of left hand, acute subdural hemorrhage (traumatic head injury, such as a blow to the head or a fall), idiopathic orofacial dystonia (involuntary, spasmodic movements of the muscles of the orofacial (mouth and face), masticatory (chewing muscles), and lingual (tongue) region and torticollis (rare condition which the neck muscles contract, causing the head to twist to one side). Review of current Care Plan for Resident #6, revised on 9/9/23, revealed the focus, .Resident has an ADL self-care performance deficit related to: Adult failure to thrive, tardive dyskinesia, to thrive, chronic pain, T2DM, prostate CA, schizophrenia, left hand contracture, muscle cramps, BPH (enlarged prostate gland), restless leg syndrome, incontinence, traumatic subdural hemorrhage, anxiety, anemia, GERD, IBS, vascular dementia, dysphasia . with the interventions .DRESSING: 1 person assist .PERSONAL HYGIENE: 1 person assist . Review of Minimum Data Set (MDS) dated [DATE], revealed, .A. Eating: Setup or clean-up assistance - Helper SETS UP or CLEANS UP; resident completes activity .F. Upper body dressing: ability to dress and undress above the waist .Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity . During an observation and interview on 2/27/24 at 2:35 PM, Resident #6 was self-ambulating in a wheelchair by using a hand railing on D Hall. Caught under his wheelchair was a yellow plastic Caution sign. His facial hair appeared to be unshaven with several days of growth for a reasonable person. His head was tilted towards his left shoulder. Housekeeping observed the caution sign and removed the sign. Resident #6 who was in his wheelchair next to his bed was observed with food on resident's face and in the folds of his sweatshirt on his chest. During an observation on 2/28/24 at 3:20 PM, Resident #6 was observed seated in his wheelchair by the nurse's station between the station and the wall heading towards the hallway entrance. He was observed leaning to the left side, moving his feet but was not self-propelling or ambulating anywhere. Resident #6 was observed to have 5-6 whole peas on the left chest area of his shirt with various dried food and liquids spilled on the left chest area of his shirt running down the front of his shirt. Resident #6's shorts were observed to have dried food scattered all over the front of his shorts, in his lap, and down the legs of the short. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Portage	7855 Currier Dr Portage, MI 49002

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During and observation at 2/28/24 at 3:26 PM, Certified Nursing Assistant (CNA) AA walked past him and did not speak to him, offer assistance to propel him to his destination or make note of his soiled shirt and shorts and offer to get him cleaned up. CNA X walked past him as well and did not greet him, offer assistance to propel him in his wheelchair, or make note of his dirty shirt and short and offer to get him cleaned up. During an observation on 2/29/24 at 9:26 AM, Resident #6 was observed in his room seated in his wheelchair with his tray table and breakfast in front of him. He had the spoon in his right hand and was holding it in a bowl of oatmeal, he held the spoon in the bowl for a few moments and slowly brought it up to his mouth with his hand shaking and large pieces of oatmeal were falling of the spoon. It appeared his right hand was twisted to the inside of his wrist. Resident #6 leaned to the left while sitting in his wheelchair, head tilted forward appearing as if his left side of his jaw and chin were resting on his left shoulder/chest area. Resident #6 did not drool out the side of his mouth. In an interview on 2/29/24 at 9:29 AM, Licensed Practical Nurse (LPN) CC reported if Resident #6 soiled his clothing while eating, the staff would change his clothes. During an observation on 2/29/24 at 9:33 AM, this writer observed Resident #6 with chunks of oatmeal down the left side of his shirt into his vest down into the chest area. During an observation on at 2/29/24 at 12:22 PM, Resident #6 was observed sitting in his room in his wheelchair with oatmeal down the left front of the vest he was wearing. As he leans to the left, his clothing gathers on that side creating a concave space where food gathers. In an interview on 2/29/23 at 2:53 PM, Certified Nursing Assistant (CNA) OO reported Resident #6 when he needed cleaned up, never denied any care from him. CNA OO reported if you talk to him, explained what you wanted to do, he did not have any problems from Resident #6. CNA OO reported if he needed his shirt changed, he would let me change his shirt. In an interview on 2/29/23 at 2:54 AM, CNA NN reported she didn't have any problems with Resident #6. She reported if you approached him respectfully and let him know what you were doing, he wouldn't give her any problems, just need to explain to him and he would be receptive of care as she knows others have had issues with him. CNA NN reported Resident #6 allowed her to clean him up and to change his clothes as needed. In an interview on 2/29/24 at 02:37 PM, Director of Nursing (DON) B reported she would expect the nursing staff to assist Resident #6 with any personal hygiene he needed completed and if he had a soiled shirt and/or pants, she would expect the staff to assist him in cleaning up and changing the shirt and/or pants. Review of policy, Activities of Daily Living (ADLs) revised on 1/1/2022, revealed, .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 This citation has two Deficient Practice Statements (DPS). DPS 1 Based on observation, interview, and record review, the facility failed to ensure a safe environment and adequate safety measures for one resident (R9) of 22 residents reviewed for accidents and hazards, resulting in a fall with injury and the potential of additional falls with injuries. Findings include: According to the Minimum Data Set (MDS) dated [DATE], R9 scored 2/15 on her BIMS (Brief Interview Mental Status) indicating the resident was severely cognitively impaired, experienced bowel/bladder incontinence. The resident had no impairment in her arms or legs, high-risk medications included antianxiety, antidepressant and sedative medications. Section J1900- two or more falls since admission. Review of R9's Diagnoses included dementia, diastolic congestive heart failure, hypertension, anxiety, major depressive disorder recurrent mild, urinary tract infection (1/15/2024), repeated falls (1/9/2024), pain in left leg, developmental disorders of speech and language, dependence on wheelchair, generalized muscle weakness, and insomnia. During an observation and interview on 2/27/24 at 11:38 AM, R9 was in her room awake and supine (positioned on back) sitting up in bed. On the