STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235608	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Pines Nursing and Rehabilitation Center	2121 Rockwell Dr Midland, MI 48642

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on interview and record review, the facility failed to inform the resident and/or the resident's responsible party, in advance of care, of the risks, benefits, and possible alternatives of treatment for the use of psychoactive medications for 1 of 1 resident (R71) reviewed for dementia care, resulting in the potential for the responsible party being uninformed of the resident's treatments and not able to choose to continue the treatments and/or choose an alternative preferred option. Findings include: A review of R71's Admission Record, dated 1/29/25, revealed R71 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, the Admission Record revealed multiple diagnoses that included Alzheimer's Disease, dementia with behaviors, depression, and anxiety. The Admission Record also revealed R71 had a Financial Power of Attorney (Durable Power of Attorney Q) and listed the resident and Durable Power of Attorney (DPOA) Q as the responsible parties. A review of R71's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 12/17/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 13 which revealed R71 was cognitively intact. A review of R71's Physician Determination of Decision Making Capability, dated 5/31/24, revealed R71 had been determined unable to make medical treatment decisions by their attending physician and a supporting physician/licensed psychologist. A review of R71's Specific Durable Power of Attorney for Personal and Medical Care, dated 1/17/23, revealed R71 had designated DPOA R and DPOA S (alternative) as the individuals who were to make medical decisions for R71 if they could no longer make medical decisions. A review of R71's Durable Power of Attorney form, dated 1/17/23, revealed R71 had designated DPOA S and DPOA Q (alternative) as the individuals who were to make financial decisions for R71 if they could no longer make financial decisions. A second review of R71's Admission Record, dated 1/29/25, failed to reveal any listing by name and/or contact information for DPOA R and/or DPOA S. A review of R71's January 2025 Medication Administration Record (MAR) revealed R71 was receiving Lexapro 20 milligrams (mg) for depression, Zyprexa 5 mg for delusions, and Ativan 0.5 mg for anxiety. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R71's Informed Consent for Medication for Lexapro, dated 8/12/24, revealed DPOA Q (R71's financial, not medical DPOA) had been informed on 8/8/24 of the reason for it's usage, the expected therapeutic goal, possible consequences of not taking the medication, the possible side effects of the medication's usage, and the ability to refuse to consent to R71 taking the medication at any time. A review of R71's Informed Consent for Medication for Zyprexa, dated 1/27/25, revealed DPOA Q (R71's financial, not medical DPOA) had been informed on 1/24/25 of the reason for it's usage, the expected therapeutic goal, possible consequences of not taking the medication, the possible side effects of the medication's usage, and the ability to refuse to consent to R71 taking the medication at any time. A review of R71's Informed Consent for Medication for Ativan, dated 1/27/25, revealed DPOA Q (R71's financial, not medical DPOA) had been informed on 1/24/25 of the reason for it's usage, the expected therapeutic goal, possible consequences of not taking the medication, the possible side effects of the medication's usage, and the ability to refuse to consent to R71 taking the medication at any time. A review of R71's progress notes, dated 3/14/24 to 1/30/25, failed to reveal any documentation that DPOA R and/or DPOA S had ever been contacted regarding R71's medical care/needs, including the risks, benefits, and possible alternatives of treatment for the use of psychoactive medications (medications that affect an individual's mental processes- e.g., antidepressants, anti-anxiety, and medications for delusions). In addition, R71's progress notes failed to reveal that the facility had ever talked to R71 specifically about the psychoactive medications she was taking. A review of R71's Interdisciplinary Documentation, dated 3/18/24, revealed R71's son (DPOA Q) informed the nurse that R71's other son (DPOA S- alternate medical decision maker) and his wife (DPOA R- primary medical decision maker) were R71's medical DPOA's. DPOA Q stated DPOA S had terminal cancer and could not make decisions for R71 anymore. The nurse told DPOA Q that she would relay the message to the social worker and have her call him. However, there was not any documentation that the message had been relayed to the social worker and/or that the social worker had followed up with DPOA Q regarding this information. During an interview on 1/29/25 at 1:40 PM, the Director of Nursing (DON) stated she called DPOA Q and he informed her that DPOA S passed away two days ago. She stated they do not have a phone number or contact information for DPOA R. The DON stated she was aware that DPOA Q had been notified every time that the facility needed medical decisions made, even though he was only listed as the Financial DPOA. The DON verified she could not find any documentation that DPOA R and/or DPOA S had participated in care conferences and/or been notified regarding making any medical decisions for R71, including the risks, benefits, and possible alternatives of treatment for the use of psychoactive medications.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on interview and record review, the facility failed to conduct a care conference timely for 1 of 18 sampled residents (R43), resulting in the potential for R43 and/or their responsible party not having an opportunity to participate in their person-centered plan of care and/or the planning process for their care. Findings include: A review of R43's Admission Record, dated 1/29/25, revealed R43 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R43's Admission Record revealed multiple diagnoses that included a cerebral infraction (stroke), dementia, and depression. A review of R43's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 11/12/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 12 which revealed R43 was moderately cognitively intact. A review of R43's Physician Determination of Decision Making Capability, dated 8/16/24, revealed R43 had been determined to be unable to make medical treatment decisions by their attending physician and a supporting physician/licensed psychologist. A review of R43's electronic medical record, dated 8/8/24 to 1/30/24, revealed R43 had only one care conference on 8/12/24 (the Admission care conference). A review of R43's progress notes, dated 8/12/24 to 1/29/25, failed to reveal any attempts by the facility to schedule a care conference for R43 after the initial Admission care conference. During an interview on 01/30/25 at 11:50 AM, Social Services Director (SSD) F, confirmed R43 had not had a care conference where R43 and/or their responsible party would have an opportunity to participate in their person-centered plan of care and/or the planning process for their care since August 2024 (over 5 1/2 months ago). SSD F stated that they have not had one because R43 was going to court on 2/4/25 for guardianship and hopefully then we can finally get someone to come in to talk to about her care. SSD F further stated residents are supposed to have resident care conferences at least every 3 months, or sooner if the family requests one. A review of R43's Petition for Appointment of Guardian of Incapacitated Individual, dated 11/26/24, revealed the facility was petitioning the court to appoint a guardian because the current patient advocate is not acting consistent with the ward's (R43) best interests by not participating in care conferences. However, no care conferences had been scheduled, or attempted to be scheduled, since R43 was determined unable to make medical treatment decisions on 8/16/24. A review of R43's Notice of Hearing, dated 11/26/24, revealed R43 had a court date of 2/4/25 to petition for the appointment of a guardian. Therefore, according to SSD F, by the time the next care conference would be scheduled R43 would not have had a care conference in 6 months or more.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on interview and record review, the facility failed to notify the resident's responsible party of the resident's preferred treatment options for 1 of 18 sampled residents (R71). Findings include: A review of R71's Admission Record, dated 1/29/25, revealed R71 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, the Admission Record revealed multiple diagnoses that included Alzheimer's Disease, dementia with behaviors, depression, and anxiety. The Admission Record also revealed R71 had a Financial Power of Attorney (Durable Power of Attorney Q). A review of R71's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 12/17/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 13 which revealed R71 was cognitively intact. A review of R71's Physician Determination of Decision Making Capability, dated 5/31/24, revealed R71 had been determined unable to make medical treatment decisions by their attending physician and a supporting physician/licensed psychologist. A review of R71's Specific Durable Power of Attorney for Personal and Medical Care, dated 1/17/23, revealed R71 had designated Durable Power of Attorney (DPOA) R and DPOA S as the individuals who were to make medical decisions for R71 if she could no longer make medical decisions. A review of R71's Durable Power of Attorney form, dated 1/17/23, revealed R71 had designated DPOA S (primary) and DPOA Q (alternative) as the individuals who were to make financial decisions for R71 if they could no longer make financial decisions. A second review of R71's Admission Record, dated 1/29/25, failed to reveal any listing by name and/or contact information for DPOA R and/or DPOA S (who are designated to make the medical decisions for R71). A review of R71's Resident Preferred Treatment Option form, dated 3/14/24, revealed the resident had chosen Status 3: The resident is to be hospitalized for any treatments that exceed the nursing home's capability and that are necessary to extend life or maintain comfort. Such treatments are not to include resuscitation. Surgical intervention is limited to conditions with a high probability of a successful outcome. A review of R71's progress notes, dated 3/14/24 to 1/30/25, failed to reveal any documentation that DPOA R and/or DPOA S (the medical DPOA's) had ever been contacted regarding R71's preferred treatment options. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R71's Interdisciplinary Documentation, dated 3/18/24, revealed R71's son (DPOA Q) informed the nurse that R71's other son (DPOA S- alternate medical decision maker) and his wife (DPOA R- primary medical decision maker) were R71's medical DPOA's. DPOA Q stated DPOA S had terminal cancer and could not make decisions for R71 anymore. The nurse told DPOA Q that she would relay the message to the social worker and have her call him. However, there was not any documentation that the message had been relayed to the social worker and/or that the social worker had followed up with DPOA Q regarding this information. During an interview on 1/29/25 at 1:40 PM, the Director of Nursing (DON) stated she called DPOA Q and he informed her that DPOA S passed away two days ago. She stated they do not have a phone number or contact information for DPOA R. The DON stated she was aware that DPOA Q had been notified every time that the facility needed medical decisions made, even though he was only listed as the Financial DPOA. The DON verified she could not find any documentation that DPOA R and/or DPOA S had ever been notified regarding R71's preferred treatment options.

