STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235482	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fenton Healthcare	512 Beach St Fenton, MI 48430

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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** 22347 Based on observation, interview and record review, the facility 1) Failed to ensure the dignity and privacy of one resident (Resident #265) while doing a bed bath, and 2) Failed to ensure that one resident (Resident #212) had their call light within reach, resulting in the likelihood for shame, embarrassment, anger towards staff, feeling of isolation and fear of not having a readily available call light. Findings Include: Resident #265: Review of the Face Sheet, physician orders dated 9/21/24 through 10/1/24, and care plans dated 9/21/24 through 9/26/24, revealed Resident #265 was [AGE] years-old, admitted to the facility on [DATE], alert and able to make healthcare decisions, and dependent on staff for assistance with Activities of Daily Living (ADL). The resident was dependent on oxygen at 2 liters and his diagnosis included, encephalopathy (swelling of the brain), muscle weakness, high blood pressure, Atrial Fibrillation, sepsis, anemia, heart failure, acute respiratory failure, urinary tract infection, history of lung cancer, pleural effusion, end stage renal disease and dependent on renal dialysis. Review of the resident's Respiratory and ADL care plans dated 9/24/24, revealed chronic respiratory failure with oxygen use, weakness, and the need for staff assistance with ADL's (including bathing). Observation was made on 10/1/24 at 9:02 a.m., revealed Nursing Assistant/CNA F was giving the resident a bed bath. The following are the steps done during the resident's bed bath: -Gave wash cloth to resident to wash his face. -Took brief off, washed bottom and dried bottom. -Washed peri area. -Put depends on resident, washed under his arms and top chest area. -Grabbed his shirt from closet and put on him. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-After shirt put on went back to closet, got sweat pants and put them on the resident. -Touched bed controls to raise the head of the bed. -Tied the dirty linen bag, got into second drawer of bedside stand and got toothbrush, basin and tooth paste out for resident and gave it to him. -Left resident's room and walked down the hallway and went into the soiled utility room. -No cover, blanket, cover or bath blanket was on resident during the entire bed bath. During the above entire process, the same gloves were left on CNA F, she did not remove gloves, nor wash her hands the whole time she gave ADL care. No cover was put on the resident at all; dignity was not protected during his bed bath while 2 people were in the room performing and observing the bed bath. Review of the facility Resident Dignity & Personal Privacy policy dated 3/28/24, stated Drape and dress residents appropriately at all times to avoid exposure and embarrassment; maintain resident privacy during toileting, bathing and other activities of personal hygiene, use a top sheet or bath blanket as a cover-up during bedside care. Review of the facility CNA orientation (un-dated), revealed new CNA's are educated on Residents Rights, Abuse, Dignity, and demonstration of bed bath. 37771 Resident #212: A review of Resident #212's medical record revealed an admission into the facility 9/24/24 with diagnoses that included fusion of spine lumbar region, chronic pain, polyneuropathy, cervical disc disorder with myelopathy, and fusion of spine cervical region. Further review of the medical record revealed the resident needed substantial/maximal assistance for bathing, toilet hygiene, and lower body dressing and partial/moderate assistance for upper body dressing, transfers with slide board, and toilet transfers. On 10/1/24 at 9:42 AM, an observation was made of the Resident sitting on the side of his bed. The Resident was interviewed, answered questions and engaged in conversation. The Resident was observed to be sitting on the side of the bed facing away from the door. The Resident had pants on that were not pulled up but positioned on his thighs and his brief he had on was exposed. The Resident could be seen from the hallway with the curtain not pulled to provide the Resident privacy. When asked the Resident reported he had been waiting for staff to come back and help him into his wheelchair. When asked how long staff had left him, the resident was unsure and stated, It hasn't been too long. Staff had not been seen exiting the room when the Resident's room was approached and there was not staff at or around the Resident's room at that time. The Resident reported he had to wait for staff to return to get into the wheelchair. An observation was made of the Resident's call light not in reach and was positioned on the floor at the head of the bed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at 9:45 AM, after the conclusion of the interview with Resident #212, Nurse M who was down the hallway at the medication cart was informed of the Resident's call light on the floor. When queried, the Nurse reported the call light should be in reach for the Resident and went to place the call light in reach for the Resident. A review of facility policy titled, Call Lights, dated 12/16/21, revealed, Policy: Call lights will be placed within the guest's/resident's reach and answered in a timely manner. Procedure: .3. When a guest/resident is in bed or confined to a chair be sure the call light is within easy reach of the guest/resident .