middle of her forehead were two scabbed over lacerations, with her left cheek and eye having multiple shades of bruising. The resident's bed was positioned with the head-of-bed (HOB) against wall and both sides open. A fall mat was on the floor to the right side of the bed. There was no fall mat to the left side of the bed. The resident reported she liked to drink water as she tried twice to drink from her empty drinking cup. Resident asked surveyor to have her brief changed because she was soiled. Review of R9's Incident Report (IR) #771 dated 1/3/2024 20:50 (8:50 PM) reported the resident had an unwitnessed fall in her room. She was found laying on the floor beside her bed. R9 told staff she was getting up to go downstairs. The resident's care plan had been updated to include encourage and assist resident up in her wheelchair when anxious/restless and calling out. Staff had last seen the resident at 2040 (8:40 PM) in bed. Staff statements included resident was laying under her bed laughing was on the floor with her head under the foot of the bed closest to the door last checked at 8:30 (PM). Was told by co-worker resident was on the floor, was happy, smiling, saying she was going out. It was noted that the side of the bed the resident was found was not indicated. Review of R9's Fall Initial Report 1/3/2024 reported the resident had fallen on this date while trying to go out. Interventions were updated in care plan included frequent observations. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R9's Care Plan 1/3/2024 Risk of falls/injury Revision 12/26/2023. Focus was related to unsteadiness on feet, dementia, congestive heart failure, hypertension, anxiety, generalized muscle weakness, reduced mobility, pain, neuropathy, constipation, insomnia, and depression. The resident chooses not to use her call light and attempts to self-transfer/ambulate at times. It was noted the resident could not complete her BIMS due to severely impaired cognition. The goal was to reduce the risk of injury through the next review. Frequent observations as reported in the Fall Initial Report 1/3/2024 was not an updated intervention after R9's fall on 1/3/2024. Review of R9's IR #777 dated 1/8/2024 00:30 (AM) reported the resident had an unwitnessed fall in her room. She was heard calling out and observed laying on the right bedside floor with her head towards the foot of the bed. The resident had been incontinent of diarrhea. The resident's care plan had been updated to include a medication review for bowel medications. The resident was receiving a constipation medication with a history of bowel obstruction. Staff statements included The resident was incontinent of bowel and bladder the resident was on her back lying on the floor with her head toward the foot of bed .had previously last seen by this nurse at 2300 (11 PM) saw her on the floor on the opposite side of the bed with head toward the door. It was noted the side of the bed the resident was found was not indicated. However, the last witness statement saw her on the floor on the opposite side of the bed with head toward the door indicates the resident was on the left side of the bed. Review of R9's Fall Initial Report 1/8/2024 reported the resident had fallen on this date. The resident was laying in bed sleeping prior to the fall. Interventions were updated in care plan included floor mat on right side of bed. Review of R9's Care Plan 1/8/2024 Risk for Falls/Injury updated interventions did not include Fall mat to right bedside floor when resident is in bed as reported in the Fall Initial Report 1/3/2024 until 2/19/2024 when the resident fell and sustained lacerations to her forehead that required medical attention. Review of R9's IR #864 dated 2/18/2024 19:30 (7:30 PM) reported the resident had an unwitnessed fall in her room. The resident could be heard calling out from the hallway. She was found resting supine of the floor next to her bed bleeding from her forehead. An assessment presented with impairment to R9's forehead and arm. The resident was sent to the ER (emergency room) for evaluation. R9's care plan was updated to include referral to therapy for evaluation of side rails, discontinue wheelchair at bedside, and fall mat to right bedside floor when resident in bed. Staff statements included resident was put to bed around 1920 (7:20 PM). Resident was checked and changed during this time. It was noted the side of the bed R9 was found not indicated. Review of R9's Fall Initial Report 2/18/2024 reported the resident had fallen on this date and was sent to the ER for further evaluation of a forehead injury. The resident was laying in bed and was toileted at 7 PM prior to the fall. Interventions updated in the care plan included vital sign monitoring may include orthostatic (laying/sitting/standing blood pressure). Review of R9's Care Plan 2/19/2024, Risk for Impaired Skin Integrity -Left forearm skin tear 2/15/2024 -Left eyebrow laceration with 2 staples (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Forehead laceration with 3 staples The goal was for the resident was to have intact skin. No interventions were documented for the lacerations. Review of R9's Care Plan Risk of falls/injury updated interventions did not include vital sign monitoring may include orthostatic (laying/sitting/standing blood pressure) as reported in the Fall Initial Report 2/18/2024. Review of R9's Order Summary revealed: -2/19/2024 Fall mat to right bedside floor when resident is in bed every day and night shift. -2/26/2024 Forehead laceration: Cleanse and pat dry. Apply A&D ointment to scab area and cover with a large bandage every day shift for wound care. -2/26/2024 Forehead laceration: Cleanse and pat dry. Apply A&D ointment to scab area and cover with a large bandage as needed. -2/26/2024 left eyebrow laceration/scab: Leave OTA (open to air). Notify MD/NP of any negative changes every day shift for wound care. -2/26/2024 left forearm scab: Apply skin prep. -2/21/2024 Monitor bruising to face: notify MD/NP of abnormal changes every day and night shift DC (discontinue) upon completion. Observed on 2/27/24 at 1:27 PM, on the floor to R9's right side was a fall mat. No fall mat was on the floor to the resident's left side. Observed on 2/28/24 at 9:05 AM, on the floor to R9's right side was a fall mat. No fall mat was on the floor to the resident's left side. During an observation, interview, and record review on 2/28/24 at 1:27 PM, Licensed Practical Nurse (LPN) N stated, (R9) falls out of bed. Staff cannot figure out what she is doing. One time she was screaming before she fell . She was referred to therapy. She always falls to the right that is why the fall mat is only to her right side. She panics when being moved in