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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** 31771 Based on observation and interview, the facility failed to formulate and implement a comprehensive, personalized Care Plan for one resident reviewed for Care Plans (R15) resulting in a comprehensive Care Plan without individualized or measurable interventions to assist the Resident to attain or maintain the highest practicable physical and psychosocial well-being. Findings: R15 admitted to the facility 5/17/19 with diagnoses that included Multiple Sclerosis (an autoimmune central nervous system condition), History of Stroke, Hemiplegia (weakness to one side of the body) and Anxiety. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the Resident was cognitively intact. Review of the Care Plan for R15 reflected a Focus of (R15) is here as a long-term resident. (R15) has expressed a desire to discharge at times, however reports wanting to lose weight and become stronger before she feels comfortable doing so. Initiated 5/17/19 and revised 4/26/23. The facility's documented goal to achieve the Residents desire reflected, Physical and psychosocial needs regarding ongoing care needs and preferences will be addressed. This goal for the Resident's desire to lose weight and become stronger included two Interventions. (1) Arrange for Care Conferences . and (2) MDS Section Q reviewed with appropriate contact agency referral PRN (as needed). No further interventions to demonstrate measurable or a personalized resident-centered approach to promote or maintain the Resident's physical well-being as indicated in the Focus were located. Therefor, no meaningful revisions could be made to the plan of care. On 1/29/25 at 5:03 PM an interview was conducted with the Director of Nursing (DON). The DON was asked about the current Care Plan for R15 and requested any information of the facility efforts to attain the Residents goals or improve or preserve function, range of motion (ROM), and well-being. On 1/30/25 at 12:17 PM an interview was conducted with Social Services Director (SSD) F. SSD F reported that R15 likes to stay in her room and doesn't like to go to Activities. SSD F was reminded of the Care Planned focus for R15 and reported that R15, did, at one time, indicate she wanted to go home. SSD F was asked to review the Care Plan and report what efforts were being made for R15 toward her goals as the interventions listed do not appear to be personalized or measurable. SSD F reviewed the Care Plan and suggested that SSD H has known R15 prior to his involvement with the Resident and may be able to better answer the question. On 1/30/25 at 12:26 PM an interview was conducted with SSD H who reported that R15 likes to keep to herself and, despite indicating she wants to improve, the Resident does not put forth an effort. On 1/30/25 at 12:33 PM an interview was conducted with Clinical Care Coordinator (CCC) T who reported that staff do encourage R15 to get out of bed often. The Care Plan for R15 was discussed and CCC T was asked if staff perform any ROM with R15 to improve or maintain the Residents mobility or ROM. CCC T reported that Certified Nurse Aides (CNA) perform ROM daily with R15. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR Tasks reflect ROM for R15 included 1) passive (without resident effort) range of motion of the left foot and 2) encourage to apply a resting hand splint to the left hand. The documentation reflected R15 often refused. There was no further documentation demonstrating a comprehensive effort to propel R15 toward the goals in the Care Plan. On 1/30/25 at approximately 12:45 PM, CCC T was informed of the ROM exercises of the foot and a splint assigned for R15 and was asked to provide any further documentation of facility efforts to maintain basic ROM for R15. CCC T indicated she would review the Resident's record and reported that at this time R15 was out of bed and in the common area. On 1/30/25 at 12:55 PM an interview was conducted with R15 in the common area. R15 was asked if staff were performing or having her perform any daily ROM exercises with her. R15 stated No. As of survey exit no additional information was received.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview and record review, the facility failed to address and provide assessments, catheter care, and wound care for one (R10) of three residents reviewed for skin conditions. Findings include: Resident #10 (R10) Review of a Face Sheet for R10 revealed she originally admitted to the facility on [DATE] and has pertinent diagnoses of infection and inflammatory reaction due to indwelling urethral catheter. Review of the Minimum Data Set (MDS) dated [DATE] revealed R10 is cognitively intact. In an interview on 1/28/25 at 12:20 PM, R10 was in the room and expressed recent concerns with her suprapubic catheter getting plugged up and leaking at the insertion site and not draining. She reported she had to wait until the next day to get it changed. During an observation and an interview on 1/29/25 at 10:48 AM, Licensed Practical Nurse (LPN) J removed a split 4x4 gauze that was used as a barrier between the suprapubic catheter and the insertion site. The nurse inserted a new split gauze over the open area of the wound, approximately the size of a marble. No measurements or assessment of the wound was observed. Review of a Skin assessment dated [DATE] (Monday) and locked on 1/29/25 (Wednesday) for R10 revealed she had 2 pressure ulcers and a suspected deep tissue injury. Assessment notes included: . s/p (status post) catheter patent and functions free of complication. No documentation indicating a wound at catheter insertion site. Review of the January Treatment Administration Record 2025 (TAR) for R10 revealed an order for Suprapubic Cath Care every shift. Empty Foley Catheter drainage Bag [every] shift & record output. Not marked as done on 1/11, 1/12, 1/21, 1/25, and 1/27. Review of an Order Summary for R10 revealed no orders for care of the catheter insertion site. In an interview on 1/29/25 at 3:43 PM, LPN J reported she last took care of R10 on Sunday (1/26/25) and her catheter insertion site was just a little red with little drainage, but no signs or symptoms of infection. Today she just had a little more drainage. LPN J reported she talked to the Nurse Practitioner this day who gave orders to start using a blue antimicrobial foam on the catheter insertion site. Review of the electronic medical record (EMR) on 1/30/25 for R10 revealed no new skin assessment of the suprapubic catheter insertion site, no new orders for wound care of the catheter insertion site, and no other documentation indicating it was addressed. Review of the Care Plan for R10 revealed: Interventions: Elimination: Suprapubic catheter to drainage, catheter care with soap and water with am/pm care and [as needed]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SKIN IMPAIRMENT LOCATION: coccyx, bilateral plantar feet, suprapubic catheter site, colostomy-notify nursing if dressings are soiled or falling off; . Focus: .potential for alteration in comfort related to decreased mobility, paralysis from he (sic) chest down, current suprapubic catheter . Focus: impaired skin integrity: Intervention: . Measure open areas upon admission, weekly, prn [as needed] ., re-evaluate treatment and resident condition prn with no improvement to wound appearance and/or measurements .