STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235577	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McLaren Lapeer Region	1375 N Main St Lapeer, MI 48446

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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 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** 22348 Based on observation, interview, and record review, the facility failed to ensure that needs were being accommodated for three residents [Resident # 70 (R70), Resident #116 (R116), and Resident #120 (R120)], including comfortable room temperatures for Resident #70 and Resident #120, a request for a room change for Resident #116 and a request for a wider bed for Resident #120 of a total sample of 15 residents, resulting in discomfort and being unable to get enough rest and sleep for Resident #116, feeling unsafe to move and afraid of falling out of a narrow bed for Resident #120 and feeling too cold in the room for Resident #70 and Resident #120. Findings include: FACILITY Resident #120 (R120): Environment R120, on 09/03/24 at 11:59 AM, complained about the room being so cold upon admission. R120 complained to staff about the room temperature since admission on 8/30/24, but nothing has been done. R120's roommate (in room [ROOM NUMBER]), Resident #121, was interviewed on 9/3/24 at 2:30 PM. R121 agreed that the room (1139) was always very cold. An interview with R70, who was in room [ROOM NUMBER] on 9/5/24 at 10:55 am, revealed that he was cold and was freezing in room [ROOM NUMBER]. R70 was observed to have his head wrapped in a towel over his head and his body covered with blankets. On 9/4/24 at 3:30 PM, The maintenance staff was notified of a cold room issue in room [ROOM NUMBER] and other residents' rooms. A recent temperature monitoring was requested. Maintenance staff explained that they only kept a record if staff called them asking to lower the temperature or to increase the room temperature manually. Otherwise, it is set at a specific temperature for all rooms. When examining the request adjustment log, 1139 was not on the request list. The maintenance staff revealed he did not work over the weekend or during the Labor Day holiday. Resident #116 (R116): (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial tour, R116 was observed talking to her neighbor who was visiting on 09/04/24 11:25 am. R116 complained about not getting enough rest and sleep because her roommate kept her awake all day and night. The roommate's TV was loud. R116 explained that her roommate has behaviors, and at times, R116 has to use the call light for the staff to come. As a result, R116 indicated that she could not rest or sleep because she kept an eye out for her roommate. She had told staff that she wished to be in a different room to get some rest so she could get better, but nothing had been done. On 09/04/24 at 12:05 PM, an electronic medical record review revealed, R116 was [AGE] years old, admitted to the skilled nursing facility on 8/16/24 with a diagnosis of Fibromyalgia, Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, and Stage 1 pressure ulcer of the right heel in addition to other diagnoses. On 9/05/24 at 1:30 PM, the Admission Staff K was interviewed. Admission Staff K revealed that she had not heard about this issue and that no one had told her about the complaint. On 09/09/24 at 1:42 PM, R116 was found in a different room. R116 indicated that she had a restful weekend and on the road to recovery. R116 indicated she was pleased with the move and stated: I can now focus on getting better and get home soon. Resident #120 (R120): During an interview with R120 on 09/03/24 at 11:52 am, R120 revealed that the room (#1139) was too cold and they had not done anything to get the room warmer. During the interview, R120 was observed all covered with blanket sheets, and his head wrapped in a towel. R120 had requested a wider bed since admission on 8/30/24. He indicated that he felt uncomfortable and unsafe moving side to side because the bed was too narrow, and he could fall anytime. R120 claimed he has a sore on the butt and wishes to take the pressure off to avoid the sore from worsening. On 09/04/24 at 12:00 PM, an electronic medical record review revealed, R120 was [AGE] years old, admitted to a skilled nursing facility on 8/30/24 with a diagnosis of General Muscle Weakness, Type 2 Diabetes Mellitus, and Essential Hypertension in addition to other diagnoses. On 09/05/24 at 11:30 AM, R120 was observed moved to a new room. R120 revealed that the room temperature in the new room is much warmer, and was on a wider bed. He stated that it feels much safer to move from side to side. R120 denied anyone measuring the side rails. The nurse and rehab looked at it but did not measure the bed. 37666 Resident #70: A record review of the Face sheet and medical record indicated Resident #70 was admitted to the facility on [DATE] with diagnoses: history of a stroke, COPD, and heart disease. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/03/24 at 11:40 AM, Resident #70 was observed lying in bed in his room, awake alert and talkative. He said he did not eat breakfast that morning. The resident said he was not hungry, because he was up all night and did not get any sleep. Resident #70 said he didn't sleep because his room was cold; he said he was not sure if he would want to eat lunch. When further questioned Resident #70 said his room was very cold at night. On 9/9/2024 at 1:00 PM, Resident #70 was observed in a different room. He said he was moved into the room that day. When asked how the temperature was he stated, A lot better than the other room. The resident was asked if he had eaten lunch and he said he had. On 9/09/2024 at 3:14 PM, Registered Dietitian/ RD H was interviewed. She noted Resident #70 was weighed weekly and appeared to have lost 6 lbs. since admission. She said the dietitians completed weekly assessments on the resident and reviewed weights, the diet and the residents food intake. Reviewed the resident was satisfied with his room move. A review of the Centers for Medicare and Medicaid Services/CMS document Your Rights and Protections as a Nursing Home Resident, dated 9/6/2023 provided the following, . As a nursing home resident, you have certain rights and protections under Federal and state law that help ensure you get the care and services you need. You have the right to be informed, make your own decisions a, and have your personal information kept private . You have the right to: Be Treated with Respect: You have the right to be treated with dignity and respect .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 This Citation pertains to Intake Numbers MI00141690 and MI00145384, Based on observation, interview, and record review, the facility failed to ensure a safe environment with adequate supervision and implement interventions to prevent a fall for two residents (Resident #14 and Resident #119) and failed to do a complete investigation for both residents resulting in Resident #14 sustaining multiple rib fractures after a fall and a potential for pain and a decline in medical condition and the likelihood of fall with injury to recur due to incomplete investigations for both Resident #14 and Resident #119. Findings include: Accidents Resident #14 (R14): According to the review of electronic medical records (EMR) on 9/4/24 at 1:00 PM, R14 was [AGE] years old and admitted to the skilled nursing facility on 5/5/24 with a diagnosis of Postoperative (Postop) ORIF (Open Reduction Internal Fixation) of the left trimalleolar fracture with general weakness in addition to other diagnosis. On 5/10/24, the facility assessment deemed R14 alert, oriented X 4, and her own person. R14's Brief Interview for Mental Status (BIMS) Score was 15/15 on 5/10/24. A score of 13 to 15 points suggests that cognition is intact. R14's other assessments, dated 5/10/24, revealed that R14 had a one-sided impairment in both the upper and lower extremities. R14 has typically ambulated using a wheelchair in the last seven days. The plan for R14 's admission at the skilled facility was to receive physical and occupational therapy Postop ORIF. A review of the written summary submitted by the facility was conducted on 9/4/24 at 1:05 PM. Essential details were missing, such as the date and time of the fall, the name of the resident involved, and the writer of the summary. It noted: Resident was in the bathroom with hands-on grab bars and gate belt on. CNA was adjusting and the pant leg caught on the cast. Simultaneously, the resident turned spontaneously, slipping on pant leg and landing on garbage can . Later in the day, resident c/o pain to the left side and x-ray ordered. X-ray showed Acute minimally displaced fractures anterior left rib number seven and six. Treatment with Lidocaine patch improving pain. The investigation did not identify the Certified Nurse Aide (CNA) and the nurses who responded to the incident. There was no contact information available and no interviews or written statements from the staff to indicate that the facility ruled out that abuse or neglect did or did not occur as the final analysis of the investigation. Upon request, the facility did not have an incident report (I/A) of the fall. According to the nurse's progress notes dated 5/8/24, the fall occurred at approximately 1:33 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Diagnostic Radiology (X-ray) Report performed on 5/9/24 at 16:01 revealed that the reason for the exam: (XR Ribs with PA Chest Bilateral) Left Rib pan: Fall .Findings: Acute minimally-displaced fractures anterior left rib number seven and six. A Closed Record Review was conducted on 09/05/24 at 12:45 PM. According to the Nurse's Progress notes dated 5/8/2024 at 1:56 PM, it wrote: While patient was transferring in the bathroom back to wheelchair (w/c) patient left leg got caught on her pant leg and her right leg slipped and patient fell .CNA was in the bathroom at the time of the fall. Patient tried grabbing w/c while falling and hit her left arm and side on the garbage can . In the Nurse's Progress Notes dated 5/8/24 at 1:56 PM, there was no explanation if the CNA was near the resident, assumed a