bed, even when she is turned by staff. She has never been seen to fall to the left. She initially had a perimeter standard sized mattress so staff got her a bariatric bed to see if that would help her. Grab bars were tried but she did not use them, so they were removed. She was sent to the emergency room (ER) after her last fall and has a few staples in the laceration. During an observation and interview on 2/29/24 at 8:30 AM, LPN CC with surveyor toured R9's bed area. A fall mat was on the floor to the right side of the resident. There was no fall mat to the left side of the bed. LPN stated, I do not know why there is not a fall mat on the left side of her (R9's) bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview and record review on 2/29/24 at 11:00 AM, Therapy R stated, (R9) crosses her left leg over right leg and leans more to the right. She is inconsistent with her body position but mostly it is to her right side. I do not know if she would fall to the left because she mainly leans to the right. Review of R9's Nursing Quarterly/Significant Change Evaluation 2/29/2024 reported the resident scored 16.0 (Falls-High Risk). The resident had had 1-2 falls in the last 90 days with the most recent fall on 2/18/2024. Her mobility was described as confined to chair. Balance while standing, sitting, and during transitions was not able to attempt without physical help. Review of R9's Progress Note 2/19/2024 16:36 (4:36 PM) IDT-Interdisciplinary reported the clinical team reviewed the resident's fall report from 02/18/24 at 1930 (7:30 PM). The report stated This resident was observed resting supine on the floor next to her bed. Neurochecks and vital signs were completed, a head-to-toe assessment was completed with impairment noted to forehead and arm. Notifications made per facility protocol and order obtained from (name of Nurse Practitioner) to send the resident to the ER for evaluation. This resident was also referred to therapy to assess her grab bars because she is using them to self-transfer out of bed. A fall mat was then placed to the right, bedside floor (while the resident is in bed.) Staff will continue to monitor these new interventions for efficacy. Review of R9's NP Progress Note 2/19/2024 09:29 (AM) reported as a hospital extended care note, the resident had been seen in the ER after a fall and had a laceration on the forehead. The note indicated R9 had received staples that would require removal in approximately seven days. The diagnosis after evaluation indicated the resident received a concussion and two lacerations to the forehead, one that measured 2.5 cm (centimeters) and required stitches. Bruising was present on the resident's face. Review of R9's Progress Note 2/22/2024 10:19 (AM) reported occupational therapy had assessed the resident and at that time did not require bilateral grab bars. Review of R9's Progress Note 2/25/2024 14:31 (2:31 PM) reported the skin tear to the resident's left forearm was healing. No dressing was applied at that time. A scabbed area was OTA. Review of facility policy Fall Prevention Program revised 1/1/2022, revealed, .Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls . Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care . Interventions will be monitored for effectiveness .The plan of care will be revised as needed . When any resident experiences a fall, the facility will . Review the resident's care plan and update as indicated . 38905 DPS 2 Based on observation and interview, the facility failed to minimize the risk of scalding and burns by allowing domestic hot water to exceed 120 F. This resulted in an increased risk of injury among residents who are ambulatory. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Findings Include: During a tour of the B hall shower room, at 3:18 PM on 2/27/24, it was observed that no shower head was located on the shower. When asked if this room was still used for given resident showers, Maintenance Director (MD) S stated yes, but he wasn't sure where the shower head has gone or when it was used last. During a tour of the facility, with MD S, at 3:30 PM on 2/27/24, observation of empty resident rooms B-9 and B-11 found that the shared bathroom sink reached 136F when tested with a rapid read thermometer. At this time, an interview with MD S found that each hall has its own hot water supply. When asked why the water temperature would be so high, MD S stated the lack of hot water usage on this hall might have helped stack the hot water and deliver high temperatures. During a tour of the facility, at 3:36 PM on 2/27/24, observation of the B hall soiled utility room found that hot water reached 135F after running for one minute and sustained the temperature. During a revisit to the B hall spa room, at 3:39 PM on 2/27/24, found the hot water from the sink reached 133F while running while MD S was actively flushing hot water from the system to help decrease the temperature. During a revisit to the D-hall spa room, at 4:50 PM on 2/27/24, it was observed that the spa room sink reached a hot water temperature of 127F. During a tour of resident room C-2, at 4:55 PM on 2/27/24, it was observed that the bathroom sink was found to reach 126F. During a tour of resident room A-1, at 4:58 PM on 2/27/24, it was observed that the bathroom sink was found to reach 123F. During an interview with MD S at 8:15 AM on 2/28/24, in the B hall boiler room, found that the their plumbing vendor came yesterday and discovered that the mixing valve was not working properly as it dispensed hot water to resident care areas and will need to be repaired. When asked about the about the excess hot water in the other hallways, MD S stated the water heaters have been readjusted to maintain hot water levels below 120F. During an interview with MD S, at 10:40 AM on 2/28/24, the surveyor asked if the facility kept track of the hot water temperatures and if they could provide a log of temperatures for the domestic hot water. MD S stated his staff performs the logs and he could get them. During an interview with MD S at 11:10 AM it was found that he can't find the book used to document hot water temperatures. No documentation was provided.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on interview, and record review, the facility failed to ensure that a resident who was a trauma survivor received care and services that addressed their psychosocial needs in 1 of 3 residents reviewed (Resident #408) for trauma-informed care, resulting in Resident #408 experiencing emotional distress, and thoughts of physical aggression toward others. Findings include: Review of Key ingredients for Successful Trauma Informed Care published by the Substance Abuse and Mental Health Services Administration (SAMHSA), 2021, revealed trauma informed care acknowledges the need to understand a patient's life experiences to deliver effective care . Resident #408 Review of an Admission Record dated 2/25/23 revealed Resident #408 was admitted to the facility with pertinent diagnoses that included: depression. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Inventory for Mental Status (BIMS) score of 15/15 which indicated Resident #408 was cognitively intact. Review of a current Care Plan for Resident #408 dated 9/14/23 revealed the focus, .Resident is at risk for/has an impaired mood/psychiatric status related to depression .with intervention .observe for signs of mood changes or distress . Review of a Social Services Progress Review dated 11/17/23 revealed section E (Trauma Informed Care, question 1, Does resident have a diagnosis of Post-Traumatic Stress Disorder (PTSD) .the documented answer: No. Review of a Nursing Progress Note documented on 12/31/23 at 7:23pm revealed Resident #408 sought out a nurse following an encounter with his roommate and stated, I have PTSD and I've had thoughts of hurting that son of a b*tch. The nurse documented Nursing Home Administrator (NHA) A was immediately informed. In an interview on 2/28/24 at 1:53pm, Registered Nurse (RN) L reported Resident #408 had several roommates in the past that he was not comfortable with. RN L reported she learned from the resident that he had PTSD (Post Traumatic Stress Disorder- a mental health condition triggered by a terrifying event with symptoms that may include flashbacks, uncontrollable thoughts, and anxiety) from his military service. RN L reported Resident #408 told her that he had the urge to hit his former roommate when he awoke and saw someone standing over him. RN L reported Resident #408 appeared upset about having thoughts of hurting someone. RN L reported the facility had several residents with prior military service, and all received services from a governmental agency because they were disabled from military service. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/29/24 at 11:29am, Registered Nurse (RN) L reported she did not know what trauma informed care was. RN L reviewed her education record and reported she completed computer-based learning for Trauma Informed Care within the last twelve months but did not recall any information from the training. In an interview on 2/28/24 at 2:41pm, Social Services Director (SSD) D reported Resident #408's only psychiatric diagnosis was depression. SSD D reported Resident #408 was a recipient of services from a government organization that cares for veterans who had a service-related disability, and the resident had a care coordinator from that organization. SSD D reported she had not communicated with the care coordinator to determine if Resident #408 had a diagnosis of PTSD. SSD D also reported she was not aware of the situation that arose between Resident #408 and his roommate on 12/31/23. In an interview on 2/28/24 at 3:36pm, Resident sat on the edge of his bed, with his eyes directed downward and when asked, he confirmed he had a diagnosis of PTSD related to his service in the military. Resident #408 reported the roommate he had in December frequently entered his personal space, sorted through his personal belongings, and appeared manipulative. Resident #408 reported on the evening of 12/31/23, he awoke and saw the roommate standing over him. Resident #408 stated it really upset me when I woke up and that guy was standing over me. It triggered me from my time in the service. Resident #408 reported he worried he would get another roommate that did similar things and that would cause him to relapse with symptoms of PTSD. Resident #408 gestured toward his current roommate and stated I worry what kind of roommate I'll get when he leaves. I don't want to go through that situation again. In an interview on 2/29/24 at 9:34am, Resident #408's Care Coordinator (CC) II from the government agency, reported Resident #408 had a diagnosis of chronic PTSD related to war-time combat. CC II reported Resident #408's PTSD was significant and caused 50% of his status of being disabled. CC II reported her agency provided a diagnosis list for each resident at the time of their admission, and that a thorough assessment of a resident by the facility was important to provide adequate care. CC II reported the facility was responsible for the resident's care, should have known if a resident had a diagnosis of PTSD, and should have implemented interventions to avoid re-traumatization. CC II stated implementation of interventions to avoid re-traumatization would minimize the risk of (Resident #408) experiencing a psychosocial decline. Review of an Active Problems list dated 2/28/24, generated by the governmental agency for military veterans, revealed Resident #408 had a diagnosis of chronic PTSD. In an interview on 2/29/24 at 10:28am, Social Services Director (SSD) D reported she had reached out to the government agency involved in Resident #408's care and learned he had a diagnosis of PTSD. SSD D reported it was her responsibility to ensure residents were paired with roommates that would be the most compatible, and that she should have been informed of the situation that arose between Resident #408 and his previous roommate. SSD D reported Resident #408 should also have a care plan in place to provide interventions that would mitigate his PTSD triggers, including roommates with certain behaviors. Review of Room Change Record revealed Resident #408 moved to another room on 1/3/24, 2 days after he voiced concern that he might harm his roommate because his PTSD was triggered by the roommate's actions. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Trauma Informed Care with a reference date of 10/24/22 revealed .Potential causes of re-traumatization by staff may include .being unaware of the resident's traumatic history .failing to provide adequate safety . Review of a facility policy titled Trauma Informed Care with a reference date of 10/24/22 revealed .Potential causes of re-traumatization by staff may include .being unaware of the resident's traumatic history .failing to provide adequate safety .