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 37573 Based on observation, interview, and record review, the facility failed to provide restorative care, range of motion, and/or positioning devices for one (R10) of two residents reviewed for positioning and mobility. Findings include: Resident #10 (R10) Review of a Face Sheet revealed R10 originally admitted to the facility and has pertinent diagnoses of quadriplegia, weakness, and rheumatoid arthritis. During an observation and an interview on 1/28/25 at 12:00 PM, R10 was in bed and her fingers were observed to have limited range of motion. R10 reported she is to have special gloves/braces that are to be put on each shift, but the staff do not put them on. The gloves were observed across the room on top of a stand. During an observation and an interview on 1/29/25 at 8:47 AM, R10 was observed in her room and not wearing her special gloves. She reported she did not wear her special gloves/braces last night or this morning. In an interview on 1/29/25 at 8:58 AM, Occupational Therapist (OT) P reported R10 does not have contractures but does have a weakness tone to her hands and receives restorative therapy. She is to wear finger flexion gloves for 30 minutes in the mornings and 30 minutes in the evenings. Staff were trained on how to put the gloves on. Review of an OT discharge summary for R10 dated 6/5/24 to 7/26/24 revealed: Summary Since Eval: [Patient] and Caregiver Training: Instructed patient and primary caregivers in restorative Nursing Program in order to prevent decline from current level of skill performance with 100% carryover demonstrated by primary caregivers. Discharge Status and Recommendations: . RNP (Restorative Nursing Program)/ FMP (Function, Motion, Prevention): Finger flexion gloves on 30 mins in a.m., 30 mins in p.m. [with] skin check prior to donning and after doffing. In an interview on 1/29/25 at 3:48 PM, Licensed Practical Nurse (LPN) J reported she just took off R10's flexion gloves. Any passive range of motion (PROM) services should be documented in her chart including when her flexion gloves are applied. LPN J reported R10 refuses at times. LPN J verified she did not see any such documentation. In an interview on 1/29/25 at 3:54 PM, R10 reported she has not received any PROM. Review of the Activities of Daily Living (ADL) Care Plan for R10 revealed: RESTORATIVE PROGRAM: Place finger flexion gloves on bilateral hands for 30 minutes in AM and 30 minutes in PM daily, initiated 7/22/24. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No active or passive ROM in the care plan. Review of the Tasks in the electronic medical record (EMR) for R10 revealed the following tasks had no documentation showing it was completed: - Amount of minutes spent providing Range of Motion (active). -Amount of minutes spent providing splint or brace assistance. Review of the Restorative-Other program: Place finger flexion gloves on bilateral hands for 30 minutes in AM and 30 minutes in PM daily. Assess skin pre/post gloves and notify nurse with any observations task for R10 revealed there were 17 refusals check marked and 10 not applicable check marked. Some refusals and not applicable checks occurred between the hours of 2:00 AM and 6:00 AM. Review of the Progress notes for R10 revealed no documentation of the resident refusing her splints and no documentation addressing the Restorative-Other program task list addressing the refusals or if she was reapproached, or a root cause to her check marked refusal.

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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** 31771 Based on observation, interview, and record review, the facility failed to follow policies and procedures for falls, implement meaningful care plan interventions, post fall neurological assessments, for two (R65 and R66), of three residents reviewed for accidents and supervision. Findings: R65 Review of the medical record reflected R65 admitted to the facility 7/30/24 with diagnoses that included Alzheimer's Disease and Parkinsons Disease. Review of the admission Minimum Data Set (MDS) dated [DATE] reflected the Resident was at risk for falls and had fallen twice since the admitted [DATE]. The cognitive evaluation conducted during the admission MDS of 8/6/24 for R65 reflected a Brief Interview for Mental Status (BIMS) score of 4. The following quarterly MDS of 11/5/24 reflected R65 was unable to complete the cognitive evaluation which indicated a cognitive decline since admission. On 1/29/24 at 9:44 AM, a request was submitted to the facility for the incident reports for R65 since 10/1/24. The facility provided documentation of ten incident reports of which nine were falls or suspected falls (10/21/24, 11/4/24, 12/1/24, 12/9/24,12/23/24, 12/27/24, 1/3/24, 1/4/24, 1/6/24), and one incident on 1/17/24 when R65 was found ambulating unsupervised. Review of the fall documentation of 12/27/24 at 9:00 AM reflected a staff member had just arrived at work and was putting away personal belongings. The staff member heard an audible alarm, came around a corner and observed R65 up walking, very unsteady on his feet and fell . The documentation reflected R65 was placed back into his chair, indicating that R65 was not supervised by staff prior to the arriving staff. Review of the incident documented 12/9/24 at 11:00 AM reflected staff identified a new bruise near the Resident's left eye measuring 2 centimeters (cm) x 4 cm, a reddened area on the top left of head, and a skin tear on the left shoulder. The documentation reflected R65 has been observed multiple times throughout the day attempting to self-ambulate. A Conclusion that an unwitnessed fall was suspected. The documentation reflected Neuros initiated (serial neurological evaluations) but no documentation of this was found in the EMR. The documentation reflected the Immediate Action was to have Therapy evaluate resident's ability to safely self-transfer from the floor to his bed/chair with no further documentation to indicate any immediate action was implemented to prevent future falls or increase supervision. The incident documented 12/27/24 at 9:00 AM revealed R65 had fallen while unsupervised. The Immediate Action documented reflected a referral was made to Therapy, the same as on 12/9/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the documentation of the falls R65 sustained on 10/21/24, 12/1/24, and 12/23/24 all revealed the same Immediate intervention to offer more activities and snacks (10/21/21 and 12/1/24), and encourage resident with activities (12/23/24). On 1/3/25 an unwitnessed fall was documented at 9:25 AM when R65 had slipped out of his chair in a common area. Following the fall the intervention implemented was to place a Dycem (a non-slip mat) in the Resident's chair to help prevent more falls. On 1/4/25 at 7:35 PM the fall documentation reflected R65 was observed slipping on to floor (sic). The documentation reflected, No Dycem in (R65's) chair at the time. Review of the non-fall incident documented on 1/17/24 at 3:30 AM reflected R65's Broda chair outside the Resident's bathroom door and he was standing in the bathroom. The documentation reflected R65 was . unattended, without his tab alarm attached to his shirt. The Resident was assessed and found to have a 2.4 cm x 4.2 cm abrasion on his right knee and an abrasion on his left knee. The documentation reflected R65 is severely cognitively impaired. Despite this and abrasions to the knees, staff accepted the Resident's explanation that I think I bumped it on the wall' (his knees) and that R65 said he did not fall. The documentation did not indicate why R65 was unsupervised in a Broda chair and not in his bed at 3:30 AM. Review of the medical record did not reflect that serial neurological checks were performed following this incident. On 1/30/25 at 1:19 PM an interview was conducted with the Director of Nursing (DON) in her office. The documentation of the incidents of R65 were reviewed. The DON was asked to provide any further information or documentation regarding these incidents. As of survey exit no additional information was provided. 37573 Review of a policy titled Accident/Incident Report Fall Management last revised 6/2018 revealed: Purpose: To establish a standard for accident/incident completion and to evaluate the facility responsibility to make every effort to decrease the likelihood of a recurrence by investigating incidents, understand how they occur and applying appropriate action. 