stand-by assist, held the patient (contact guard assist CGA), or was anywhere else when R14 slipped and fell . The May 10, 2024, MDS assessment indicated that R14 showed a one-sided impairment of both upper and lower left extremities. The left lower extremity had a cast (post-surgical cast) at the time of the fall. A Nursing Narrative Note dated 5/9/24 at 3:36 PM revealed that R14 transfer status was changed to two-person assistance (2PA) after the fall: Patient up to wheelchair with 2 PA without difficulty. R14's updated care plan included staff adjusting clothing before standing and transferring. Electronically signed on 5/9/24 at 3:41 PM. The facility did not use an Incident Report nor submitted a facility version of an Investigation/Accident (I/A) Report. There was no summary of the investigation, including the resident's name (or Identifier), date and time of the fall, The staff involved during the incident, and their actual description of what happened. After gathering data, there was no investigative conclusion to rule out abuse or neglect in the incident file. The Registered Physical Therapy RPT M was interviewed on 09/05/24 at 01:05 PM. RPT M revealed that R14 had impaired cognition due to Traumatic Brain Injury (TBI) secondary to Motor Vehicle Accident (MVA), Closed Head Injury with Left Hemiplegia. R14 had Clavicular and left ankle fractures upon admission. R14 was cognitively impaired from admission and had an apparent left-sided upper and lower extremities impairment; therefore, she should not be left unassisted nor unsupervised in the bathroom. According to RPT M, as a result of the fall, R14 sustained a multiple rib fracture. R14 made progress but did not reach her goal. R14 was discharged and transferred to another skilled nursing facility. On 09/05/24 at 01:12 PM, OTR O described R14's Activities of Daily Living ADL, such as dressing/bathing, at 50% assistance upon admission and discharge, required 25% assistance. The left ankle cast was too bulky, huge, and heavy. R14 required maximum assistance for toileting upon admission, with minimum assistance when she was discharged on [DATE], requiring 25% minimal help. Initially, the plan was to go home to her apartment, but instead, she was discharged to another facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Director of Nursing (DON) during the interview on 09/05/24 at 11:18 AM. The DON revealed that she was not the DON when the fall occurred. Therefore, she could not speak for what happened during the fall investigation and what actions post-fall, including staff education. The DON denied access to the Facility Reported Incident file because it was before her time. When asked if there are any details of what happened and who the staff was when the fall sustaining a fracture occurred? She stated, That is all the detail. When asked if they have an investigation form or an incident and accident form where a specific date, time, staff, witness, and event description is written. The DON said, That's all they can provide. The DON submitted a Fall Policy but did not submit the requested policy on Incident and Accident Reporting as requested. The surveyor asked where the I/A reporting Policy was, the DON stated that the investigation policy is included in the fall prevention policy. Resident #119 (R119): Accidents 09/04/24 01:50 PM, a facility's Incident (I/A) Report was requested for R119 Fall on 9/2/24. The DON submitted a notepad sheet with her handwritten notes on it. She revealed that it is not completed and that all she has is a handwritten scribble, and she has yet to interview the nurse and the CNA when they return to work. On 9/4/24 at 2:00 PM, it was observed that there was no investigation nor process of data collection, including interviews completed from R119's fall that happened on 9/2/24 (two days ago). No interviews, no summary or analysis of R119's fall incident to rule out neglect or abuse did or did not occur. According to the electronic Medical Record (EMR), R119 was admitted on [DATE] at 1820 (6:20 PM). Reviewing the notes handwritten on a notepad submitted by the DON on 9/4/24 at 4:35 PM, the fall occurred the following day of admission. On 9/2/24 at 9:59 AM, Slid off the toilet no injury noted; CNA name called phone disconnected to follow-up on Friday 9/6/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/05/24 at 2:03 PM, Nurse T was interviewed. Nurse T revealed that R119 needed to do number two (bowel movement), so they transferred him to the bathroom and stated: I instructed him to use the call light when he's ready. At that time, Nurse T recalled that R119 was a 2-person assist (2PA) on transfers and had a gait belt on but did not wear the skid socks. The staff left him in the bathroom and instructed him to use his call light when ready. R119 used his call light, but after, he was already on the floor. Nurse T stated, That is when we discovered he had fallen. Nurse T continued by saying that the staff responded to his call light and found him on the floor. When staff arrived, R119 had soiled himself from the toilet seat to the floor, where