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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** 37771 Based on observation, interview and record review, the facility failed to up-date person-centered comprehensive care plans to ensure that a shaving preference was identified for one resident (Resident #20) and a transfer status was updated for one resident (Resident #212) of 17 residents reviewed for care plans, resulting in the potential for Residents' needs not being met, frustration, Resident #20 not shaved to their preference and Resident #212 not assisted with getting out of bed during the weekend. Findings include: Resident #20: A review of Resident #20's medical record revealed an admission into the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, limitations of activities due to disability, lung cancer, muscle weakness, dementia, disorientation, and need for assistance with personal care. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status score of 7/15 that indicated moderately impaired cognition, and the Resident needed partial/moderate assistance with personal hygiene. On 9/30/24 at 10:09 AM, an observation was made of Resident #20 sitting up in bed with the head of the bed elevated. The Resident was asked questions, answered simple questions and engaged in limited conversation with understanding of what the Resident was saying to take extra time. An observation was made of the Resident with facial hair covering his cheeks, chin, upper lip and neck. The Resident was asked if he liked having a beard. The Resident rubbed his cheeks, chin and indicated he didn't like it this long. When asked if he refused when they offered, the Resident reported he would not say no and stated, I don't like the beard. On 10/2/24 at 10:15 AM, an observation was made of Resident #20 lying in bed with the head of the bed elevated. The Resident continued to have facial hair that had not been shaven from the observation made on 9/30/24. The Resident was asked about his preference for having a beard and the Resident stated, Yeah, I want this off. The Resident stated, Someone was supposed to do it, rubbed his beard on his cheeks up to his ears and was talking but what was said was not completely understandable. The Resident indicated he was waiting to get a shower. On 10/2/24 at 2:19 PM, an interview was conducted with the Director of Nursing (DON). When asked about facility policy of facial hair shaving, the DON reported that it depends on their preference. The DON was asked about Resident #20's preference and how would staff know what the Resident's preference was. The DON indicated that the Kardex would contain that information. When asked to look on the Kardex, the DON stated, I don't see it documented, but it could be in his care plan, and reported she would follow up with Resident #20 on his preference. The care plan was reviewed with the DON. The care plan did not have the Resident's preference for the ADL (activities of daily living) activity of shaving. When asked if the care plan should have the Resident's preference, the DON stated, Yes we usually care plan it, it should be in there. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 4:16 PM, the DON reported that she had addressed the concern of the lack of Resident preference on shaving on the care plan. The DON reported that the resident likes to be clean shaven at least every 3 days. The DON reported she had updated the care plan and had it trigger to the Kardex. Resident #212: A review of Resident #212's medical record revealed an admission into the facility 9/24/24 with diagnoses that included fusion of spine lumbar region, chronic pain, polyneuropathy, cervical disc disorder with myelopathy, and fusion of spine cervical region. Further review of the medical record revealed the resident needed substantial/maximal assistance for bathing, toilet hygiene, and lower body dressing and partial/moderate assistance for upper body dressing, transfers with slide board, and toilet transfers. On 9/30/24 at 10:42 AM, Monday, an observation was made of Resident #212 sitting in his wheelchair in their room after returning to the room from the elevator. The Resident was interviewed, answered questions and engaged in conversation. The Resident reported he didn't have his neck brace on and indicated he was to wear a collar when out of bed. The Resident reported it was his first time getting up into the wheelchair and was figuring out how to wheel his wheelchair. When asked when he had arrived at the facility, the Resident responded he had gotten here on Tuesday. The Resident was asked why this was the first time out of bed. The Resident stated, I didn't get up on the weekend because they didn't know if I could or not. The Resident reported he got up with the slide board with staff this morning and had not gotten up through the weekend. The Resident reported wanting to stand up on his own over the weekend and stated, It's hard to just lay in the bed, just couldn't take it. The resident reported they didn't have an order for what I could do. On 10/2/24 at 3:35 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #212 not getting out of bed on the weekend. The DON reported that there was a communication form that was to be provided between therapy and nursing and that she had not received the communication. The DON reported that she had asked on Monday for the form from the Therapy department regarding the transfer status. The DON indicated that the form was dated 9/26, which was a Thursday, and indicated the Resident was to be a slide board transfer and a drop arm commode toilet, nursing had not received the updated transfer status determined by the Therapy evaluation and the DON stated, We had some conversation about process improvement, and reported that once they had the conversation, they looked at the process to see how they can improve so it does not happen again. The Resident did not have the change made until Monday, 9/30/24, when the therapy evaluation determined the updated transfer status of the Resident was completed on 9/26/24 with the Resident not getting out of bed through the weekend. On 10/3/24 at 10:11 AM, an interview was conducted with the Therapy Director -- regarding Resident #212 not being assisted out of bed over the past weekend. The Therapy Director indicated that the therapy evaluations had been completed on 9/25/24 for OT (Occupational Therapy) and PT (Physical Therapy) on 9/26/24 and the interventions on transfer status was left in the DON's mailbox and also give to the MDS Nurse on Friday morning, 9/27/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #20's care plan revealed a focus for ADL (Activities of Daily Living) with interventions for Transfer: Resident requires partial/moderate assistance of one staff and slideboard; and Toilet Transfer: Resident requires partial/moderate assistance of one staff with slideboard and bariatric drop arm commode, with revision dated on 9/30/24. A review of the facility policy titled, Care Planning, revised 6/24/21, revealed, Purpose: Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary team who includes but not limited to; attending physician, .the resident or resident representative, therapy staff as required and any other ancillary staff. Additional resources will also be utilized to ensure that any additional needs or risk areas are identified . 