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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** 41027 Based on interview and record review, the facility failed to discontinue psychotropic medications prescribed as needed (PRN), after 14 days and/or document rationale to extend prn psychotropic medication use in 1 of 5 residents (Resident #80) reviewed for unnecessary medications, resulting in the potential for adverse side effects and inability to monitor the effectiveness of the prescribed treatment due to lack of documented supporting evidence. Findings include: Resident #80 Review of an Admission Record revealed Resident #80 was originally admitted to the facility on [DATE], with pertinent diagnoses which included, alzheimer's disease. In an interview on 02/28/24 at 10:26 AM, Family Member (FM) SS reported that Resident #80 had anxiety in the afternoon, and that the facility applied a cream to calm her down. FM SS reported that it was her understanding that the cream had not been working, and that was why the resident was being prescribed an new antidepressant medication. Review of Resident #80's Medication Orders revealed, Ativan gel 0.5mg/1 ml .every 4 hours as needed for agitation/aggression related to Alzheimer's disease . Start date 8/15/2023. There was no end date on the order. In an interview on 02/29/24 at 10:21 AM, Unit Manager (UM) Q reported that Resident #80 had frequent behaviors, and had a current order for PRN Ativan, that had been in place for greater than 14 days, with no end date. UM Q reported that Resident #80 had used the PRN Ativan 12 times in the month of February. UM Q did not know the physician's rationale for writing the PRN Ativan order. In an interview on 02/29/24 at 11:36 AM, Nurse Practitioner (NP) RR reported that the facility should be writing PRN orders for Ativan for 14 days and then reevaluating the need. NP RR reported that she wrote Resident #80's order for the PRN Ativan and did not document a rationale or duration for the medication. NP RR reported that she did not know when Resident #80 was last evaluated, and did not regularly document about Ativan, because the resident saw psychiatry and behavioral health services to manage the medication. Review of Resident #80's Psychiatry Progress Notes from 7/10/23 through 1/8/24 did not list Ativan in the past, current and/or recommended medication lists. There were no notes related to Ativan. Review of Resident #80's Behavioral Health Notes from 8/7/23 through 1/23/24 did not list Ativan in the past, current and/or recommended medication lists. There were no notes related to Ativan. Review of Resident #80's Monthly Medication Regimen Reviews since August 2023 did not indicate any irregularities related to the PRN Ativan orders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed to ensure 1). proper hand hygiene was performed during brief change for one resident (R89), 2). adequate condition for cleanliness of personal equipment (R89), and 3). appropriate PPE (Personal Protection Equipment) use in a Transmission-Based Precautions Isolation room, of 22 residents reviewed for infection control, resulting in the potential for bacterial harborage, cross contamination, and the spread of disease to a vulnerable population. Findings include: R89 According to the Minimum Data Set (MDS) dated [DATE], R89 scored 2/15 on her BIMS (Brief Interview Mental Status) indicating the resident was severely cognitively impaired. The resident had no impairment in her arms or legs with diagnoses that included Alzheimer's disease. Hand Hygiene During an observation and interview on 2/27/24 at 10:49 AM, Certified Nursing Assistant (CNA) DD entered R89's room with CNA W to perform a brief change. CNA DD donned (applied) gloves without performing hand hygiene. R89 had a small bowel movement (BM) in her brief along with urine. CNA DD used wipes to clean the resident's BM and private area with CNA W assisting. Without changing gloves after cleaning the soiled areas, CNA DD applied a clean brief, clean clothes, and a mechanical lift sling to R89. CNA DD then doffed (removed) gloves, touched the resident's privacy curtain and moved a bedside table to the hall. CNA W removed her gloves, and without performing hand hygiene, took the bag of soiled items to the soiled utility room. CNA DD and W then transferred R89 from her bed to a wheelchair. Both CNAs searched R89's dresser and bed area for geri-sleeves (slide on protection against skin tears). CNA DD found the geri-sleeves on the floor and put them on the resident reporting the sleeves should be put in the wash after using them that day and finding them on the floor. During an interview on 2/27/24 at 10:49 AM, CNA W stated, Hand hygiene should be done when entering and leaving a resident's room, and when gloves become soiled during a brief change. During an interview on 2/27/24 at 1:41 PM, CNA DD stated, Hand hygiene should be done after changing a soiled brief and putting residents in clothing. During an interview on 2/29/24 at 2:02 PM, Nursing Home Administrator (NHA) A and Director of Nursing (DON) B stated, Hand hygiene should be done when staff enter and exit a resident room. During soiled brief changing, hand hygiene and changing out gloves should be done after the dirty brief is handled. Hands should be cleaned and new gloves put on before touching a clean brief, clothing, bedding; anything. Staff have been educated on hand hygiene. NHA A stated, Hand hygiene should be done during brief changing for infection control purposes. PERSONAL EQUIPMENT (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observed on 2/27/24 at 10:40 AM, R89 was in bed with the right side against the wall. A recliner positioned to the left side of the resident's bed was torn and tattered on the footrest underneath where the resident would place her feet with foam exposed across the entire end of it. The right arm of the chair was also torn and tattered with exposed foam. Observed on 2/27/24 at 1:42 PM, R89 was in bed with the right side against the wall. A recliner positioned to the left side of the resident's bed was torn and tattered on the footrest underneath where the resident would place her feet with foam exposed across the entire end of it. The right arm of the chair was also torn and tattered with exposed foam. During an observation and interview on 2/29/24 at 11:30 AM, Nursing Home Administrator (NHA) A stated while touring R89's room with surveyor, I was told by a nurse yesterday that (R89's) recliner was torn with the foam coming out of it. I think when she sits up in it her feet rub on the bar in the footrest and has put the tear in it. Observed R89 sitting in the chair with the footrest extended. The resident's feet were not in the same area of the tear and protruding foam. The right arm of the chair was torn at the end with foam exposed and sticking out. The left arm of the chair was tattered. The NHA stated, The footrest has been repaired before either with staples or sewn. It would be an infection control concern if something was spilled on it. 46999 In an interview on 2/27/24 at 9:17am, Nursing Home Administrator (NHA) A reported one resident (Resident #408) tested positive for Influenza A that morning and he and his roommate (Resident #409) were in quarantine. The residents in quarantine