he slid. He seemed alert and oriented upon admission. Nurse T stated, I trusted him to press the call light. He must have stood up after using the bathroom and fell off the toilet seat. When we got him up, we realized his left hand was weak. Nurse T further indicated that R119 's left hand was on the bar and left knee bent. The doctor responded immediately after R119's fall. Nurse T said, I did not know that he had a stroke in July of 2024 and did not know his cognition at that time. Nurse T continued, saying, It just made sense as to why his speech was slowed. Nurse T continued and described, I think he was trying to get up because of the way the feces markings were all over. It was on the toilet seat and the floor where he slipped and landed. We stood him up maybe two times to wash him. When asked how long he was left alone, Nurse T denied remembering because they waited for him to activate the call light. In his bathroom during the fall, R119's care plan was that he needed supervision and two-person assistance (2PA) with activities of daily living, especially transferring. Nurse T stated she followed the Fall protocol post-fall and filled out the Safety First post-fall on 9/2/24. On 9/4/24 at 2:00 PM, an attempt was made to call the CNA U by phone, but the message said: The call can not be completed as dialed as the person is temporarily unavailable. On 9/4//24 at 2:15 PM, a review of submitted documents for R119's fall investigation showed no I/A report, statements, or investigation summary. No statements from the CNA or the nurse were obtained. R119's fall investigation reviewed on 9/4/24 at 2:45 PM was incomplete. The DON was asked for any other documentation about R119's fall. The DON stated, Safety First is a hospital's internal information. The huddle and safety first were documents that are QA protected and therefore will not be shared with surveyors. On 09/05/24 at 01:27 PM, According to the Registered Physical Therapist M (RPT M), R119's fall was not reported to Therapy. RPT M stated, This is the first time she heard about R119's fall. No one had told us about him falling on 9/2/24. Since 9/2/24 was Labor Day Holiday, we were not here, and there was no one for Therapy that day. RPT M described R119's status upon admission evaluation, requiring moderate assistance in sitting to maintain balance. On 9/3/24, an admission assessment revealed that R119 needed 50% help. RPT M PT notes from 9/5/24 indicated that R119's participation was better in the morning and very challenged in the late afternoon. RPT M denied evaluation was done after the fall on 9/2/24. She stated: It was not done because the therapy department did not receive a report. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 9/4/24 at 1:50 PM, according to the DON, they use the Fall Prevention Policy for their I/A reporting procedure. After a review of the Fall Prevention Policy, the Fall Huddle was requested, and the Safety First form was requested per their Fall Policy. The DON insisted that they are not to provide the Fall Huddle nor the Safety First information because it is protected by Quality Assurance (QA). The Fall Prevention Policy was reviewed on 9/4/24 at 4:32 PM. The Policy dated May 2022 revealed: Purpose: To evaluate and determine the level of fall risk for all residents, implement safety precautions/ interventions for residents based on criteria for low fall risk, moderate fall risk, and high fall risk. To improve the prevention and management of falls. .l. Complete a Nurse Fall Huddle. Include who fell , when discovered, where, what happened, why, if known, the observer's findings, patient's comments/statements exactly, observation of surroundings for spills, hazards, whether the patient had slippers on, or any other information to prevent future falls. Initiate Safety First. DO NOT refer to the occurrence report in the nursing record. Refer to Quality Management Policy #71:82:08. Occurrence Reporting Process

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation pertains to Intake Number MI00141690. Based on observation, interview and record review, the facility failed to perform assessments and perform ongoing monitoring of all bed rails to identify potential areas of entrapment for all facility residents including the following residents: #'65, #70, #115, #116, and #120, resulting in the potential for zones of entrapment to remain unidentified, posing a risk to all 15 residents. Findings Include: Resident #65: A record review of the medical record, indicated Resident #65 was admitted to the facility on [DATE] with diagnoses: history of falls with left knee fracture, arthritis, neck pain, hypertension, atrial fibrillation and macular degeneration. On 9/03/2024 at 11:33 AM, Resident #65 was observed sitting in her wheelchair in the day room waiting for lunch. She said she had a history of falls at home, and her left knee cap had a fracture. She said she was at the facility for therapy. On 9/9/2024 at 11:37 AM, the Maintenance Technician L was interviewed while standing outside Resident #65's room. She was lying in bed and her upper