7. The care plan must be specific, resident centered, individualized and unique to each resident .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to ensure that residents received assistance with showering and shaving for one resident (Resident #20) and failed to use appropriate hand hygiene during ADL (activities of daily living) care for Resident #265, of five residents reviewed for ADL care and 3 of 5 confidential group of residents voicing concern of not receiving bathing activity, resulting in the potential for embarrassment, frustration, needs not meet, infection and lack of feelings of self-worth. Findings include: Resident #20: A review of Resident #20's medical record revealed an admission into the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, limitations of activities due to disability, lung cancer, muscle weakness, dementia, disorientation, and need for assistance with personal care. A review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview of Mental Status score of 7/15 that indicated moderately impaired cognition, and the Resident needed partial/moderate assistance with personal hygiene. On 9/30/24 at 10:09 AM, an observation was made of Resident #20 sitting up in bed with the head of the bed elevated. The Resident was asked questions, answered simple questions and engaged in limited conversation with understanding of what the Resident was saying to take extra time. An observation was made of the Resident with facial hair covering his cheeks, chin, upper lip and neck. The Resident was asked if he liked having a beard. The Resident rubbed his cheeks, chin and indicated he didn't like it this long. When asked if he refused when they offered, the Resident reported he would not say no and stated, I don't like the beard. On 10/2/24 at 10:15 AM, an observation was made of Resident #20 lying in bed with the head of the bed elevated. The Resident continued to have facial hair that had not been shaven from the observation made on 9/30/24. The Resident was asked about his preference for having a beard and the Resident stated, Yeah, I want this off. The Resident stated, Someone was supposed to do it, rubbed his beard on his cheeks up to his ears and was talking but what was said was not completely understandable. The Resident indicated he was waiting to get a shower. On 10/2/24 at 11:03 AM, an interview was conducted with CNA K regarding facility policy for shaving. The CNA indicated that med and women should be shaved as needed as soon as the hair grows back. When asked about Resident #20 facial hair, the CNA reported she had that Resident today and he had just taken a shower and got him shaved and stated, When I have him, I try to shave him, I have not had him in a while. When asked when facial hair assistance was offered to Residents, the CNA reported that she offers on a daily basis. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 2:19 PM, an interview was conducted with the Director of Nursing (DON). When asked about facility policy of facial hair shaving, the DON reported that it depends on their preference. The DON was asked about Resident #20's preference and how would staff know what the Resident's preference was. The DON indicated that the Kardex would contain that information. When asked to look on the Kardex, the DON stated, I don't see it documented, but it could be in his care plan, and reported she would follow up with Resident #20 on his preference. The care plan was reviewed with the DON. The care plan did not have the Resident's preference for the ADL (activities of daily living) activity of shaving. When asked if the care plan should have the Resident's preference, the DON stated, Yes we usually care plan it, it should be in there. On 10/2/24 at 4:16 PM, the DON reported that she had addressed the concern of the lack of Resident preference on shaving on the care plan. The DON reported that the resident likes to be clean shaven at least every 3 days. The DON reported she had updated the care plan and had it trigger to the Kardex. 22347 Resident #265: Review of the Face Sheet, physician orders dated 9/21/24 through 10/1/24, and care plans dated 9/21/24 through 9/26/24, revealed Resident #265 was [AGE] years-old, admitted to the facility on [DATE], alert and able to make healthcare decisions, and dependent on staff for assistance with Activities of Daily Living/ADL's. The resident was dependent on oxygen at 2 liters and his diagnosis included, encephalopathy (swelling of the brain), muscle weakness, high blood pressure, Atrial Fibrillation, sepsis, anemia, heart failure, acute respiratory failure, urinary tract infection, history of lung cancer, pleural effusion, end stage renal disease and dependent on renal dialysis. Review of the resident's Respiratory and ADL care plans dated 9/24/24, revealed chronic respiratory failure with oxygen use, weakness, and the need for staff assistance with ADL's (including bathing). Observation was made on 10/1/24 at 9:02 a.m., revealed Nursing Assistant/CNA F was giving the resident a bed bath. The following are the steps done during the resident's bed bath: -Gave wash cloth to resident to wash his face. -Took brief off, washed bottom and dried bottom. -Washed peri area. -Put depends on resident, washed under his arms and top chest area. -Grabbed his shirt from closet and put on him. -After shirt put on went back to closet, got sweat pants and put them on the resident. -Touched bed controls to raise the head of the bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Tied the dirty