were in Room C13. NHA A reported droplet precautions were in effect for those residents. During an observation on 2/27/24 at 11:05am, a 9x11 brightly colored sign that stated :Special Droplet Precautions, Everyone must clean hands when entering, wear mask, wear eye protection, gown and glove at the door hung on the door frame of room C13. A personal protective equipment (PPE) cart was in the hallway under the sign. During an observation on 2/27/24 at 11:14am, Occupational Therapist (OT) FF and Certified Nursing Assistant (CNA) J entered room C13 without donning any PPE. The staff members assisted Resident #409 out of bed and into a standing position. Resident #409 then walked into the hallway as OT FF walked alongside and held on to a gait belt that was wrapped around Resident #409's waist. Neither Resident #409 or OT FF wore any PPE until they had walked at a slow pace, approximately 50' down the hallway. CNA J then donned a surgical mask onto the resident's face. The resident pulled the mask below his nose, exposing his nostrils throughout the remainder of the time he was in the hallway, approximately 7 minutes. Several residents and staff nearby in the hallway at the time. In an interview on 2/27/24 at 11:19am, CNA J reported one of the residents in room C13 had tested positive for Influenza A that morning and as a result, both residents were in quarantine. CNA J reported she should have donned a mask, eye protection, gloves, and a gown prior to entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/27/24 at 11:21am, OT FF reported she overlooked the infection control precautions sign on the door frame of room C13 and that she should have donned a mask, gloves, eye protection, and gown prior to entering the room. OT FF reported Resident #409 should have worn a mask during the time that he was in the common area/hallway to reduce the risk of other resident's contracting influenza. OT FF confirmed that her lack of use of PPE for herself, and lack of proper use of PPE for Resident #409 were breaches of the facility's infection control process and could result in further spread of illness. In an interview on 2/29/24 at 12:47pm, Infection Preventionist (IP) Y reported both residents in Room C13 were under droplet precautions effect approximately 9:00am on 2/27/24. When queried about how staff were informed when infection control precautions were implemented, IP Y reported staff were educated via word of mouth although therapy staff may not have been informed and it was difficult to educate everyone in this manner. IP Y reported it was the expectation that staff would look for infection control signage posted near resident doors before they entered a room. IP Y confirmed that the lack of use of PPE by OT FF and CNA J, as well as taking an unmasked resident under droplet precautions into a common area, were breaches of the facility's infection control processes.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981 Based on observation, interview, and record review, the facility failed to maintain general cleanliness and repair of the premises. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living, affecting residents in following areas: Findings include: In an observation on 2/27/24 at 11:01 AM., noted both privacy curtains in room A-3 were visibly soiled in various areas with dark stains, and an overall soiled/dirty appearance. Bed 1 had multiple missing hanging hooks where the privacy curtain was not attached to the ceiling slide runner, which left the privacy curtain unattached and hanging down. In an observation on 2/27/24 at 11:13 AM., noted both privacy curtains in room A-8 were visibly soiled in various areas with dark stains, and an overall soiled/dirty appearance. In an observation on 2/27/24 at 11:39 AM., noted the floor in room A-11 bed 2 had multiple random medical supply items scattered underneath and next to the bed. The top of a nebulizer-machine was noted on the floor, multiple single use normal saline (NS) tubes also on the floor and underneath bed 2. The floor in A-11 had multiple areas dried liquid spillage, food crumbs, random pieces of paper-wrappers. While walking and observing room A-11 the floor was noted to be sticky on the soles of this surveyors shoes. In an observation on 2/28/24 at 2:42 PM., noted a sit to stand lift in an alcove between the C/D halls. The base of the lift was noted to be soiled with dust, debris and food crumbs. The knee pad (where resident legs are stabilized) was noted to have a dried white substance stuck on the surface in various areas of the knee pad. In an observation on 2/28/24 at 3:01 PM., noted a hoyer lift parked next to room D-11 The mechanical portion of the lift was noted to have multiple areas of dried stuck on substances that resembled dried food. The base of the lift had an area of what appeared to be a substance which resembled yellow dried stuck on urine. During an interview on 2/28/24 at 3:04 PM., Certified Nurse Aide (CNA) PP reported CNA staff and or any nursing staff are to sanitize all resident shared equipment before and after each use. CNA PP reported she was unsure if the resident lifts, wheelchairs, walkers and canes get deep cleaned on a regular basis. CNA PP reported there was no log book or audit type documentation that staff use to document these resident shared items, and or who would be responsible for the deep cleaning. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/28/24 at 3:18 PM., Registered Nurse (RN) L reported nursing staff (both CNA/Nurses) were responsible for ensuring resident shared equipment was sanitized before and after each use. RN L reported whenever a staff member notices something soiled or not working properly staff are responsible to clean up anything they made a mess of, and or if time was an issue the staff should be requesting assistance from housekeeping/maintenance. RN L reported she was unaware of any audit tool, deep cleaning documentation or log book of resident shared equipment, wheelchairs and any other deep cleaning schedule for those items. RN L reported when assisting residents with care, meals, and Activity of Daily Living (ADL's) that specific staff was expected to clean up after themselves, and the resident. In an observation on 2/28/24 at 3:21 PM., noted in room D-3 bed 1 (which was positioned against the wall) had large gouges out of the drywall/sheet-rock. The paint was chipped off from what appeared to be from the bed being raised and lowered coming into contact with the wall. Noted near bed 1 was what appeared to be a dark substance smeared on the wall, the substance appeared to be dried food or fecal matter. In an observation on 2/28/24 at 3:36 PM., noted the hand rails on the D hall were heavily soiled with dried