siderails were up. They were observed to have several large openings in the middle of the rails. Maintenance Technician L was asked about the siderails on the bed and he said every bed had siderails. He said the maintenance department would check the siderails if someone complained that they were not functioning properly. Maintenance Technician L was asked if he assessed the gaps in the siderails or gaps between the siderail and headboard or siderail and side of the bed for potential entrapment and safety issues. He said he thought the Biomedical (Biomed) technician did that. On 9/9/2024 at 11:50 AM, the Director of Nursing/DON was interviewed about the siderails on the residents' beds; she was asked if there were documents with the siderail measurements for each bed. The DON stated, I have not seen them. I think Biomed does that if the nurse has a problem with the gap. Reviewed with the DON that the residents had orders for Restorative Program Bed Mobility: bilateral siderails . She said the facility did not have a Restorative Program, as the residents were all receiving Therapy services. She said the only way to input the order into the electronic medical record was to place it under the Restorative program option. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse J was interviewed on 9/9/2024 at 12:30 PM about the residents' siderails. She said there were 2 forms the nurse completed for the siderails at the time of the resident's admission. One form was an informed consent for siderail use and the other was a nursing assessment for the siderails. She said the siderails were on all the beds and usually people signed that they wanted them. She said the assessment form asked about a gap between the mattress and the bed, but she said they didn't measure the gap, they eyeballed it and filled out the form. She said if a family member or someone had a question about the siderails, then they would measure the gaps, otherwise they did not. She said she had never measured the gaps. Resident #70: Accidents A review of the medical record for Resident #70 indicated an admission to the facility on [DATE] with diagnoses: history of a stroke, heart disease, hypertension, hypothyroidism and arthritis. On 9/03/2024 at 11:39 AM, Resident #70 was observed in room [ROOM NUMBER]. On 9/4/2024 at 8:00 AM, he was observed in room [ROOM NUMBER] and on 9/9/2024 at 1:00 PM, Resident #70 was observed in room [ROOM NUMBER]. He said they had moved his room the first time because his room was too cold and then the new room (1139) was too cold. He was moved to room [ROOM NUMBER] on 9/9/2024. The resident was moved to each new room without his current bed. He had a new bed with each room move. There were no siderail assessments for each bed. A review of the Care Plans for Resident #70 identified a Baseline Care Plan with Fall risk- interventions, including left and right quarter rails on bed for mobility. A review of the physician orders identified Restorative Program Bed Mobility: . bilateral side rails for bed mobility, strength/condition and increased independence. Dated 9/3/2024 a 8:34 AM. The order did not specify if the resident was to have upper or lower siderails. On 9/9/2024 at 1:15 PM, the DON said the Biomed department did not assess the siderails for the residents' beds. 22348 Resident #115 (R115): On 9/9/24 at 12:30 PM, R115 was observed sleeping in bed with both side rails up and her head positioned almost at the edge of the right side, touching the side rails while her body was across the bed and both legs positioned on her left side. R115 was very confused in bed and was not interviewable. Resident #116 (R116): R116 was transferred to another room on 9/5/24 with a different bed with bilateral side rails and bilateral mid-body side rails attached. No new assessments were made, and no measurement of a gap for entrapment was noted. No updates on the care plan were found related to side rail use after R116's room transfer on 9/5/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McLaren Lapeer Region	1375 N Main St Lapeer, MI 48446

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #120 (R120): R120 was transferred to another room on 9/4/24 with a different bed with bilateral side rails and mid-body side rails attached. No new assessments were made, and no measurement of a gap for entrapment was noted. There were no updates on his care plan related to side rail use after R120's room transfer was found. Resident #70 (R70): R70 was transferred to another room observation on 9/4/24 with a different bed with bilateral side rails and mid-body bilateral side rails attached. There is no new assessment measurement on the gap for entrapment. There were no updates on his care plan related to side rail use after transfer. The following Assist Bar/Side Rails Assessments were reviewed. Residents: R70, R115, R116, R119, and R120's Assist Bar/Side Rails Assessments did not reflect any measurements with bilateral side rails and mid-body side rails. R116's Side Rail Assessment record was dated 8/16/24. On 9/9/24 at 3 PM, No updated assessment was performed