linen bag, got into second drawer of bedside stand and got toothbrush, basin and tooth paste out for resident and gave it to him. -Left resident's room and walked down the hallway and went into the soiled utility room. -No cover, blanket, cover or bath blanket was on resident during the entire bed bath. During the above entire process, the same gloves were left on CNA F, she did not remove gloves, nor wash her hands the whole time she gave ADL care. Review of the facility Hand Hygiene policy dated 10/11/23, stated Hand Hygiene should be performed: Before and after contact with the resident, after contact with blood, body fluids, visibly contaminated surfaces or after contact with objects (including soiled linen bag) in the resident's room, staff involved in direct resident contact must perform hand hygiene. Gloves are to be removed and hands washed after contact with peri care and/or washing the buttock area. Resident Group Meeting: On 10/1/24 at 2:00 p.m., a confidential resident meeting was done. During the meeting, 3 of 5 confidential resident's verbalized we missed a shower because of low staffing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 Based on observation, interview, and record review, the facility 1) Failed to ensure a safe environment with adequate supervision and implement interventions to prevent a fall for three residents (Resident #2, Resident #53 and Resident #54) and failed to do a complete fall investigation for those three residents and 2) Failed to ensure that Resident #212 had their C-collar (Cervical collar or brace used to support the neck and spinal cord, often used for neck pain, spinal fractures, surgery recovery or trauma) on while out of bed as ordered by the physician of 7 residents reviewed for falls and accident hazards, resulting in potential for pain and decline in medical condition and the likelihood of repeated fall with serious injury to occur due to incomplete investigations for R2, R53 and R54 and the potential for pain or worsening/decline in medical condition for Resident #212. Findings include: Resident #2 (R2): Accidents According to the review of the Electronic Medical Records (EMR) on 10/2/24 at 3:00 PM, R2 was [AGE] years old, admitted to the facility on [DATE] with a diagnosis of Vascular Dementia, Protein Calorie Malnutrition and Cerebral Infarction in addition to other diagnoses. Brief Interview of Mental Status (BIMS) Score dated 7/02/2024 was 03. A score of 0-07 means that the person has severe cognitive impairment. Minimum Data Set (MDS) Section GG, as assessed on 7/02/2024, revealed that R2 required maximum assistance with toileting, showering, and most ADL's (Activities of Daily Living, including oral hygiene). She required partial to moderate assistance with sit-to-stand, from bed to sitting on one side of the bed, and toilet transfers. R2 is non-ambulatory and was always incontinent with bowel and bladder elimination patterns. A care plan for Falls was noted last revised on 10/1/2024 during the survey, including the history of placing self on the floor with a pillow and blanket, crawling around on the floor, self-transferring, and the intervention of communicating with hospice as needed. On 12/02/2024 at 9:45 AM' R2 was observed lying in her bed with half of her body (left shoulder and head) off to the very side of the bed. R2's eyes were closed, and she was sound asleep. When the surveyor confirmed the observation with the Nurse (LPN M), the nurse revealed that sometimes she is unpredictable with her movements. LPN M stated, It depends on the day. And that's why she is a fall risk. There are times she will not move and times when she will move. The LPN M went to find the CNA assigned to reposition R2 in the middle of the bed. In an interview with the Nurse Manager JB on 10/3/24 at 11:03 AM, she stated: R#2's mental status depends on the day. R2 does not move, and all of a sudden, she would. R2 requires assistance with transfers and is non-ambulatory. A review of R2's 3 Fall Incident Reports (I/A) Report is as follows: Fall 1: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall #1 dated 7/8/24. Incident description revealed: Called to the resident's room per activities staff. The resident noted lying on the left side of the bed on the floor, she was lying on her left side. Resident Description: head pointed towards footboard. Resident Unable to give description. No staff witnesses were mentioned, nor were staff statements found. Some blanks were left, and checkboxes essential for the investigation were not marked. R2's I/A Report #1 was incomplete. Fall 2: Fall#2 dated 8/3/24. Incident Description revealed: Nurse was making rounds on the floor. The nurse heard resident calling out for help. Upon entering resident's room, the nurse observed the resident lying on R side between the bed and wall. Feet towards FOB, head towards HOB with head resting on the floor under her bed. W/C located at foot of bed on same side as Resident without locked wheels. Gripper socks on. Resident Description: I was trying to go to bed and fell . R2's I/A Report #2 was incomplete. No staff witnesses were mentioned, nor were staff statements found. The incident report left some blanks, and some checkboxes were not marked. Fall 3: Fall#3 dated 8/7/24. The incident Description revealed: This Nurse heard moaning coming from the resident's room, upon arrival to the resident's room, Resident was observed on the floor face down with left side of face in direct contact with the floor next to the right side of her bed, bed noted to be in low position at this time. Resident has a knot on left side of forehead. No other injuries were observed. Passive and active ROM was completed for BLE and BUE per resident's baseline without complaints of pain. Resident assisted back into bed with a 2 PA for her safety. Resident Description: When Resident was asked what she was doing before she ended up on the floor, Resident stated that she was trying to get up. When asked where she was going, Resident could not say where she was going. R2's I/A Report #3 was incomplete. No staff witnesses were mentioned, and no staff statements were found. The incident report #3 