stuck on substances. The hand rails were noted to be painted with the tan paint which was chipping off (along the entire hallway both sides of the walls) exposing the old original color of deep purple. Noted the handrail on the right hand side of the D hall near room D-10 was missing the end cap exposing sharp edges. In an observation on 2/28/24 at 3:55 PM., noted the floor in room A-11 bed 2 had multiple random medical supply items scattered underneath and next to the bed. The top of a nebulizer-machine was noted on the floor, multiple single use normal saline (NS) tubes also on the floor and underneath bed 2. The floor in A-11 had multiple areas dried liquid spillage, food crumbs, random pieces of paper-wrappers. While walking and observing room A-11 the floor was noted to be sticky on the soles of this surveyors shoes. During an interview on 2/29/24 at 10:24 AM., Housekeeper (Hsk) JJ reported resident rooms are suppose to be cleaned/sanitized daily including all commonly used equipment, bed side tables, night stands, windowsills, remote controls for call lights, beds and TV's. Hsk JJ reported resident room floors should be swept and mopped daily, and and the entire bathroom. 38905 During a tour of the facility, starting at 2:05 PM on 2/27/24, observation of the C hall linen closet floor found excess accumulation of debris, used gloves, trash, and dust. An interview with Housekeeping Manager HH found that her staff did not know the code to the closets in order to clean them. During a tour of the D hall, at 2:17 PM on 2/27/24, found that the linen closet floor was found with an excess accumulation of debris, including trash, used gloves, and dust. During a tour of the A hall medical supply closet, at 2:39 PM on 2/27/24, found an excess accumulation of debris on the floor, including paper wrappers, used gloves, and dust. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a tour of the Beauty Shop, at 2:43 PM on 2/27/24, it was observed that the sprayer used for washing and rinsing hair was hanging below the overflow rim of the sink and was found to not have a proper backflow prevention device, such as an atmospheric vacuum breaker. During a tour of the B hall spa room, at 2:47 PM on 2/27/24, it was observed that no shower head was located on the shower and excess black rubber and plastic debris was observed in the corner of the shower, on the walls, and on the shower ledge next to the sink. Observation of the shower floor found some missing tiles and grout. Further observation of the spa room found the cabinet to the left of the sink was observed with heavy deterioration of the surface inside of the cabinet allowing for flaking of wood particles and not allowing for a smooth and easily cleanable surface. An interview with Maintenance Director S found that staff use this area to pressure wash wheel chairs and give resident showers. 38384 R89 According to the Minimum Data Set (MDS) dated [DATE], R89 scored 2/15 on her BIMS (Brief Interview Mental Status) indicating the resident was severely cognitively impaired. The resident had no impairment in her arms or legs with diagnoses that included Alzheimer's disease. Observed on 2/27/24 at 10:40 AM, R89 was in bed with the right side against the wall. The walls next to the bed were in disrepair as evidenced by gouges in the wall and large pieces of missing sheetrock material, and holes covered with patches painted in a different color. A recliner positioned to the left side of the resident's bed was torn and tattered on the footrest underneath where the resident would place her feet with foam exposed across the entire end of it. The right arm of the chair was also torn and tattered with exposed foam. Observed on 2/27/24 at 1:42 PM, R89 was in bed with eyes open with the right side of the bed against the wall. The wall was in disrepair missing sheetrock material with large gouges. Higher on the wall were multiple holes covered with patches in different colors. The recliner next to her bed was torn and tattered on the footrest with foam exposed and hanging out of it. The tear was on the bottom of the footrest and not where the resident places her feet. The right arm of the chair had a hole at the end with foam exposed and sticking out. The left arm of the chair was tattered. Observed on 2/29/24 at 11:00 AM, R89 was in bed with eyes open with the right side of the bed against the wall. The wall was in disrepair missing sheetrock material with large gouges. Higher on the wall were multiple holes covered with patches in different colors. The recliner next to her bed was torn and tattered on the footrest with foam exposed and hanging out of it. The tear was on the bottom of the footrest and not where the resident places her feet. The right arm of the chair had a hole at the end with foam exposed and sticking out. The left arm of the chair was tattered. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/29/24 at 11:30 AM, Nursing Home Administrator (NHA) A stated while touring R89's room with surveyor, I was told by a nurse yesterday that (R89's) recliner was torn with the foam coming out of it. I think when she sits up in it her feet rub on the bar in the footrest and has put the tear in it. Observed R89 sitting in the chair with the footrest extended. The resident's feet were not in the same area of the tear and protruding foam. The right arm of the chair was torn at the end with foam exposed and sticking out. The left arm of the chair was tattered. The NHA stated, The footrest has been repaired before either with staples or sewn. Observed with NHA R89's wall next to her bed. NHA stated, Oh, I had no idea that wall was like that. That is bad. I will tell Maintenance about it. 41027 In an observation on 02/27/24 12:05 PM, in room B-10 noted the wall on the right side of the room near the head of the beds, the rubber trim at the bottom of the wall was not attached and hanging off of the wall, which revealed crumbled paint and dirt. 41424 During an observation on 2/28/24 at 2:57 PM, outside of room A15 there was a Sit to stand and the handles the residents grabbed had soiling in the grooves of the bumps for grips on the handles. The footrest had dirt and debris on it and there were bunches of brown hair wrapped in the back wheel on left side. Resident #91: Review of an Admission Record revealed Resident #91 was a male with pertinent diagnoses which included cerebral infarction (disrupted blood flow to the brain cells deprives them of oxygen), traumatic brain injury with loss of consciousness (Note: pedestrian struck by vehicle), contracture right ankle, oral cancer, and fracture of thoracic vertebrae (bone in the spine collapses creating a compression fracture). Review of current Care Plan for Resident #91, revised