after she transferred to the new room and new bed. R120's Side Rail Assessment record was submitted on 9/9/24 at 3:00 PM, for No updated assessment was performed after R120 transferred to the new room and bed. On 9/9/24 at 3:00 PM, the R70 Side Rail Assessment Record was reviewed. It revealed that the assessment was done on 9/2/24. It was noted that during the assessment on 9/2/24, it indicated: > Is there a measurable gap between the assist bar/side rail and the mattress? YES (was checked) > If the answer to the above question is yes, is the gap less than 2/12 inches? YES (was checked) No updated assessment and further action regarding the measurement of the gap was found and no Biomed referral was noted. No further updates and new assessment was performed after R70 transferred to the new room and new bed on 9/4/24. R120 was interviewed on 09/05/24 at 11:54 AM after the transfer to his new assigned bed. R120 revealed that the bed feels wider and safer on it. Much better. R120 denied seeing staff taking measurements of the side rails. On 09/09/24 at 12:05 PM, During an interview with the Director of Nursing (DON), the Side Rails Policy and the side rail assessments for each of the above residents were requested. The side rails, mattress, and bed measurements were also asked. According to the DON, she revealed that anything over two inches gap between the bed and the rails would require Biomed to measure. Otherwise, the nurses visually measure the gap between the bed and the side rails. No measurements in terms of centimeters or inches were taken using a ruler or tape measure. The DON, 09/09/24 at 12:07 PM, explained that if there's anything more than two inches, Biomed will be notified. Nurses document them in the assessment checklist upon admission. The DON denied any measurement done on R120's bed when he was moved to his new room. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/9/24 at 4:00 PM, the Proper Use of Assist Bars /Bed Rails Policy, dated 7/25/2024, was reviewed. The purpose specified: It is the policy of this facility to utilize a person-centered approach when determining the use of assist bar/bed rails. Assistive devices are to be used to enhance the resident's self-performance and promote independence with bed mobility to attain and or maintain the resident's highest practicable level of physician or psychological well-being . .4.1.4. The resident assessment should assess the resident's Risk for entrapment between the mattress and the bed rail or the bed rail itself. 4.1.5. The facility will assess to determine if the bed rail meets the definition of a restraint. A bed rail is considered to be a restraint if the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bedrail independently. If it is determined to be a restraint, the facility will follow their procedures related to physical restraint . .4.3.3 . Assessment of the resident, the bed, the mattress, and rail for entrapment risk (which would include ensuring bed dimensions are appropriate for resident's size/weight), and Risk and benefits were reviewed with the resident or resident representative and informed consent was given before installation or use . .4.5. Ongoing Monitoring and Supervision .4.5.4 . The facility will continue to provide necessary treatment and care to the resident who has bedrails in accordance with professional standards of practice and the resident's choice. This should be evidenced in the resident's records, including the care plan .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review the facility failed to appropriately store supplies in one Clean Utility/ Medication Storage Room of one room reviewed and ensure that one Medication/Treatment Cart of two carts reviewed was properly secured and that confidential resident information was secured, resulting in the potential for use of contaminated and outdated supplies and access to residents' medications and confidential information. Findings Include: FACILITY Medication Storage and Labeling A review of the facility medication carts with Nurse J, on 9/4/2024 at 2:00 PM, identified a medication cart unattended in the hallway outside of the day room with several medication drawers open; the medication cart was unlocked. In addition, resident information was on the computer screen: visible to anyone nearby. Nurse J shut the medication cart drawers, closed the computer screen and ensured the cart was locked. She said she thought Nurse D had stepped away from the cart and was in the medication room down the hallway. On 9/04/2024 at 2:20 PM, the facilities medication room was reviewed with Nurse A. She said the medication room/clean utility room contained a locked medication dispensing machine, a locked medication dispensing refrigerator and new facility supplies. The medication room had a double door cupboard with clear boxes and other equipment inside. Nurse A said the equipment belonged to Occupational Therapy/OT. Upon inspection, the equipment included old metal eating utensils and additional old equipment with opened wrappers. There was a large fingernail brush with hair stuck