left some blanks, and some checkboxes were not marked. Resident #53 (R53): Accidents During observation and interview on 9/30/2024 at 10:15 AM, R53 was alert, awake in his room, lying in bed, and stated that the facility needed more bathrooms. They had to wait in line to get to the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the review of the Electronic Medical Records (EMR) on 10/2/24 at 3:00 PM, R53 was admitted to the facility on [DATE] with a diagnosis of Diabetes Mellitus, Hypothyroidism, and Wedge Compression Fracture of first lumbar vertebra, unsteadiness on feet and repeated falls in addition to other diagnoses. R53's BIMS Score is 13/15. Section GG of the Minimum Data Set (MDS), assessed on 7/24/24, revealed that mobility devices such as a walker and wheelchair were used. R53 was deemed dependent on ALL transfers (Sit-to-stand, chair transfers, and toilet transfers). This further explained R53's ability to safely come to a standing position from sitting in a chair or on the side of the bed. R53 was dependent, meaning the helper did ALL of the effort. R53 makes no effort to complete the activity. Walking 10 feet and 50 feet, assessment was not attempted due to medical condition or safety concerns. Additionally, R53 was occasionally incontinent with Bladder Elimination. However, he was always continent with bowel elimination patterns. R 53's Fall Care Plan initiated on 1/19/24 revealed to: o Encourage Resident to wear non-skid footwear when out of bed. Assist Resident as needed. o Keep the Resident's environment as safe as possible with even floors free from spills and/or clutter; adequate lighting; call light within reach, commonly used items within reach, avoid repositioning furniture, and keep the bed in the appropriate position. On 10/2/24 at 3:05 PM, a review of the Facility incident/accident (I/A) report revealed: Fall 1: Fall#1 on 6/27/24 at 23:00 (11:00 PM) described: Writer called into room by patient roommate. The roommate stated that the patient had rolled out of bed. Pt was sitting on the side of the bed. The Resident Description: getting himself off the floor, when the writer entered the room. Patient was asked what happened and he stated he fell . He was asked if he hit his head, and patient stated, No. R53's I/A Report #1 was deemed incomplete. No staff witnesses were mentioned, nor were staff statements found. The incident report #1 left some blanks, and some checkboxes were not marked. Fall 2: According to the I/A report, the fall#2 occurred on 9/15/24 at 8:15 AM. It described: 'Resident was walking in the hallway to obtain an item from breakfast cart, observed knees buckling and Resident falling slowly to the floor. The resident landed on the backside, scraping arm across the leg of mechanical lift that was located in the hallway. On assessment, Resident was noted to have sustained a 2.5 x 1.5 cm. skin tear to the left forearm. Resident Description: Walking in the hall, I didn't think I would need my walker. I felt weak and fell , I am fine. As a result, R53 sustained a skin tear to the left elbow. R53's mental status, predisposed environmental or the predisposed situation factors were not marked. No witness or staff statements were entered. Other information indicated that R53: did not use call light or walker; non-skid socks not on feet. R53's I/A Report #2 was deemed incomplete. No staff witnesses were mentioned, nor were staff statements found. The incident report #1 left some blanks, and some checkboxes were not marked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to Nurse Manager JB on 10/03/24 at 11:34 AM, R53 is forgetful and needs reminders to use his walker. Nurse JB described R53's mental status and revealed that R53 is usually confused and forgetful. Nurse Manager JB further commented, R53 needed constant reminders to use his walker when he's up and about. R53 does not remember to use the call light either. Staff anticipates his needs, and constant supervision from Staff is essential. Resident #54 (R54): Accidents According to the review of Electronic Medical Records (EMR) on 10/2/24 at 3:30 PM, R54 was [AGE] years old and admitted to the facility on [DATE] with the following diagnoses: Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left non-dominant side, difficulty in walking, syncope and collapse, hypotension and essential hypertension in addition to other diagnoses. R54's Brief Interview of Mental Status or BIMS Score assessed on 5/16/24 was 15/15. R54's Functional Limitation in Range of Motion (ROM) revealed that her Upper Extremity (shoulder, elbow, wrist, and hand) was impaired on one side. ADL's, shower, and upper and lower body dressing were substantial to max assistance. Personal hygiene (combing, shaving, washing, and drying face and hands): Partial to moderate assistance. Mobility: roll left to right: Dependent, Sit to lying: Dependent; lying to sitting on the side of the bed: Dependent; sit to stand: Dependent. Chair to bed- to chair: Dependent, Toilet transfer: Dependent, Tub/shower transfer: Dependent. Dependent means that the helper does ALL of the effort. The resident does none of the effort to complete the task. R54 is always incontinent for both bladder and bowel elimination patterns. The Fall Care Plan for R#54 was reviewed on 10/3/12:15 PM: Amongst other interventions, the facility had the following action plans: o Educate Resident on maintaining bed at wheelchair level for transfers and locking wheelchairs prior to transfers. o Encourage the Resident to wear appropriate footwear as needed. These interventions are in place for R54 to prevent falls and minimize injuries to occur and considering R54's Left sided impairment and mobility conditions. The following Fall I/A for R54 was reviewed: Fall 1: Fall #1, on 5/17/24 at 8:15 AM, Staff assisted the patient to the bathroom. R54 said she readjusted herself on the toilet and slipped off of the toilet. Staff assisted. Resident Description: (R54) stated back on the toilet and then back into bed. Resident stated that she adjusted her position on the toilet. R54's I/A Report #1, dated 5/17/24, was deemed incomplete. No staff witnesses were mentioned, nor were