5. The resident should not be moved until the initial evaluation is completed. If an injury is suspected, the resident should not be moved until Emergency Medical personnel arrive, unless prevention of such movement would result in increased risk for exacerbation of potential injury such as the case with a demented resident exhibiting behavior. d. the resident may be transferred via mechanical lift, backboard, or rolled onto a blanket and lifted by three or four caregivers to their bed. 6. It is recognized that not all falls can be prevented, the facility will utilize applicable elements of the systematic process of assessment, intervention, and monitoring to minimize fall risk and injury including: a. Fall risk screening b. Care plan interventions c. Evaluation of the response to interventions and balancing risk with the residents right to self-determination and independence d. Comfort Rounds and promotion of a culture of safety e. Assessment of sensory contributors f. Medication Review g. Orthostatic Hypotension h. Behavioral and Diagnosis risk factors i. History of falls with root cause analysis j. Pain management . 9. Following unusual occurrences, vital signs will be monitored as followed; a. Residents who have sustained a fall or resident observed on the floor resulting in no apparent injury will have their vitals taken immediately and as indicated by clinical assessment thereafter. b. A resident who sustains a head injury or suspected head injury will have the neurological assessment completed as indicated. c. Assessment will occur immediately and as indicated by the extend of the injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #66 (R66) Review of the Minimum Data Set (MDS) dated [DATE] for R66 revealed he admitted to the facility on [DATE] and is cognitively intact and has limited range of motion (LROM) on his upper extremity on one side. Review of the Electronic Medical Record (EMR) Diagnoses of weakness, difficulty walking, repeated falls, metabolic encephalopathy, orthostatic hypotension or metabolic encephalopathy, dementia, oxygen therapy, or fractures. Review of the Care Plan for R66 reveals no orthostatic hypotension or metabolic encephalopathy, dementia, oxygen therapy, or fractures. No transfers or mobility addressed before 1/2025. In an interview on 1/28/25 at 1:31 PM, the wife of R66 reported he had several falls at home and has had several falls here at the facility and broke some ribs. Review of the Incident/Accident Reports for R66 revealed the following unwitnessed falls: 9/6/24, 9/16/24, 9/28/24, 9/29/24, 10/8/24 at 4:25 AM, 10/15/24, 10/30/24, 11/7/24 at 11:00 AM, 11/7/24 at 10:30 PM, 11/12/24, 11/30/24, 12/4/24, and 1/12/25. Review of the Electronic Medical Record (EMR) for R66 revealed no post un-witnessed fall neurological checks for R66 for the following dates, 9/16/24, 9/29/24, 10/8/24, 11/7/24, 11/30/24, and 12/4/24. Review of the facility Neurological Assessment document revealed: FREQUENCY OF ASSESSMENT: Complete Neurological Assessment per facility policy. Use the following key for the frequency of neurological checks: Q [every] 15 minutes x 4 [hours]; Q 1hr [hour] x 4; Q 2hr x 8; Q 4hr x 6; Q 8hr x 3; then QD [every day] x4 (Total 7 days). Review of an Un-Witnessed Fall incident for R66 dated 9/6/24 at 6:45 PM revealed: Staff notified this nurse that resident was on the floor. Resident denied falling. Resident verbalized that he slipped out of his wheelchair. Root cause: [R66] denies falling, but rather slipping out of his wheelchair. [R66] has a Vitamin D deficiency identified in the hospital and was associated to recent falls. [R66] also has Orthostatic hypotension and metabolic encephalopathy. Resident is on Cholecalciferol for Vitamin D deficiency, midodrine for orthostatic hypotension. Conclusion: There is no violation of plan of care by staff. [R66] personal needs were met within one hour prior to the event. There is no allegation of abuse or neglect by [R66] or family. Care plan initiated for falls with interventions that included Encourage Non-skid Footwear shoes, Maintain personal items within reach, encourage to be in common areas between meals. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Un-Witnessed Fall incident for R66 dated 9/16/24 at 1:45 PM revealed: . resident is on the floor between the toilet and the wheelchair, no shoes or socks on. [R66] stated he tripped transferring himself and lowered himself to the floor. Able to move all extremities on his own. Has scrape to left back. Root cause: Resident continues to self-transfer despite being a 1-assist with a 2-wheeled walker. [R66] was attempting to self-transfer in the bathroom without shoes or socks on, without using call light for assistance prior to ambulating, and slid down the wall and onto the floor. updated care plan for resident to be in common area between meals. Conclusion: There is no violation of plan of care by staff. Call light was in reach and wheelchair was functioning appropriately. [R66] personal needs were met within one hour prior to the event. There is no allegation of abuse or neglect by [R66] or family. Resident is receptive to interventions to decrease risk of injury yet continues to be self-determined to self-transfer. No new care plan interventions. Review of an Un-Witnessed Fall incident for R66 dated 9/28/24 at 8:00 PM revealed: During med pass this nurse heard a voice calling for help to get off the floor. This nurse ran to the room where the voice was coming from and found the resident sitting on the floor. Resident verbalized that he got up from his wheelchair to close the window shade and tripped over his wheelchair pedals and fell by his bed, then reached for the call light. Root cause: Continues to be self-determined and not use his call light and wait for assistance. Resident self-ambulated from his wheelchair and attempted to walk independently to the window to close the blind, and he tripped on his wheelchair pedals and fell on to the floor. Conclusion: There is no violation of plan of care by staff. [R66] personal needs were met within an hour prior to the event. There is no allegation of abuse or neglect by [R66] or family. Care plan interventions were: 9/28/24 [NAME] (sic) on wheelchair, Encourage toileting more frequently. Keep W/C (wheelchair) locked at bedside. Review of Un-Witnessed Fall incident for R66 dated 9/29/25 at 3:18 AM revealed: This nurse heard a voice screaming for help. I ran to the back hall and saw resident sitting in the doorway. He had a raised area and abrasion on his forehead, skin tear to his right nuckle (sic) and wrist. Resident verbalized that he was confused and didn't know where he was at the time. He got up out of bed to look for his wife and he hit his head on the floor. Root Cause: [R66] displayed increased confusion, Hospital Imaging results: CT head without contrast: Findings: Intracranial Hemorrhage . Small right frontal scalp contusion. Conclusion: There is no violation of plan of care by staff. [R66] personal needs were met within an hour prior to the event. There is no allegation of abuse or neglect by [R66] or family. No Care Plan interventions. Review of Un-Witnessed Fall incident for R66 dated 10/8/24 at 4:25 AM revealed: He stated he was attempting to transfer himself into his wheel chair (sic) from his bed to go to the bathroom but slipped and landed on the floor. He was able to reach his call-light to call for help. Root Cause: Resident is self determined and doesn't not (sic) use call light appropriately. Conclusion: New intervention is to keep wheelchair locked and at bedside and to encourage toileting more frequently. There is no violation of plan of care by staff. [R66] personal needs were met within an hour prior to the event. There is no allegation of abuse or neglect by [R66] or family. Intervention is already on the care plan from 9/28/24, no new intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Un-Witnessed Fall incident for R66 dated 10/15/24 at 7:15 AM revealed: Root Cause: [R66] continues to be self-determined and was attempting to dress himself without asking staff for assistance. Resident states he was behind his wheelchair, attempting to change his shirt, and fell . Conclusion: There is no violation of plan of care by staff. [R66] personal needs were met within an hour prior to the event. There is no allegation of abuse or neglect by [R66] or family. Care plan interventions included: Reeducate resident regarding safety and the use of call light. Toilet riser with sides. Review of Un-Witnessed Fall incident for R66 dated 10/30/24 at 9:50 PM Staff notified this nurse that resident was on his knees by his bed. This nurse