in it. Nurse A said the therapy department would know about the items. On 9/04/2024 at 2: 35 PM, the medication room cupboards were observed/ reviewed with Occupational Therapist/ OT N. She said the cupboard had OT equipment in them, but she said no one had used it. She said it hadn't been used in the entire time she worked at the facility- about [AGE] years. On 9/04/2024 at 3:20 PM, the Therapy Manager O was interviewed about the clean utility room/medication room, and said Therapy did not store any equipment in the medication storage/clean utility room. He said he had never seen it. He said they do not store equipment in the medication room, only in the therapy gym. On 9/4/2024 at 4:00 PM, the Director of Nursing/DON was interviewed about the findings in the medication room and said the items would be disposed of. Also reviewed one medication cart was observed to be unlocked with open drawers and resident information unsecured. She said she would handle it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Medication Storage Areas and Monthly Pharmacy Inspections/Temperature Monitoring, effective date [DATE] revealed, . Proper storage and accountability are intended to assure the availability of medications for patients that are within the manufacturer's intended potency and safety standards .Each medication storage area shall be locked . Monthly medication checks shall include the pharmacy and all areas where medications are stored .

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 37666 Based on interview and record review the facility failed to ensure that the Quality Assessment and Process Improvement (QAPI) meetings were held quarterly, resulting in the lack of identification of concerns in the facility or corrective action being provided and no monitoring of issues, potentially affecting all residents living in the facility. Findings Include: FACILITY QAPI and QAA On 9/09/2024 at 3:54 PM, the Director of Nursing/DON was interviewed about the facility Quality Assurance Process Improvement/ QAPI program. When asked how often the QAPI committee met, the DON said the committee was supposed to meet quarterly and showed 2 meeting sign in sheets for a QAPI meeting in May 2024 and June 2024. She said she started at the facility in June 2024 and when she looked for the QAPI committee meeting minutes and sign in sheets, there were none. The DON said the interim DON had a meeting in May 2024 and she had a meeting in June 2024, but there were no meeting sign in sheets prior to that. The DON said she did not know if the committee met quarterly over the past year. A review of the facility policy titled, (Facility) Quality Assurance Committee, effective date March 2022 provided, Purpose: Identify issues and implement appropriate plan of action to correct identified deficiencies . The Quality Assurance Meetings will be held at least quarterly to identify quality-related issues .

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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** 37666 Based on observation, interview, and record review, the facility failed to ensure Infection Prevention and Control standards of practice were followed for 1). Hand Hygiene and Personal Protective Equipment/PPE use for one resident (Resident #120), 2.) a Water Management program specific to the facility, and 3.) Pneumonia and COVID Vaccination consent was not obtained and administered for one resident (Resident #71), resulting in the potential for the spread of infection, which could cause serious illness. Findings Include: FACILITY Infection Control: On 9/05/2024 at 9:38 AM, during an interview with the Infection Preventionist/IP A she was asked about the facilities Water Management Program. The IP A said the maintenance department in the hospital handled the Legionella water testing for the facility and it was last performed in the summer. She said she had seen the results and had communication with the Maintenance Director. IP A was asked for a copy of the Water Management Plan and she said the hospital Maintenance Director had the plan. Water mgt program for Hospital does not mention the facility TCU (Transitional care unit) LTC- there is water testing for Legionella, test results reviewed, no positive water samples in the TCU, a positive water sample in a closed hospital building, addressed by the hospital, On 9/5/2024 the Legionella water sample testing results for 10/4/2023- 7/12/2024 were reviewed; sampling was completed quarterly. The samples taken in the long-term care facility were of the same 2 rooms each quarter 1137 and 1145 and twice an additional site was added- such as the day room sink. A review of the attached hospital's Water Safety and Management Plan, date issued 1/31/2020 and revised 3/5/2024 revealed the following, . This purpose of this water safety and management plan (WSMP) is to minimize risk for Legionella associated with the building water systems at (the hospital) . Legionella is a bacterium that belongs to the Legionellaceae family . Approximately half of the species have been implicated in human disease. Legionella pneumophila contaminates up to 70% of all building water systems, both potable and non-potable, and is the species responsible for approximately 90% of Legionnaires' disease infections . The hospital's Water Safety and Management Plan, contained a section titled, Building Services Description, that included, List the services provided on each floor or area of the buildings included in this WSMP. For each floor or area describe any infection concerns relative to the services provided. Infection concerns should be based on the types of patients/services provided . The hospital's Long-Term Care unit referred to as TCU (Transitional care unit) provided services to vulnerable patients (residents), many of them elderly, who needed additional medical care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The WSMP Building Services Description did not mention the Long-Term Care unit/TCU. There was quarterly water testing in rooms [ROOM NUMBERS], but there was no mention of the facility or the risk to the residents admitted to the facility. Many of the residents were post-surgical or had wounds of other types and some had infections with Multi-drug resistant organisms (MDRO); this can add to a patient's susceptibility to other infectious organisms. On 9/5/2024 at 11:30 AM, during an interview with the Maintenance Director P he reviewed the hospital's Legionella water samples and the WSMP. The Maintenance Director P was asked why the WSMP did not mention the Long-Term Care unit/TCU, but mentioned other areas of the hospital. He said he wasn't sure why it wasn't included. The Maintenance Director was asked if the Infection Preventionist from the TCU was included in meetings related to the Legionella water testing in the TCU; he said she was not a member of the meeting but could be included. The WSMP was reviewed with the Maintenance Director and he was asked if the TCU Infection Preventionist had any input into the WSMP and he said the hospital IP assisted with the program. Reviewed the IP in the TCU collected Infection Surveillance with monthly summary reports of her findings and could share them to aid in ensuring a Water Management program was specific to the TCU's resident population. 22348 Vaccination Resident #71 (R71): R71 was [AGE] years old and admitted to the facility on [DATE]. On 9/9/24 at 2:30 PM, R71's Vaccination Record was reviewed. The Pneumococcal Vaccination Screening form dated 9/3/24 was not completed. R71 or R71's designated representative's consent and signature were not obtained. There was no COVID vaccination screening, and the consent form was not obtained for R71. The designated Infection Control Preventionist (ICP Nurse) was interviewed on 9/9/24 at 2:35 PM. She revealed that she was responsible for the implementation of the facility's Vaccination Program and indicated that it was not done. The ICP Nurse revealed that R71 was deemed unable to consent to the vaccination and had not seen the resident's representative for consent. The influenza vaccine was not offered to residents because it is not flu season yet. Wound Observation Resident #120 (R120): On 09/09/24 at 11:07 AM, a wound care observation was conducted. Resident #120 (R120) had previously told the surveyor that he received treatments on his bottom. Registered Nurse (RN) S was assigned to provide wound care for R120. During an interview on 9/9/24 at 11:15 AM, RN S stated that the treatment would be applying the fungal powder to R120's abdominal fold. The wound observation was conducted on 09/09/24, starting from 11:17 AM up to 11:25 AM. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/24 at 11:17 AM, RN S put her gloves on, started cleansing the abdominal fold with a wound solution, and later applied the cream on R120's abdominal fold. RN S was observed wearing the same glove from the start of the treatment, removing the dirty incontinence pad, cleansing the abdominal fold using a sponge and wound cleansing solution, applied the prescribed nystatin powder. RN S asked to leave the room to get the nursing assistant at 11:20 AM. Meanwhile, R120 was on his back and abdomen, and his privates were exposed. The nurse left to get the nurse's aide for assistance. RN S returned with a Certified Nursing Assistant CNA T on 09/09/24 at 11:21 AM. RN S returned with fresh gloves. CNA T and the nurse completed the incontinence care. R120's coccyx was observed clear. The skin was intact, and no redness or discoloration was noted on R120's coccyx. After the observation was completed on 9/9/24 at 11:25 AM, the surveyor discussed the observation with Nurse S. Nurse S agreed that she did not change gloves, did not wash hands and did not sanitize hands in between steps and process during the wound care treatment. Nurse S also removed R71's dirty incontinence pad, cleansed the abdominal folds, applied the prescribed treatment, and replaced R120's clean incontinence pad. The nurse agreed she was too focused on the treatment process and forgot the importance of hand washing, hand hygiene techniques, and changing gloves as Personal Protective Equipment when necessary.