staff statements found. The incident report #1 left some blanks, and some checkboxes were not marked. Important details such as R54's mental status predisposing factors (Environmental and situation) were not checked or filled out. The level of pain was not assessed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall 2: Fall #2, on 6/13/24 at 01:00 AM, described: Staff were called to room by a roommate who had called her son to call the facility to let Staff know that this Resident was on the floor. Resident Description: The resident noted that on the floor on the right side of the bed, she was lying on her left side. No noted injuries, denied hitting the head. The resident stated, I just turned over too far and rolled out of bed. After a review of the Fall#2 I/A dated 6/13/24, it was deemed incomplete because the level of pain and the mental status were not assessed, considering that the fall was unwitnessed, there were no statements from the nursing assistant (Staff assigned), and the predisposed environmental and situation factors were left blank. Fall 3: Fall#3 occurred on 6/23/24 at 18:35 (6:35 PM). In the report,Nurse called to Resident's room. Resident was sitting on the floor next to her bed. She was sitting upright, facing the door with her legs extended. Resident said she was sitting on the side of her bed praying. She was reaching into her bedside table for a prayer book that was recently bought for her. Resident Description: Resident said she was sitting on the side of her bed praying. She was reaching into her bedside table for a prayer book that was recently bought for her. Resident also stated that the remote/cord to raise and lower the bed was tangled under the bedside table and was trying to untangle it. In the same report, the nurse wrote: Resident said she was sitting on the side of her bed praying. She was reaching into her bedside table for a prayer book that was recently bought for her. Resident also stated that the remote/cord to raise and lower the bed was tangled under the bedside table and was trying to untangle it. The I/A Report #3, dated 6/23/24, was deemed incomplete because of the following : 1.) The level of pain was not assessed. 2.) R54's Mental status was left blank 3.) Predisposed factors (environmental/ physiological/situation) were not marked or checked. There were no statements, and the incident was unwitnessed Fall 4: Fall#4 occurred in R54's room on 7/26/24 at approximately 18:35 (6:35 PM). Nursing description revealed: Called to the room and observed resident sitting on the floor with knees bent. Facing HOB (Head of Bed). Hands on Mattress of bed. The bed was in the lowest position, and the wheels were not in the lock position. Resident Description: Resident stated she had lowered the bed to get back into it. When she attempted to transfer from the w/c to the bed, the bed was not locked and slid away from her when she pushed on it. She lost her balance and fell on to her buttocks. The I/A Report dated 7/26/24 was deemed incomplete because of the following: The post-fall pain level and R54's mental status were not assessed. No statements were obtained from the Staff assigned on the day of the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall 5: Fall#5, dated 9/20/24 at 14:31 (2:31 PM), revealed R54 was observed on the floor in bathroom laying on her right side and facing the closed north side door of the bathroom. South side door open with wheelchair in the doorway. Resident had her house shoes and grippy socks on. The toilet was empty, and clothing was on. No signs of injury noted, and resident denied any pain. Resident Description: The resident reported that she slid to the floor while trying to self-transfer back to her wheelchair from the toilet. The resident states she was trying to pull her pants up all the way when she started sliding to the floor and landing on her right side. Resident denied hitting head and any injury or pain. The I/A Report dated 9/20/24 was deemed incomplete because R54's Mental Status and the level of pain were not assessed. The I/A Report noted: Resident attempted to transfer herself without assistance from toilet to wheelchair. There was no statement from the nursing assistant assigned on where the assigned Staff was during the fall and what interventions were put in place to avoid reoccurrences and prevent the potential for serious injuries to occur post-fall. During the interview with Nurse Manager JB, she indicated that most falls are caused by R54, forgetting that she needs to ask for help and assistance. Nurse JB stated that R54 needs monitoring and supervision. R54 thinks she can be independent. R54 wants to go home in assisted living. Nurse JB that they continue to educate and remind R54 to keep interventions in place. On 10/3/24 at 12:00 PM, the facility's Abuse Prohibition Policy had specified Reports and Investigations, dated 9/30/2024, was reviewed. It indicated: The facility Quality Assurance Performance Improvement Committee will investigate occurrences, patterns, and trends that may indicate the presence of abuse, neglect, or misappropriation of guest/resident property and to determine the direction of the investigation/intervention through analysis of systems, audits, and reports. 2. Identification through the safety program begins with the Incident Report. 3. The Director of Nursing and Administrator review all incident reports to identify and further investigate any suspicious incidents . The Director of Nursing and Administrator review all incident reports to identify and further investigate any suspicious incidents. E. Investigation: . 2. The Director of Nursing or designee will complete an assessment of guest(s)/resident(s) and document findings in the medical record. 3. An Incident Report (and/or grievance forms per state-specific requirements) will be completed. 4. The licensed Nurse will: a. Notify the physician if required b. Notify the family member/responsible party/emergency contact/legal guardian (not necessarily all individuals) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A preliminary, on-site investigation will be initiated within twenty-four (24) hours of any report. 