on 12/17/23, revealed the focus, .Resident has an ADL self-care performance deficit related to: cerebral infarction, hx of intracerebral hemorrhage . with the intervention .Resident dependent on broda chair for locomotion throughout facility with staff assistance . During an observation of the resident equipment storage area across from the nurse's station on 2/28/24 at 2:58 PM, there was a sit to stand with the letter A on the base on the right side which had white dried liquid streaking down the sides of the base with dirt and the extended piece which held the handles had the dried white liquid on it, and debris on the footrest. There were purple wipes hanging from the side of the machine in a clear plastic bag with drawstring. A broda chair had dried brown dirt appearing material on the headrest where the head layed, the padding on both sides of the head rest area, the armrest had dried brown material appearing like dirt. There was dried white/pinkish material on the outside of the cloth in the hip area on the left side. It had a tag on the bag which indicated it was Resident #91. Resident #78: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #78 was a female with pertinent diagnoses which included history of traumatic fracture, dependence on wheelchair, muscle weakness, and need for assistance with personal care. During an observation of the resident equipment storage area across from the nurse's station on 2/28/23 at 2:59 PM, observed a high back wheelchair with a black pad on the seat which which had splatters of white speckles spread about the seat, the back of the head area had white dried speckles as well. A tag revealed it was for Resident # 78. Resident #76: Review of an Admission Record revealed Resident #76 was a female with pertinent diagnoses which included reduced mobility, muscle weakness, contracture of left foot, disorders of tendon right ankle and foot, disorders of tendon left ankle and foot, and wernicke's encephalopathy (neurological condition, life threatening illness caused by thiamine deficiency which primarily affects the peripheral and central nervous system). During an observation of the resident equipment storage area across from the nurse's station on 2/28/24 at 3:03 PM, observed a broda chair had white dried food material on the seat pad. There was a blue/black foot boot lying in the seat. The wheelchair frame had dust, dirt, and debris on the entirety of the frame. The black foam on the handles were coated in a brown/tan material. The tag on the broda chair indicated it was for Resident #76. Resident #48: Review of an Admission Record revealed Resident #48 was a female with pertinent diagnoses which included paralysis on right side following a cerebral infarction, adult failure to thrive, dependence on wheelchair, contracture of right knee, contracture of left knee, monoplegia of upper right limb (type of paralysis that impacts one limb). During an observation of the resident equipment storage area across from the nurse's stationon 2/28/24 at 3:05 PM, observed a broda chair with dried dirt and debris on the left side of the chair with dried liquid running down the side of the chair. The footrest area had dried brown material on the outside padding on the left side. There was dirt and debris on the frame of the chair. The tag on the handle revealed the chair belonged to Resident #48. Resident #42: Review of an Admission Record revealed Resident #42 was a male with pertinent diagnoses which included paralysis on left side following cerebral infarction, charcot's joint, right ankle and foot (chronic devastating and destructive disease of the bone structure and joints in patients with neuropathy), neuropathy (weakness, numbness, and pain from nerve damage), muscle spasm, reduced mobility, and dependence on wheelchair. During an observation on 2/28/24 at 3:10 PM, observed a wheelchair in the hallway outside of Resident #42's room which had a black pad on the seat with crumbs, dirt, and debris on it with those located under the black seat pad as well. The padded arm rests also had scattered pieces of white debris on them. The band on the wheelchair indicated it was Resident #42's chair. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #63: Review of an Admission Record revealed Resident #63 was a male with pertinent diagnoses which included reduced mobility, chronic pain, muscle spasm, sciatica nerve pain (lower back area), carpal tunnel syndrome, pain in right arm, stroke, muscle weakness, paralysis affecting right side, and spina bifida (birth defect spinal cord failed to develop properly). During an observation on 2/28/24 at 3:11 PM, observed the wheelchair for Resident #63 in the hallway outside of his room and it had dust/ dirt on the frame of his power chair behind the seat pad there was dust, dirt, and white specks. The entire frame was covered in dirt and debris. On the front of the black seat pad there was dried orange/red liquid/food material. During an observation on 2/28/24 at 3:07 PM Outside of Room B1 there were dried brownish/dark grey liquid streaks down the lower wall. There was noted to be no hand sanitizer dispenser at this location. In an interview on 2/29/24 at 10:45 AM, Certified Nursing Assistant (CNA) J reported the resident wheelchairs were cleaned by third shift CNAs. She reported there was a schedule at the nurse's station which would indicate what the schedule was. In an interview on 2/29/24 at 2:30 PM, Director of Nursing (DON) B reported the third shift CNAs were responsible for cleaning the resident equipment. Review of the 3rd Shift CNAs to do list on 2/29/24 revealed, .Clean all lifts .Wash wheelchairs and walkers as assigned . Review of policy, Routine Cleaning and Disinfection revised on 2/1/22, revealed, .It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235399	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Portage	7855 Currier Dr Portage, MI 49002

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. 38384 Based on observation and interview, the facility failed to provide a safe hand railing on Dogwood Trail, resulting in the potential of injury, affecting all residents with the need of handrail assistance while on that hall, a safe way to stabilize or propel themselves. Findings include: Observed on 2/27/24 at 2:48 PM, the metal hand railing ending at room D10 on Dogwood Trail with a broken and sharp end. During an observation and interview on 2/29/24 at 10:00 AM, Maintenance Director S stated, I have three other buildings besides this one. Observed the hand railing outside of room D10 on Dogwood Trail. Maintenance Director stated, There is no end cap. I would expect the nurses to tell me about this one. It has exposed metal edges. All that needs is an end cap.