went to the room and saw resident on his knees. Call light was not on at the time of the fall. Residence (sic) verbalized that he was trying to get himself in to bed and he fell on his knees. Resident voiced that he does not need anyone's help to get in his bed. Root Cause: Resident continues to be self determined. Conclusion: There is no violation of plan of care by staff. [R66] personal needs were met within an hour prior to the event. There is no allegation of abuse or neglect by [R66] or family. Care Plan interventions included: Mattress on the floor by the bedside. Review of an Un-Witnessed Fall incident for R66 dated 11/7/24 at 11:00 AM revealed: Observed resident sitting on floor next to toilet and back resting on the wall. I was trying to go to the bathroom. Intervention: Frequent checks and offering toileting. Conclusion: There is no violation of plan of care by staff. [R66] personal needs were met within an hour prior to the event. There is no allegation of abuse or neglect by [R66] or family. The intervention is already on the care plan from 9/28/24. Review of an Un-Witnessed Fall incident for R66 dated 11/7/24 at 10:30 PM revealed: Staff notified this nurse that resident was on the floor in his room. Resident stated that he was trying to spread his blanket on his bed, and he fell out of his chair. Care plan was updated: Resident should not be left alone in room. Conclusion There is no violation of plan of care by staff. [R66] personal needs were met within an hour prior to the event. There is no allegation of abuse or neglect by [R66] or family. According to the care plan, his interventions dated 11/7/24 were: Resident should not be left alone by himself in the room. During this survey, R66 was observed alone in his room on 1/28/25 at 12:00 PM, 1/29/25 at 8:00 AM, 1/29/25 at 9:00 AM, 1/29/25 at 3:00 PM, and 1/30/25 at 11:00 AM. Resident was not observed outside his room in common areas with constant supervision. Review of an Un-Witnessed Fall incident for R66 dated 11/12/24 at 12:19 AM revealed: Resident observed on floor near recliner, yelling for help. Resident states he was going to the bathroom. Care Plan updated. Dycem (non-slip device) placed in recliner. Root Cause: Resident was attempting to self-ambulate from his recliner in the main living room to restroom without asking staff for assistance. [R66] does not recognize when his movements exceed his functional capabilities and attempts to self-transfer, despite being a 1-assist with a 2-wheeled walker for transfers and ambulation (not on care plan). Just prior to the event, [R66] was observed sleeping in his recliner by staff. Conclusion: There is no violation of plan of care by staff. [R66] personal needs were met within an hour prior to the event. Investigation does not include when his toileting needs were last met. The care plan intervention dated 11/11/24 (day before incident) included Dycem in recliner. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Un-Witnessed Fall incident for R66 dated 11/30/24 at 2:36 AM revealed: Root cause: Resident has ulcerative colitis and had a flare up this morning. Resident had 5 watery stools. Resident was attempting to self-transfer to the toilet from his wheelchair and fell . He was attempting to provide care to self without using call light for staff assistance. Conclusion: There is no violation of plan of care by staff. [R66] personal needs were met within 30 minutes prior to the event. There was no care plan for ulcerative colitis and the previous care plan interventions were not followed. Review of an Un-Witnessed Fall incident for R66 dated 12/4/24 at 3:21 PM revealed: Root cause: [R66] was attempting to independently place his guitar into the guitar case that was on the floor in his room. He leaned forward in his wheelchair and fell forward onto the ground, resulting in abrasion to bilateral knees, right elbow skin tear, and abrasion to forehead. Care plan updated: If [R66] wants to play guitar, place case on bed for him to use contents without having to reach to the floor to not fall out of his wheelchair. This intervention is placed under Recreational Pursuits and was initiated on 11/19/24 by the social worker. Conclusion: There is no violation of plan of care by staff. [R66] personal needs were met within one hour prior to the event. Review of an Un-Witnessed Fall incident for R66 dated 1/12/25 at 8:13 PM, revealed: [R66] was heard by writer scream, Can somebody help me? . [R66] was found on all fours, hand and knees, kneeled in front of locked wheelchair (that had a Dycem pad securely flushed in wheelchair seat), with call light lying on the ground, next to the patient's hand . The writer kneeled down to help the patient and the patient arms gave out before she could reinforce the patients arms, and the patient hit his head approximately 2 from the ground on to the floor. Patient was then lowered to the ground . R66 had bruising on his forehead and wounds on his bilateral knees. Patient states, I was trying to pick things off the floor. I seen my remote and tried to grab it and slid out of my chair and I caught myself from hitting the floor. Care Plan updated to reinforce use of call light for staff assistance. Staff to continually re-educate. Conclusion: There is no violation of plan of care by staff. [R66] personal needs were met within one hour prior to the event. There is no allegation of abuse or neglect by resident or family. According to the Care plan, interventions on 1/13/25 included: Staff to continually reinforce call light use when resident needs assistance. Frequent rounding to offer resident assistance, reacher assistive device. Floor bed with high safety mattress. Anti-roll back to wheelchair. This was the last intervention that was revised on 1/28/25 during this survey. Review of a Physician Progress note dated 1/13/25 for R66 revealed: HPI (history of present illness): . history limited secondary to dementia. experiencing shortness of breath at times. Patient reports that oxygen is something new for him . patient also had a fall last night while sitting at the edge of the bed trying to grab something off the floor. Assessment/Plan: 1. Debility, 2. Orthostatic hypotension . 4. Anemia. Patient saturating well on 2 L (liters) O2 (oxygen) via nasal cannula, baseline does not require oxygen. Review of an Incident Report titled Other for R66 dated 1/16/25 at 2:57 PM revealed: Resident right rib pain to [Physician] on 1/14/25. X-ray on 1/15/25 shows acute nondisplaced fracture to right 10th rib. Review of a Physician Progress note dated 1/16/25 for R66 revealed: Assessment/Plan: 1. Debility, 2. Rib pain on right side, 3. Closed fracture of one rib of right side with routine healing, 4. History of fall, 5. Orthostatic hypotension. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plan for R66 revealed no specific fall care plan. The Activities of Daily Living (ADL) care plan revealed: FALL - RISK MANAGEMENT: Encourage Non-skid Footwear shoes, Maintain personal items within reach. encourage to be in common areas between meals. 9/28/24 [NAME] (sic) (Dycem-non-slip device) on wheelchair, Encourage toileting more frequently. Keep W/C locked at bedside. 10/15 Reeducate resident regarding safety and the use of call light. Toilet riser with sides. 10/30/24: Mattress on the floor by the bedside. 11/7/24: Resident should not be left alone by himself in the room. 11/11 Dycem in recliner 1/13: Staff to continually reinforce call light use when resident needs assistance. Frequent rounding to offer resident assistance, reacher assistive device. Floor bed with high safety mattress. Anti-roll back to wheelchair. Date Initiated: 09/06/2024. Revision on: 01/28/2025 No care plan interventions for falls on 9/16/24, 9/29/24, 10/8/24. In an interview on 1/30/25 at 9:37 AM, the Director of Nursing (DON) reported Staff know how to care for residents based on their care plans, which are inside the residents' closet doors in their rooms. When queried about the frequent falls R66 experienced, the lack of neurological checks after un-witnessed falls, the relevance of some interventions to fall prevention, and the repetitive copy-and-paste conclusions from the investigations stating There is no violation of plan of care by staff. [R66] personal needs were met within one hour prior to the event, the DON reported she did do a thorough investigation but may not be reflected in the reports provided. The DON reported she had more information in handwritten notes but were not available at this time or present in the EMR. She reported they addressed R66's falls in their interdisciplinary team (IDT) meetings. The DON acknowledged R66's care plan reflected frequent toileting, encourage to be in common areas, he is not to be left alone in his room, and encourage/educate call light use but these were not addressed in the investigation. The DON was informed that R66 was observed multiple times alone in his room and not in the common areas with supervision. The DON reported they are doing interventions but not always documenting it. When questioned about the call light intervention and the residents understanding of when or how to use it, the DON acknowledged the concern but did not have an answer. In an interview on 1/30/25 at 1:05 PM, the DON reported some of the falls that did not have neurological checks post un-witnessed falls had short term care plans in place where his vital signs and neurological assessments were done twice a day indicating the resident was being monitored, he just did not receive the frequent neurological checks. At the end that as of survey additional information was provided but did not address the concerns. Each patient has a different set of fall risk factors, so critical thinking must be applied during assessment to identify each patient's unique needs. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 415). Elsevier Health Sciences. Kindle Edition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Risk for falls. As you assess both a patient's health care and home environments, you simultaneously consider presence of fall risks. The identification of fall risks (e.g., impaired balance, reduced visual acuity) is essential to determine the targeted interventions needed to prevent falls. There are many fall risk-assessment instruments used by health care agencies. Most tools include risk categories based on age, fall history, elimination habits, high-risk medications, mobility, and cognition. Some include assessment for presence of patient care equipment (such as indwelling catheter or IV infusion) that makes mobility awkward. At a minimum the assessment needs to be completed on admission, following a change in a patient's condition, after a fall, and when the patient is transferred (AHRQ, 2018). Patients who are at risk for falling require ongoing assessments. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 420). Elsevier Health Sciences. Kindle Edition.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview, and record review, the facility failed to ensure oxygen therapy was received for one (R10) of three residents reviewed for respiratory care. Findings include: Review of a Face Sheet revealed R10 originally admitted to the facility on [DATE] and has pertinent diagnoses of chronic obstructive pulmonary disease (COPD), dependence on supplemental oxygen. In an observation and interview on 1/28/25 at 12:20 PM, R10 was in the room and reported she sometimes falls asleep, and the staff does not put her BiPAP (bilevel positive airway pressure, a noninvasive ventilation therapy) machine on at night. The BiPAP machine was observed on the nightstand next to R10's bed. Review of the Order Summary for R10 revealed no orders for a BiPAP machine. Review of the January 2025 Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for R10 revealed no documentation her BiPAP machine was applied. Review of the Care Plan for R10 revealed: RESPIRATORY EQUIPMENT: oxygen and use of bi-pap at HS [bedtime], Date Initiated: 05/15/2023. Review of an Interdisciplinary Progress Note dated 11/18/24 for R10 revealed: She has occasional SOB (shortness of breath) while lying flat. Requires the use of Bipap. In an interview on 1/30/25 at 11:38 AM, the Director of Nursing (DON) reported R10 uses a BiPAP machine, verified that no active orders exist in the EMR, and noted that they appeared not to have been restarted when R10 returned from the hospital. The DON verified that there is not documentation to show R10 had had received her BiPAP therapy at night.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on interview and record review, the facility failed to 1) ensure clinical staff reviewed dialysis communication post dialysis and 2) ensure post dialysis monitoring for 1 resident (R11) of 1 resident reviewed for dialysis care. Findings include: Review of an Admission Record revealed R11 admitted to the facility on [DATE] with pertinent diagnoses which included diabetes and kidney disease. Review of a current hemodialysis (treatment for kidney failure that removes waste and extra fluids from the blood) Care Plan intervention for R11, initiated 12/23/2019, revealed .Establish communication with dialysis center process of communication is as follows . Review of R11's Physician's Orders, active 1/29/2025, revealed R11 was dependent on hemodialysis every Monday, Wednesday, and Friday. In an interview on 1/29/2025 at 7:59 AM, Licensed Practical Nurse (LPN) C reported night shift prepared R11 to leave for the dialysis clinic. LPN C reported there was no communication paperwork that went back and forth between the facility and dialysis. LPN C reported she routinely took care of R11 after her dialysis treatments and never reviewed any documentation or communication from the dialysis clinic after R11 returned from dialysis. Review of R11's electronic medical record (EMR) on 1/29/2025 at 9:51 AM revealed dialysis communication forms had been uploaded into the EMR after dialysis. The EMR did not reveal any confirmation that these forms had been reviewed by clinical staff. Review of R11's Post Dialysis Assessment Care Plan, dated 1/13/2025, revealed .assess B/P (blood pressure) routinely post dialysis . Weight and temperature upon return from dialysis and PRN (as needed) . In an interview on 1/29/2025 at 2:43 PM, LPN C reported she never saw dialysis communication forms when R11 returned from the dialysis clinic. R11 reported front office staff scanned these into the EMR. In an interview on 1/29/2025 at 2:49 PM, the Director of Nursing (DON) reported nursing staff were required to review the dialysis communication forms upon R11's return from dialysis to ensure that important clinical communication was reviewed. In an interview on 1/29/2025 at 2:57 PM, Medical Records Manager (MRM) B reported she scanned dialysis communication forms into the EMR upon R11's return from dialysis and then destroyed the original copies. MRM B believed nursing staff reviewed these prior to them being given to her to scan. MRM B reported was not sure nursing staff was reviewing the dialysis communication forms and she planned to discuss the process with the DON. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/29/2025 at 3:15 PM, LPN C reported R11 returned from dialysis at lunch time. LPN C reported she had not yet documented R11's post dialysis assessment on the Post Dialysis Assessment Care Plan. LPN C reported she did not obtain new vital signs upon R11's return from dialysis. LPN C reported she routinely filled in the morning vital signs on the Post Dialysis Assessment Care Plan when R11 returned from dialysis. LPN C reported she had not reviewed any documentation from the dialysis clinic. In an interview on 1/29/2025 at 3:22 PM, the DON reported the weight, vital signs, and assessment were to be assessed after dialysis as the Post Dialysis Assessment Care Plan form directs. The DON confirmed nursing staff should be reviewing the dialysis communication form each time R11 returned from dialysis. Review of facility policy/procedure Dialysis Communication, effective December 2021, revealed .Ongoing provision of assessment, care planning and provision of care with the dialysis facility will be in collaboration with facility services. Communication tools, short term care plans and assessment collaboration with medication and nutritional services will be ongoing for the continuum of care .

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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. 30120 Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled in 1 of 3 medication carts (Meadowbrook North Medication Cart) and 1 of 2 medication rooms (Meadowbrook South Medication Room) inspected. Findings Include: During an observation on 01/29/25 at 08:15 AM, the Meadowbrook North Medication Cart (as identified by staff) was inspected with Licensed Practical Nurse (LPN) J. R47's Breo-Elipta 100 micrograms (mcg)/25 mcg discus was observed in a box labeled with R47's name. However, the discus itself was not labeled with any identifying information (e.g., resident's name or resident's room number) that would indicate who the discus belonged to should it get separated from the box. LPN J stated the nurses usually do not label the discus with the resident's name because it already comes to the facility in a box that is labeled. She stated they do at least label the discus with the resident's room number in case it gets separated from the box. LPN J verified that R47's discus was not labeled with her name and/or room number. During an observation on 01/30/25 at 09:45 AM, the Meadowbrook South Medication Room was inspected with Registered Nurse (RN) G. An open vial of Tuberculosis (TB) Purified Protein Derivative (PPD) was observed in a box with an open date of 1/20/25. However, the individual vial was not labeled with an open date. RN G verified this observation and stated if the vial had not been in the box, then she would not know when it was opened. RN G further stated she has seen individual TB vials labeled with an open date, but she did not know if the nurses were supposed to label them or not. RN G stated that the TB vials are good for only 5 days after they are opened. During an interview on 01/30/25 at 9:55 AM, LPN I stated she labels everything. LPN I stated individual TB vials are supposed to be labeled with an open date. She stated the TB vials are good for 30 days in the refrigerator (after she checked a pharmacy list of medications in a binder on the medication cart). LPN I also stated discus', vials, and inhalers in the medication cart are supposed to be labeled with the residents' names when they are opened. She stated, There's usually a tag to pull from somewhere with the patient's (resident's) name to place on the vial/discus/inhaler. During an interview on 01/30/25 at 10:46 AM, the Director of Nursing (DON) stated the nurses should be labeling individual vials, inhalers, and discus' with the resident's name when the boxes are opened. The DON also stated TB vials are supposed to be labeled with an open date. She stated she was not sure on the number of days a TB vial is good for after it is opened, but she can look it up on a sheet the pharmacy sends them with all the use by dates for different multi-use medications. A review of the TB PPD package insert, revised 3/16, revealed, Vials in use for more than 30 days should be discarded due to possible oxidation and degradation (lowered quality due to a chemical reaction when the solution comes into contact with oxygen in the air) which may affect potency (the dose required to produce the correct result).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37872 Based on observation, interview, and record review, the facility failed to ensure physical facilities and equipment were maintained in proper condition potentially affecting all residents that receive food and beverages from the kitchen. Findings include: On 1/29/25 between 8:45 AM and 10:30 AM the following concerns were observed during a tour of the kitchen and kitchenette: Observation of the kitchenette located outside the kitchen revealed the following concerns were shared with Dietary Manager (DM) L. Observation of the hand washing area revealed a missing employee hand washing reminder sign. Review of the FDA 2017 Food Code Section, 6-301.14 Handwashing Signage. Reflected the following, A sign or poster that notifies FOOD EMPLOYEES to wash their hands shall be provided at all HANDWASHING SINKS used by FOOD EMPLOYEES and shall be clearly visible to FOOD EMPLOYEES. Observation of two water filters (located on the wall that supplies water to the ice and water machines) were found undated/labeled. During the observation/interview with the DM L revealed she was unaware of when the filters were last changed and was unsure how long the filters were good for. DM L was asked to provide information regarding how long the filters were good for and when they were last replaced. The information was not received prior to the end of survey. Review of the FDA 2017 Food Code Section, 5-204.13 Conditioning Device, Location. Reflected the following, A water filter, screen, and other water conditioning device installed on water lines shall be located to facilitate disassembly for periodic servicing and cleaning. Review of the FDA 2017 Food Code Section, 5-205.13 Scheduling Inspection and Service for a Water System Device. A device such as a water treatment device or backflow preventer shall be scheduled for inspection and service, in accordance with manufacturer's instructions and as necessary to prevent device failure based on local water conditions, and records demonstrating inspection and service shall be maintained by the PERSON IN CHARGE. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further observation of this area revealed, two drain lines coming off the fresh water supply lines were discharging water directly onto the flooring beneath the ice machine (not into the drain) resulting in some standing water and a white substance coating the flooring beneath the ice machine and along the wall. Review of the FDA 2017 Food Code Section, 6-501.12 Cleaning, Frequency and Restrictions. Reflects the following, (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. Observation of the kitchen revealed the coving (throughout the kitchen) had been removed from along the floor/wall junctures. Resulting in the area no longer being smooth, non- absorbent and easily cleanable. Review of the FDA 2017 Food Code Section, 6-201.13 Floor and Wall Junctures, Coved, and Enclosed or Sealed. Reflected the following, (A) In FOOD ESTABLISHMENTS image cleaning methods other than water flushing are used for cleaning floors, the floor wall junctures shall be coved and closed to no longer than 1mm (one thirty-second inch). Further observation of the kitchen revealed the wall (located behind the steamer unit) needed repair due to visible wall joists resulting. The wall joists were visible because of missing and crumbling [NAME] board and missing coving along the floor/wall juncture. Review of the FDA 2017 Food Code Section, 6-501.11 Repairing. Reflected the following, PHYSICAL FACILITIES shall be maintained in good repair. Review of the FDA 2017 Food Code Section, 6-201.11 Floors, Walls, and Ceilings. Reflected the following, . floors, floor coverings walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are SMOOTH and EASILY CLEANABLE.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on interview and record review, the facility failed to maintain complete and accurate medical records for three residents (R9, R65, and R71) of 18 residents reviewed for accuracy of medical records. Findings include: R9 Review of an Admission Record revealed R9 admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and depression. Review of R9's care conference documentation in the electronic medical record (EMR) on 1/30/2025 at 9:38 AM revealed the last care conference was documented on 8/19/2024. In an interview on 1/30/2025 at 9:48 AM, Social Services Director (SSD) F looked at the care conference schedule and reported R9 had a care conference on 11/1/2024 but he did not document this in the EMR. SSD F showed me undated handwritten notes in a journal and indicated that those notes were from R9's 11/1/2024 care conference. SSD F reported he should have documented the care conference at the time it occurred, and he would enter the document as a late entry. In an interview on 1/30/2025 at 10:29 AM, Clinical Support (CS) A reported care conferences should be documented the same day or as soon as possible. CS A reviewed the EMR and reported R9 was at the hospital on 11/1/2024 and could not have had a care conference on that day. A care conference note dated 11/1/2024 and locked on 1/30/2025 was viewed. SSD F entered the conversation and confirmed he had just documented this care conference note after our discussion. SSD F viewed the EMR with CS A and reported the care conference he documented as taking place on 11/1/2024 must have taken place on another date. SSD F reviewed his care conference schedule and reported R9's care conference had been rescheduled for 11/13/2024 because of his hospitalization and must have taken place on that date. SDD F was unable to confirm from his handwritten notes what day R9's care conference took place. Review of facility policy/procedure Medical Record Documentation Principles, revised September 2010, revealed .Entries should be made as soon as possible after an event or observation is made . Entry out of sequence procedure . When a pertinent entry was missed or not written in a timely manner . The current date and time of the entry is used . Identify or refer to the date and situation for which the additional information entry out of sequence is written . 31771 R65 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record reflects R65 admitted to the facility 7/30/24 with diagnoses that included Alzheimer's Disease and Parkinsons Disease. Review of the Minimum Data Set (MDS) dated [DATE] reflected R65 was unable to complete the cognitive evaluation and was determined to be impaired for daily decision making. The medical record reflected that a Durable Power of Attorney (DPOA) was on file. Review of the Electronic Medical Record (EMR) revealed the last Care Conference for R65 was documented on 8/13/24. This indicated that the next Quarterly Care Conference would have been conducted on or about December 2024. On 01/30/25 12:22 PM an interview was conducted with Social Services Director (SSD) F in his office. SSD F reported the facility calendar reflected a Care Conference for R65 was conducted on 11/7/24. SSD F was asked if the documentation was available in the EMR. SSD F stated, those notes are not in the computer. 30120 R71 A review of R71's Admission Record, dated 1/29/25, revealed R71 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, the Admission Record revealed multiple diagnoses that included Alzheimer's Disease, dementia with behaviors, depression, and anxiety. A review of R71's Interdisciplinary Care Conference Documentation, dated 3/14/24 to 1/29/25, revealed R71 had care conferences on 3/15/24 (admission), 4/26/24 (other), and 9/26/24 (quarterly). A further review of R71's electronic medical (health) records (including progress notes), dated 9/26/24 to 1/29/25, failed to reveal that any care conferences were conducted after 9/26/24 (four months prior to the survey). During an interview on 01/30/25 at 11:39 AM, Social Services Director (SSD) F stated the facility had a care conference for R71 on 1/3/25 (approximately four weeks prior to the survey). SSD F stated he just had not gotten around to putting any documentation detailing the care conference into R71's medical record. SSD F showed the surveyor his care conference schedule (which SSD F verified was not part of the medical record) and the surveyor verified R71's care conference had been scheduled for 1/3/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care . Communications with other health care professionals regarding the patient; Communication with and education of the patient, family, and the patient's designated support person and other third parties . Patient responses and outcomes, including changes in the patient's status; and Plans of care that reflect the social and cultural framework of the patient . Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org).

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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** 37573 Based on interview and record review, the facility failed to implement appropriate infection control interventions, and root cause analysis for one (R71) of three residents reviewed for urinary tract infections. Findings include: Review of a Face Sheet for R71 revealed she admitted to the facility on [DATE] with pertinent diagnoses of Alzheimer's disease, dementia with behavioral disturbances, and a history of urinary tract infections. In an interview on 1/29/25 at 2:04 PM, the Infection Preventionist/Registered Nurse (RN) O reported that their facility commonly sees urinary tract infections (UTI) and skin infections. Last month (December 2024), they recorded 9 urinary tract infections but observed no trends. Many incontinent residents including R71 reside on the [NAME] unit. RN O encourages more fluids for residents who get frequent UTI's. More information and any interventions for R71's UTI's was requested. RN O reported he provided staff with education pertaining to infection control every month via reading materials and will have them sign it. RN O reported they do audits on staff but did not provide specifics of what or when the last audit was such as hand hygiene audits, pericare audits, and prompt/appropriate incontinence care. Review of a Urinalysis history document for R71 revealed a history UTI's on 4/4/24, 4/6/24, 5/8/24, and 5/13/24. Review of the Infection Control Resident Surveillance record shows that R71 experienced a UTI in October 2024, November 2024, and January 2025. Each time, staff administered an antibiotic before receiving the cultures and sensitivities, which led to the initiation of another new antibiotic once the results arrived. Review of the Urinalysis collected on 10/10/24 for R71 revealed a positive result. A culture and sensitivity test were indicated, and the patient started on Cephalexin (Keflex, an antibiotic) on 10/11/24. The cultures, which resulted on 10/14/24 showed growth of Escherichia Coli (E. coli), Proteus Mirabilis, and Viridians Streptococcus bacteria, prompting a change in her antibiotic to Bactrim on 10/14/24. Review of the Urinalysis collected on 11/14/24 for R71 revealed a positive result. A culture and sensitivity test were indicated, and R71 started on Augmentin (an antibiotic) on 11/16/24. The cultures, which resulted on 11/17/24 showed growth of E. coli prompting a change in her antibiotic to Bactrim on 11/18/25. Review of the Urinalysis collected on 1/17/25 for R71 revealed a positive result. A culture and sensitivity test were indicated, and R71 started on Augmentin (an antibiotic) on 1/18/25. The cultures, which resulted on 1/19/25 showed growth of E. coli prompting a change in her antibiotic to Bactrim on 1/19/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/30/25 at 9:08 AM, RN O was queried about R71's frequent UTI's and E. coli as the main bacterial growth. RN O reported R71 is frequently resistive to receiving care. R71 will have more behaviors when she is feeling independent which waxes and wanes. When queried about the origins of E. coli and the correlation to UTI's and potential preventative measures, RN O did not have any comments. RN O reported if a resident is suspected of having a UTI, they collect a urine sample before starting a broad-spectrum antibiotic. Once the culture results return, they change to the appropriate antibiotic if indicated. Review of the Care Plan for R71 with the Focus has the potential for altered elimination related to decreased mobility and strength, a recent hospitalization due to a complicated UTI, a medical history of CKD, and kidney stones, and the need of staff assistance with transfers, toileting, and mobility. Date Initiated: 03/14/2024 and revised on: 03/21/2024 revealed interventions that included Bowel and bladder planning implemented. Review of the Activities of Daily Living (ADL) Care Plan for R71 revealed: ELIMINATION: Wears incontinence products, may use peanuts in brief, check and change before and after meals, HS [bedtime] with rounds and prn [as needed], assist when verbal or nonverbal indicators communicate toileting needs. Date Initiated: 03/14/2024 and last revised on: 10/16/2024. R71's Care Plans revealed no new interventions related to the prevention of UTI's were implemented despite the documented recurrent e. coli infections. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Urinary tract infections (UTIs) are the fifth most common type of health care-associated infection .Escherichia coli, a bacterium commonly found in the colon, is the most common causative pathogen ([NAME], 2020). The risk for a UTI increases in the presence of .urinary and fecal incontinence, and poor perineal hygiene practices. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1229). Elsevier Health Sciences. Kindle Edition. Review of a policy titled Antimicrobial Stewardship last revised on 3/2020 revealed: It is the policy of this facility to utilize various antimicrobial stewardship strategies to improve the quality of antimicrobial therapy, minimize antimicrobial resistance, and optimize clinical outcomes. The facility will utilize antimicrobial stewardship strategies in combination with infection prevention and control efforts to limit the emergence and transmission of antimicrobial-resistant pathogens. Purpose: To preserve the effectiveness of antimicrobials, reduce avoidable adverse effects, minimize healthcare associated infection, and limit the emergence and transmission of antimicrobial-resistant pathogens. 2. Antimicrobial therapy should only be prescribed if clinically indicated according to signs and symptoms of infection and/or sepsis. b. Prompt antibiotic administration for septic residents can save lives; make every attempt to obtain appropriate cultures prior to administering antimicrobials. c. Residents who receive antimicrobial therapy are at increased risk of colonization and infection with Clostridium difficile d. Document indications for antimicrobial therapy in the interdisciplinary note and or medication administration record including the indication for treatment.