6. The Administrator or Director of Nursing/designee shall initiate the Incident and Accident Investigation Form (or other grievance forms per state specific guidelines) and take the following actions to ensure that the investigation is conducted effectively . 37771 Resident #212: A review of Resident #212's medical record revealed an admission into the facility 9/24/24 with diagnoses that included fusion of spine lumbar region, chronic pain, polyneuropathy, cervical disc disorder with myelopathy, and fusion of spine cervical region. Further review of the medical record revealed the resident needed substantial/maximal assistance for bathing, toilet hygiene, and lower body dressing and partial/moderate assistance for upper body dressing, transfers with slide board, and toilet transfers. On 9/30/24 at 10:32 AM, an observation was made of Resident #212 propelling himself in a wheelchair and getting on the elevator. The Resident reported to people in the vicinity to be careful because he was not a pro on maneuvering the wheelchair and said it was his first time up. Staff were in the hallway and around the nurse's station. The Resident got in the elevator. The Resident was not gone long, came back up, got off the elevator, said forgot my collar, and propelled himself back to his room. Staff did not stop the Resident from leaving the unit without his cervical collar on. On 9/30/24 at 10:42 AM, an observation was made of Resident #212 sitting in his wheelchair in their room after returning to the room from the elevator. The Resident was interviewed, answered questions and engaged in conversation. The Resident reported he didn't have his neck brace on and indicated he was to wear a collar when out of bed, a cervical collar and engaged in conversation about the surgery he had on his neck. The Resident said he had gotten downstairs, and they told him he forgot his collar and came back up to have it put on. The Resident was asked how he got up into the wheelchair and he explained that staff helped him use the slide board for transfer to his wheelchair. The Resident was asked if staff had offered to put the C-collar on, and he indicated they did not, and he forgot. On 10/2/24 at 3:35 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #212's lack of having a C-collar on while out of bed and if the Resident needed assistance with care. The DON reported that the Resident did need assistance with care and that he should have the C-Collar on when out of bed. The DON reviewed the Resident's medical record and indicated the order was to encourage the C-collar when out of bed. A review of Resident #212's orders revealed an active order dated 9/24/24 C collar to be worn when out of bed, every shift for post neck surgery. The Resident's care plan revealed, Focus: ADL: (Resident's name) has a functional ability deficit and requires assistance with self care/mobility R/T (related to): multiple back surgeries. C-Collar when out of bed, initiated 9/24/24 and revision on 9/26/24. One of the Interventions included Encourage C-collar when out of bed, initiated on 9/26/24. A review of the Kardex revealed, Resident Care . Encourage C-collar when out of bed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22347 Based on observation, interview and record review, the facility failed to maintain the kitchen and food preparation equipment in a sanitary condition and ensure clean and ready-for-use kitchen equipment was air dried properly, resulting in an increased potential for food borne illness, potentially affecting 60 residents of a census of 62 residents who consume oral nutrition from the facility kitchen. Findings Include: Review of the U.S. Public Health Service 2009 Food Code, as adopted by the Michigan Food Law, effective October 1, 2012, directs those physical facilities shall be cleaned as often as necessary to keep them clean, food equipment was to be dried in a manner that leaves no water left inside prior to storage, and ready-to-eat foods shall be clearly marked at the time the original container is open if held for more than 24 hours. Observation was done on 10/1/24 at 10:06 a.m., accompanied by Dietary Manager/RD E. The following were observed during the initial kitchen tour done on 10/1/24: -At 10:07 a.m., the large can opener had an excessive amount of dried on food and rust-like on the blade and the surrounding area. -The plate warmer, steam table and prep table all had dried on food particles. -The oven sides were found to have dried on drippings with dried on food. -The clean and ready for use Robot Coupe food processor was found with the top on and there was an area on the top of the attachment that was wet with a dark brown substance on it. -The liquid coffee maker had dried on black thick substance on the nozzle. -The cooler had dried on drips on the sides and front. -A total of 5 stacked, clean and ready for use plate covers were found wet inside of one another. -A total of 2 black plate covers in the plate warmer were found to have dried on food particles on them. -The microwave was found to have dried on food inside on the top and sides. -The floor on the side of the oven was found to have dust and dirt on it. Review of the facility kitchen cleaning duties (un-dated), revealed the coffee pot was to be cleaned on Tuesday, the steam table on Thursday, and the stove on Tuesday. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview done on 10/1/24 at 10:40 a.m., Dietary Manager E said she had to get staff to clean more.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 22347 Based on observation, interview and record review, the facility failed to ensure a clean and safe environment for 11 residents' rooms, 2 main hallways, and 1 residential sitting area, resulting in the likelihood for resident injury (bug and spider bites and hand splinters), anger and frustration from family members and residents, and cross contamination with illnesses with increased use of antibiotics. Findings Include: During an environmental walk through done on 10/2/24 starting at 8:16 a.m., accompanied by Director of Maintenance, Housekeeping and Laundry D; the following concerns were observed: First Floor: -At 8:16 a.m., room [ROOM NUMBER], the oxygen tubing with nasal cannula was observed on the floor (not in a bag) next to his bed. The resident had no idea where his oxygen was. -room [ROOM NUMBER], the bathroom toilet had BM on the back of the seat and the floor was found dirty. -At 8:30 a.m., room [ROOM NUMBER], the window running air conditioner filter was found to have an excessive amount of dust and dirt on it. In the bathroom was found a clear plastic bag of clean linens sitting on the floor. -room [ROOM NUMBER], the window running air conditioner filter was found to have dust and dirt on it. -The first-floor shower room across from room [ROOM NUMBER], had the window open and an excessive amount of dead bugs, dirt and spider webs were found in the tract and on the window seal. -In the clean linen room, was found a dirty blue bootie sitting on clean linen and the floor had dirt and dust on it. None of the linen was covered at the time. -At 8:45 a.m., in the Therapy room was found a wheeled measuring device that was being stored behind the toilet. -In the first-floor dining room (also used for activities and council meetings), seven tables were noted to have on the edges, areas of bare wood; the venire had worn off and wood was exposed (safety and infection control concern). One light bulb was out over a dining table. -The patio off the dining room was observed; directly under the window by the door, behind two chairs was observed a medium size pile of leaves, dirt and small sticks; large spider webs were also noted behind the chairs. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 9:19 a.m., in the laundry room, the second and third driers were found to have heavy build-up of lint on the screens. The screens themselves were not visible at the time. The running washer had both screens covered with a thick layer of lint and dust. The exhaust fan above the area where clean linens were being folded at the time had a very thick layer of black dust/dirt on all blades. Laundry Staff member G was folding white towels at the time, and they were stacked directly beneath the exhaust fan. Also, Laundry Aide G was eating food, and it was sitting on the folding table by the clean stacked towels. During an interview done on 1-/2/24 at 9:06 a.m., Laundry Aide G stated Usually once a shift I clean the filters and as needed. If screens are dirty, then it is as needed. Second Floor: -At 9:22 a.m., the walls in the hallway were observed to have several areas of black marks and scuffs. Several resident rooms on the second floor also had black marks on the walls. -A heavy smell of urine was noted across from the nurse's station, and the soiled utility room door was shut at the time. -At the end of the hall, the window was open, and the window track was very dirty with dirt, dust, spider webs and dead bugs. -At 9:35 a.m., in room [ROOM NUMBER] the running air conditioner had a large amount of black and orange colored mold-like inside the top vents, and the filter was dusty. -room [ROOM NUMBER]'s running air conditioner filter was dirty with heavy dust. -At 9:40 a.m., in room [ROOM NUMBER], the running air conditioner top and filter was found to be dirty with dead bugs and heavy dust. -room [ROOM NUMBER], the floor was found dirty. -room [ROOM NUMBER], the running air conditioner was found to have a heavy coating of dust on the front and the filter. -room [ROOM NUMBER], the air conditioner and window track and window seal were found dirty with dirt, dead bugs and dust. -room [ROOM NUMBER], the wall on the right side of the door had areas of missing paint and the window seal and tracks were found to have dust, dirt and dead bugs. -room [ROOM NUMBER], the window seal and track were observed dirty. During a interview done on 10/2/24 at 8:50 a.m., the Director of Maintenance/Housekeeping/Laundry D stated I don't have a check sheet for walk through's. During an interview done on 10/2/24 at 12:05 p.m., the Director of Nursing/Infection Control nurse stated, there is always room for improvement. (continued on next page)

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility Infection Control walk through's dated 6/24, 7/24 and 8/24, revealed under nursing all areas were marked as y, nothing was observed unclean. Review of the facility Daily cleaning and disinfecting expectations sheet (un-dated), stated Dust vent grates in bathrooms, TV's and air conditioning filters, sweep then mop-place wet floor sign until dry, dust where walls meet ceiling for spider webs. 37771 On 9/30/24 at 10:09 AM, an observation was made of the second floor of a strong urine odor halfway down the hallway. On 10/2/24 at 10:27 AM, an observation was made of room [ROOM NUMBER] that had two Residents residing in the room with one of the Residents sleeping in bed. An observation was made of a strong odor of urine in the room, upon walking into the room, the floor was sticky with each footstep around the first bed area. The bathroom had a strong smell of urine. The Nurses' station was across the hall not far from room [ROOM NUMBER]. In the hallway and by the Nurses' Station, the urine odor was detected as well. On 10/3/24 at 11:59 AM, an interview was conducted with the Director of Nursing (DON) during the Infection Control task of the survey. The DON and this surveyor were on the second floor of the facility. An odor of urine was noticed in the hallway near the Nurses' Station. The Soiled Utility room was next to the Nurses' Station and the Nurses' Station was in the vicinity of Resident rooms. An observation was made inside the Soiled Utility room with the hopper/bin that held bags of soiled linen was piled high with bags and there were multiple bags of linen laying on the floor around the filled hopper/bin. The room smelled of urine. Housekeeping staff I was asked about the overflowing dirty linen bin. The Housekeeping staff indicated that the laundry staff usually comes up and collects it, and reported he would take this one down. A review of the facility policy titled, Federal & State - Resident Rights & Facility Responsibilities, revised 5/14/24, revealed, .i. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely .