STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235637	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Ave Plainwell, MI 49080

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to provide an environment that promoted and enhanced resident dignity in one resident (R7) of 12 residents reviewed for dignity, resulting in the potential of feelings of humiliation and embarrassment. Findings include: According to the Minimum Data Set (MDS) dated [DATE], R7 scored 99 on her BIMS (Brief Interview Mental Status) indicating the resident was unable to complete the interview due to her cognitive state. R7 had impairment in both of her legs requiring substantial maximal assistance for toileting. Diagnoses included fracture, anxiety, depression, and a psychotic disorder other than schizophrenia. During an observation and interview on 6/25/24 at 8:50 AM R7 was receiving incontinence care in her bed by two Certified Nursing Assistants (CNA). During care one CNA left the room to summons a nurse. The remaining CNA stood at R7's bedside while the resident was left in a supine position naked from waist down. After approximately 4 minutes, R7 was asked by surveyor if she would like to have her private area covered, the resident replied, That would be nice. At this time the CNA covered R7's nakedness. Review of R7's Care Plan dated 3/30/34, indicated a focus on the resident experiencing incontinence and the potential for loss of dignity. The goal was to not exhibit lowered self-esteem secondary to incontinence using interventions that in included assure privacy for all cares. Review of facility policy, Privacy, Dignity and Confidentially reviewed 01/2024, stated, .the resident has the right to personal privacy .which included personal care .

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 46999 Based on observations, interviews and record review, the facility failed to develop and implement person centered care plan for 1 of 12 residents (Resident #26) reviewed for care planning, resulting in unmet care needs. Findings include: Resident #26 Review of an Admission Record revealed Resident #26, was originally admitted to the facility with pertinent diagnoses which included: history of falling, unspecified dementia, and type 1 diabetes mellitus (lifelong condition in which the pancreas does not make sufficient insulin to maintain stable blood sugar levels) with diabetic retinopathy (damage to the blood vessels in the eyes causing poor vision). Review of a Minimum Data Set (MDS) assessment for Resident #26, with a reference date of 5/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 which indicated Resident #26 was severely cognitively impaired. Section GG of the MDS revealed Resident #26 required maximal assistance (helper does more than 50% of the effort) to transfer from his bed to his wheelchair and an attempt to assess the residents ability to ambulate 10' was not made due to his medical condition and/or safety concerns. Review of a Care Plan for Resident # 26, with a reference date of 4/2/24, revealed a focus/goal/interventions of: At risk for falls and subsequent injury .does not remember to use call light .is legally blind . Goal: to prevent or reduce the occurrence of falls and subsequent injury .Approaches: . call light will be in reach, instruct and remind to use call light, keep paths to bathroom and hallway clutter free, wear nonskid shoes . keep door open unless providing care .offer and assist with toileting before and after meals, leave night light on in room and bathroom . Review of a Kardex (nursing worksheet) with a reference date of 4/22/24 revealed approach descriptions: Resident prefers to eat meals in room .keep door to room open unless providing personal care .leave night light on in room and bathroom .offer activity after dinner until bedtime .encourage to eat all meals in dining room and assist as needed, offering toileting before leaving room and returning to room. Review of Activity Participation records for Resident #26, with reference dates of 5/2024 and 6/2024, revealed the resident chooses not to participate in scheduled activities, chooses not to pursue leisure activities, room preference. Resident #26 chose to attend 2 music programs but otherwise did not accept invitations to activities. During an observation on 6/25/24 at 9:40am, the door to Resident #26's room was closed. Upon opening the door, Resident #26 was observed sitting in his wheelchair in the middle of the room. No one else was present. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/26/24 at 1:21pm, Registered Nurse (RN) H greeted Resident #26 in the main hallway as he returned from an appointment and took him directly to his room. RN H prepped Resident #26's lunch tray and encouraged him to eat, then left the room. In an interview on 6/26/24 at 2:11pm, RN H reported the interventions in place to reduce Resident #26's risk of falls included remaining him to use his call light, attaching the call light to his clothing and checking on him frequently. When further queried, RN H reported she was not aware staff were supposed to assist Resident #26 with toileting before and after meals and encourage him to eat in the dining room where he would have more supervision. RN H added, he does not like to be around people anyway and he would not go to the dining room. RN H stated He has a love relationship with his music (in his room) but he does not have a love relationship with people. In an interview on 6/26/24 at 3:10pm, Director of Nursing (DON) B reported some of the interventions added to Resident #26's care plans to reduce his fall risk included adding a night light to his room and his bathroom, having him watch television in the dining room after the evening meal and keeping his door open unless providing personal care. DON B reported staff had been educated on these interventions. DON B confirmed that no new care plan interventions were developed to reduce Resident #26's risk of falls between 4/2/24 and 5/15/24, although the resident had 2 falls (1of which resulted in a fracture) during that time. In an interview on 6/26/24 at 4:21pm, Certified Nursing Assistant (CNA) P reported she was not aware of any activities that were supposed to be provided to Resident #26 after the evening meal and he generally preferred to stay in his room and listen to his music. When further queried, CNA P reported Resident #26 did not like to watch television. In an interview on 6/27/24 at 8:17am, Licensed Practical Nurse (LPN) CC reported Resident #26 preferred to have his room completely dark at night. In an interview on 6/27/24 at 8:33am, Activity Director (AD) F reported she was aware the nursing staff were supposed to encourage Resident #26 to watch television in the dining room after the evening meal, but she was not involved in providing any additional activities for him at that time of day. During an observation on 6/26/24 at 4:18pm, the door to Resident #26's room was closed. Upon opening the door, Resident #26 was observed sitting in his wheelchair, alone in the room. During an observation on 6/27/24 at 9:16am, Resident #26 was alone in his room, as he stood in front of a large window, and raised the window blinds over his head. His wheelchair was behind him, unlocked. During an observation on 6/27/24 at 11:03am, Resident #26 sat alone in his room, the room door was closed, and his call light was activated. A nurse stood at the med cart 2 door down and did not respond to the activated call light. Social Services (SS) D answered Resident #26's call light at 11:11am, resident denied any needs. As SS D began to leave the room, Resident #26 verbalized that he preferred to have his door closed. SS D left his room, leaving the door ajar approximately 2, which left the resident out of view from the hallway. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/27/24 at 11:14am, Resident #26 closed his room door. Rustling sounds were audible from behind the door. During an observation on 6/27/24 at 11:18am, 2 Certified Nursing Assistants (CNA's) walked by Resident #26's closed door. During an observation on 6/27/24 at 11:21am, Registered Nurse (RN) H walked by Resident #26's closed door and did not intervene. During an observation on 6/27/24 at 9:16am, Resident #26 was alone in his room, as he stood in front of a large window, and raised the window blinds over his head. His wheelchair was behind him, unlocked.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview, and record review the facility failed to provide adequate supervision to prevent falls for 2 (Resident #26 and Resident # 7) of 12 residents reviewed for falls, resulting in falls with fractures, decline in functional abilities, increased pain, and a potential for further injuries. Findings include: Resident #26 Review of an Admission Record revealed Resident #26, was originally admitted to the facility with pertinent diagnoses which included: history of falling, unspecified dementia, and type 1 diabetes mellitus (lifelong condition in which the pancreas does not make sufficient insulin to maintain stable blood sugar levels) with diabetic retinopathy (damage to the blood vessels in the eyes causing poor vision). Review of a Minimum Data Set (MDS) assessment for Resident #26, with a reference date of 4/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 6/15 which indicated Resident #26 was severely cognitively impaired. Section GG of the MDS revealed Resident #26 required moderate assistance (helper does less than 50% of the effort) to transfer himself from his bed to his wheelchair and could ambulate 150' with moderate assistance (helper does less than 50% of the effort). Section J revealed Resident #26 experienced no pain during the 5-day assessment period and he required no pain medication. Review of a Minimum Data Set (MDS) assessment for Resident #26, with a reference date of 5/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 which indicated Resident #26 was severely cognitively impaired. Section GG of the MDS revealed Resident #26 required maximal assistance (helper does more than 50% of the effort) to transfer from his bed to his wheelchair and an attempt to assess the resident's ability to ambulate 10' was not made due to his medical condition and/or safety concerns. Section J revealed Resident #26 occasionally experienced pain that limited his day-to-day activities, and he required the use of pain medication. Resident #26 rated his pain at a 5 on the pain scale of 1-10. Review of a Care Plan for Resident # 26, with a reference date of 4/2/24, revealed a focus/goal/interventions of: At risk for falls and subsequent injury .does not remember to use call light .is legally blind . Goal: to prevent or reduce the occurrence of falls and subsequent injury .Approaches: . call light will be in reach, instruct and remind to use call light, keep paths to bathroom and hallway clutter free, wear nonskid shoes . keep door open unless providing care . Review of a Fall Risk Assessment for Resident #26, with a reference date of 4/1/24, revealed the resident was assessed as having no history of falls, no confusion, disorientation, or overestimating/forgetting his limits, and was deemed not at high risk for falls with a fall risk score of 0. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of an Event Report for Resident #26, with a reference date of 5/7/24, revealed the resident told Therapy Manager (TM) S that he fell and had pain in his right hip. Bruising was evident on Resident #26's right hip along with rotation/deformity/shortening of his leg and an x-ray was ordered. In an interview on 6/26/24, at 9:28am, Therapy Manager (TM) S reported Resident #26 complained of pain in his right hip on 5/7/24 and told TM S he had fallen in his room. TM S reported Resident #26 never complained of pain prior to this date. TM S reported Resident #26's x-ray revealed a hip fracture that was subsequently repaired surgically at a nearby hospital. TM S reported Resident #26 had a longstanding history of falls prior to his admission to the facility, had poor safety awareness and could not retain safety strategies. When further queried about Resident #26's history of falls, TM S reported Resident #26's daughter told the care conference team, in a meeting on 4/17/24, that the resident had poor safety awareness and had multiple falls he had at her home prior to his admission. TM S reported Resident #26's daughter felt the resident needed close supervision to remain safe and could not be left unattended. TM S reported Resident #26 was improving slowly after his fracture of his hip, but his recover was further complicated by his left wrist fracture that left him unable to bear weight on his wrist. In an interview on 6/27/24 at 12:03pm, Social Services (SS) D reported Resident #26's daughter told the care conference team on 4/17/24 that the resident fell frequently, did many unsafe things and was restless at home. SS D reported this information should have been incorporated into the resident's plan of care. Efforts to contact Resident #26's daughter during the survey were unsuccessful. Review of an Event Report with a reference date of 6/15/24 revealed a Certified Nursing Assistant who was assisting Resident #26 with getting dressed, noticed the resident had a swollen left wrist on this date, and the resident reported he fell . Further review revealed Resident returned from (local hospital name omitted) emergency room today at 1:30pm. Resident diagnosed with a L (left) wrist closed fx (fracture). New orders received for opioid (brand name omitted) pain medication .to wear splint .until specialist clears him . In an interview on 6/27/24 at 8:17am, Licensed Practical Nurse (LPN) CC reported she Resident #26 was very restless throughout the day and nighttime, got up on his own, could not remember to use a call light, and frequently had urinary urgency(sudden, strong, and uncontrollable need to urinate). LPN CC reported she was not able to provide enough supervision to keep him safe. LPN CC reported she found Resident #26 lying on the floor outside his bathroom on 5/2/24. LPN CC reported when asked what he was doing before he fell , Resident #26 reported he was trying to go to the bathroom. LPN CC reported Resident #26's clothing was saturated with urine when he was found on the floor. LPN CC reported the facility needed more staff to be able to monitor Resident #26 more closely. LPN CC stated I make suggestions all the time (to the facility), but they don't follow up. He'd be safer if his room was near the nurse's station. LPN CC reported she felt the facility had not done enough to ensure Resident #26 remained safe. In an interview on 6/27/24 at 11:58am, Registered Nurse (RN) H reported Resident #26 had multiple falls at the facility because he could not be adequately supervised. RN H stated we can't watch him all the time and we've been told we can't have extra staff to provide 1:1 supervision, but that's what he needs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 6/25/24 at 9:40am, the door to Resident #26's room was closed. Upon opening the door, Resident #26 was observed sitting in his wheelchair in the middle of the room. No one else was present. During an observation on 6/26/24 at 4:18pm, the door to Resident #26's room was closed. Upon opening the door, Resident #26 was observed sitting in his wheelchair, alone in the room. During an observation on 6/27/24 at 9:16am, Resident #26 was alone in his room, as he stood in front of a large window, and raised the window blinds over his head. His wheelchair was behind him, unlocked. Resident #26 stood alone for 45 seconds, using both of his arms to hold the blinds over his head, then transferred himself back to his unlocked wheelchair. No staff witnessed the resident's actions. During an observation on 6/27/24 at 11:03am, Resident #26 sat alone in his room, the room door was closed, and his call light was activated. A nurse stood at the med cart 2 door down and did not respond to the activated call light. Social Services (SS) D answered Resident #26's call light at 11:11am, resident denied any needs and SS D left his room, leaving the door ajar approximately 2, which left the resident out of view from the hallway. During an observation on 6/27/24 at 11:14am, Resident #26 closed his room door. Rustling sounds were audible from behind the door. During an observation on 6/27/24 at 11:18am, 2 Certified Nursing Assistants (CNA's) walked by Resident #26's closed door. During an observation on 6/27/24 at 11:21am, Registered Nurse (RN) H walked by Resident #26's closed door and did not intervene. 38384 Resident #7 (R7) According to the Minimum Data Set (MDS) dated [DATE], R7 scored 99 on her BIMS (Brief Interview Mental Status) indicating the resident was unable to complete the interview due to her cognitive state. R7 had impairment in both of her legs requiring substantial maximal assistance to transfer and partial moderate assistance to walk 10 feet. Diagnoses included fracture, anxiety, depression, and a psychotic disorder other than schizophrenia. Review of R7's Care Plan, dated 4/18/24, focused on Falls including risk and subsequent injury related to history of falls with injury, impaired balance and mobility, cognitive impairment, and incontinence. The goal was to prevent or reduce the occurrence of falls and subsequent injury related to falls with interventions that included 1:1 supervision provided 1800 (6PM) until resident went to bed (5/3/24) Review of R7's Incident Report dated 6/9/24 indicated the resident was in a wheelchair with sitter by her side. Sitter turned to assist someone, and resident stood up and walked in the hallway. A witnessed fall occurred, and resident had a 3 cm x 2.5 cm skin tear to right distal elbow area. Resident also had a red area to her right shoulder. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 6/25/24 at 8:50 AM, CNA M stated, (R7) had a fall last week. She will try to walk with a walker if staff get her up. Her knees do not bend. Observed next to bed was a walker with a wheelchair at the end of the bed. Review of R7's Progress Note dated 6/9/2024 at 3:21 PM revealed, This nurse heard a scream. Resident laying on floor about 5 feet from her W/C. Facilities director was with her and had witnessed the event .Red area on skin where she had been lying on floor and 0.5cm skinned area on R (right) elbow . Review of R7's Progress Note dated 6/9/2024 at 11:03 PM revealed, Resident in wheelchair . with sitter by her side. Sitter turned to assist someone, and resident stood up and walked in the hallway. A witnessed fall occurred, and resident has a 3 cm x 2.5 cm skin tear to right distal elbow area. Resident also has red area to her right shoulder, with no open areas found . During an interview on 6/26/24 at 3:38 PM, LPN J stated, (R7) was in her chair a few days ago in the hall and I was in the nurse's station. I saw her starting to get up out of her chair and went to help her back in it. She stood up when I got there and fell on top of me. That might have been when she broke her pinky and hand. But she went for xrays yesterday and now has a cast on it she is trying to bite off. She is impulsive. Staff try to keep an eye on her but we have things to do with other residents. During an interview and record review on 6/27/24 at 1:09 PM Director of Nursing (DON) B stated, (R7) was with a 1:1 sitter on 6/9/24 when the sitter turned to help someone else and (R7) walked away fell and got an injury. She does not have a 1:1 sitter all the time because of staffing. During an interview on 6/27/24 at 2:00 PM, RN H stated, (R7) has had a lot of falls. Most of them happen on 2nd shift. She almost needs a 1:1 person.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on observation, interview, and record review, the facility failed to provide sufficient staffing to meet residents needs in three residents (Resident #7, Resident #20, Resident #26) of 12 residents reviewed for staffing resulting in falls with injuries and unmet resident care needs. Findings include: During an interview on 6/26/2024 at 8:05 AM, Certified Nursing Assistant (CNA) O' stated that staffing isn't adequate during the day to get things done and is worse on the weekends. CNA O' said that 2 CNAs during a shift isn't enough to get her tasks done. She stated that she tries her best and sometimes doesn't have time to get showers done. CNA O said sometimes management helps but not often. During an interview on 6/26/2024 at 8:20 AM, CNA Q stated that there were only 2 CNAs scheduled that day and they should have 3 on first shift. CNA Q stated she doesn't have time to get tasks done on her shift and sometimes showers aren't given because of this. During an interview on 6/26/24 at 9:49 AM, Registered Nurse (RN) H stated that time is limited to get things done since residents are harder to deal with than before and it's challenging to meet the needs of the residents. She said that residents have higher acuity levels and due to that there isn't enough time to get things done in a day. During another interview on 6/27/2024 at 7:49 AM, RN H stated the residents that are there have higher acuity now than before since there are more residents with wounds, more medications per resident and more residents that require supervision. During an interview the week of 6/25/2024, Registered nurse (RN) K stated she doesn't have time to get her tasks done during the day. She said there are residents with higher needs and there isn't enough staff to provide simple ADLS (Activities of Daily Living). RN K said she often helps the CNAs with ADLs which takes time away from passing medications, checking blood sugars on time, giving insulin on time, and completing treatments. RN K' stated that she feels like she isn't giving her full attention to residents. She said often showers can't be given because other things come up and there is so much going on. During an interview the week of 6/25/2024, CNA R stated that staffing is horrible on 2nd and 3rd shifts. She said she was the only CNA the other night. She said they are mandated to stay over a lot too. CNA R said that she can't get tasks done, showers can't be done at times and residents have to wait longer for help since there isn't enough staff. During an interview on 6/26/24 at 9:44 AM, Regional Director of Operations (RDO) X stated that there is usually 1 nurse scheduled from 6am-10am, 6pm-10pm, and 10pm-6am. RDO X' said a 2nd nurse comes in from 10am-6pm. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/2024 at 11:00 AM, Nursing Home Administrator (NHA) A stated that he determines how he is going to staff the facility by looking at the census. He said he usually has 4 nurses scheduled a day and 3 CNAs on 1st and 2nd shifts and 2 on the midnight shift. NHA A said he looks at acuity levels when completing the schedules. When asked if he has talked to staff about staffing and if they have time to get their tasks done, NHA A said he feels like staff would come to him with concerns with staffing. He stated that they should typically mandate a CNA to stay over and they shouldn't have only 1 CNA on a shift. NHA A' stated that they started using agency staff in September 2023 and he was trying to not use them anymore and use more of their own staff. NHA A also stated that he thought staffing was okay and he was not aware of recent staffing concerns. Review of the 2 person transfer list provided by facility revealed that with a census of 33 residents, 13 residents require a 2 person transfer. 46999 Resident #20 Review of an Admission Record revealed Resident #20, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral palsy (congenital disorder of movement, muscle tone, or posture), difficulty walking, dementia, major depressive disorder, unspecified abnormalities of gait and mobility, adjustment disorder, muscle weakness, other reduced mobility, weakness, lack of coordination and repeated falls. Review of a Minimum Data Set (MDS) assessment for Resident #20, with a reference date of 5/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident #20 was moderately cognitively impaired. Section GG revealed Resident #20 required maximal assistance (helper does more than half the effort) for transferring to the toilet. Section H revealed Resident #20 was occasionally incontinent of bowel and bladder. Review of a Care Plan for Resident # 20, with a reference date of 2/15/23, revealed a focus/goal/intervention of: Focus: Alteration in ADLs - self-care deficit r/t cerebral palsy, Goal: (Resident #26) will be clean/well-groomed daily and will participate in cares to their fullest ability, Approaches: Call light within reach . Do not rush . Allow them time to perform and complete ADLs as able. Staff to provide assistance as needed for completion of tasks. In an interview on 6/25/24, at 11:41am, Resident #20 she had experienced long call light wait times in the mornings and felt the facility did not have enough staff to meet each resident's needs. She reported that because of the long wait times, she had been incontinent of urine in her bed. Resident #26 reported she was very concerned about cleanliness and worried about potential bacteria on her bed as a result of her incontinence. Resident #20 also reported she felt angered, and embarrassed when she could no longer hold her urine and stated, I don't want to pee in my bed!. Resident #26 also reported she worried about the staff that had to work extra hours because the facility did not have enough staff to cover the shifts. Resident #20 stated I don't want the staff to get burned out and quit. We need them. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/27/24 at 9:22am, Certified Nursing Assistant (CNA) Q reported the facility often had only 2 CNA's for the building during the day shift and as a result, resident experienced long delays when they activated their call lights. When further queried about the impact the staffing levels had on her, CNA Q stated We're all burned out because we don't have enough help. Resident #26 Review of an Admission Record revealed Resident #26, was originally admitted to the facility with pertinent diagnoses which included: history of falling, unspecified dementia, and type 1 diabetes mellitus (lifelong condition in which the pancreas does not make sufficient insulin to maintain stable blood sugar levels) with diabetic retinopathy (damage to the blood vessels in the eyes causing poor vision). Review of a Minimum Data Set (MDS) assessment for Resident #26, with a reference date of 5/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 which indicated Resident #26 was severely cognitively impaired. Section GG of the MDS revealed Resident #26 required maximal assistance (helper does more than 50% of the effort) to transfer from his bed to his wheelchair and an attempt to assess the residents ability to ambulate 10' was not made due to his medical condition and/or safety concerns. Review of a Care Plan for Resident # 26, with a reference date of 4/2/24, revealed a focus/goal/interventions of: At risk for falls and subsequent injury .does not remember to use call light .is legally blind . Goal: to prevent or reduce the occurrence of falls and subsequent injury .Approaches: . call light will be in reach, instruct and remind to use call light, keep paths to bathroom and hallway clutter free, wear nonskid shoes . keep door open unless providing care . Review of an Event Report for Resident #26, with a reference date of 5/7/24, revealed the resident told Therapy Manager (TM) S that he fell and had pain in his right hip. Bruising was evident on Resident #26's right hip along with rotation/deformity/shortening of his leg and an x-ray was ordered. In an interview on 6/26/24, at 9:28am, Therapy Manager (TM) S reported Resident #26 complained of pain in his right hip on 5/7/24 and told TM S he had fallen in his room. TM S reported Resident #26 never complained of pain prior to this date. TM S reported Resident #26's x-ray revealed a hip fracture that was subsequently repaired surgically at a nearby hospital. TM S reported Resident #26 had poor safety awareness, was physically impulsive, and struggled to retain any new information, and as a result needed close supervision to remain safe. Review of an Event Report with a reference date of 6/15/24 revealed a Certified Nursing Assistant who was assisting Resident #26 with getting dressed, noticed the resident had a swollen left wrist on this date, and the resident reported he fell . Further review revealed Resident returned from (local hospital name omitted) emergency room today at 1:30pm. Resident diagnosed with a L (left) wrist closed fx(sic) (fracture) . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/27/24 at 8:17am, Licensed Practical Nurse (LPN) CC reported she Resident #26 was very restless throughout the day and nighttime, got up on his own, could not remember to use a call light, and frequently had urinary urgency (sudden, strong, and uncontrollable need to urinate). LPN CC reported she was not able to provide enough supervision to keep him safe. LPN CC reported she found Resident #26 lying on the floor outside his bathroom on 5/2/24. LPN CC reported when asked what he was doing before he fell , Resident #26 reported he was trying to go to the bathroom. LPN CC reported Resident #26's clothing was saturated with urine when he was found on the floor. LPN CC reported the facility needed more staff to be able to monitor Resident #26 more closely. LPN CC stated I make suggestions all the time (to the facility), but they don't follow up. In an interview on 6/27/24 at 9:34am, Certified Nursing Assistant (CNA) Q reported Resident #26 was frequently found getting himself up, usually trying to go to the bathroom, and that there was not enough staff to provide him 1:1 supervision. In an interview on 6/27/24 at 11:58am, Registered Nurse (RN) H reported Resident #26 had multiple falls at the facility because he could not be adequately supervised. RN H stated we can't watch him all the time and we've been told we can't have extra staff to provide 1:1 supervision, but that's what he needs. 38384 Resident #7 (R7) According to the Minimum Data Set (MDS) dated [DATE], R7 scored 99 on her BIMS (Brief Interview Mental Status) indicating the resident was unable to complete the interview due to her cognitive state. R7 had impairment in both of her legs requiring substantial maximal assistance for toileting, transfers, and most ADLs (activities of daily living). Diagnoses included fracture, anxiety, depression, and a psychotic disorder other than schizophrenia. Review of R7's Care Plan, dated 4/18/24, focused on Falls including risk and subsequent injury related to history of falls with injury, impaired balance and mobility, cognitive impairment, and incontinence. The goal was to prevent or reduce the occurrence of falls and subsequent injury related to falls with interventions that included 1:1 supervision provided 1800 (6PM) until resident went to bed (5/3/24) During an interview on 6/26/24 at 3:38 PM, LPN J stated, (R7) was in her chair a few days ago in the hall and I was in the nurse's station. I saw her starting to get up out of her chair and went to help her back in it. She stood up when I got there and fell on top of me. That might have been when she broke her pinky and hand. She went for xrays yesterday and now has a cast on it she is trying to bite off. She is impulsive. Staff try to keep an eye on her but we have things to do with other residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview while reviewing R7's medical records on 6/27/24 at 1:09 PM, Director of Nursing (DON) B stated, (R7) has had quite a few falls, looks like 13 since March 17 (2024). The majority of the falls look to be on 2nd shift according to my fall log. She did sustain a fracture to her hand when she fell on [DATE] on 2nd shift. (R7) had a fall on 6/9/24 when she had a 1:1 sitter who left to help another resident at which time (R7) walked away and fell . (R7) is to be checked on every 2 hours, she is checked on way more often she is visible to staff. During meals there are 2 CNAs in the dining room; one who passes trays and one to assist with eating. There are 2 residents that need assistance with eating; (R7) needs cueing to eat and one other resident that requires total assistance with feeding. (R7) sits at the same table as the total assist resident so staff can keep an eye on her. But both CNAs or staff, whoever is in the dining room, assist around 12 residents in the dining room by getting drinks, setting up trays, getting food ready, and cleaning up. They cannot always keep an eye on (R7) during this time. The Scheduler is to staff 3 CNAs and 2 nurses for the building before 6 pm. For 2nd shift after 6 PM nursing goes down to 1 with only 2 CNAs. Staff would have to keep an eye on (R7) when they come out of other resident rooms plus do showers on 2nd shift. Out of 33 residents there are 13 residents that require transfers and assistance at night. (R7) does not have a 1:1 person. There is not a lot I can do about the number of staff. Staff scheduling is done by PPD (per person-per day). I have told the Administrator and the Regional Nurse that more CNAs are needed, but I assume PPD is budget that directs staffing. During an interview on 6/27/24 at 2:00 PM, Registered Nurse (RN) H stated, (R7) has had a lot of falls. Most of them happen on 2nd shift. She will sleep in until 10 am-11 am, get up and have lunch then lay down for a little bit. Then she is out of her room and around the unit in her wheelchair. Nurses try to place her by their med carts to keep an eye on her, but they are in rooms passing medications and doing treatments and that may take more than 5 minutes and she is either trying to get up and falls or she is moving someplace else. Sometimes staff have (R7) at the nurse's station in view of all three halls, but she is fast moving, and they can't keep an eye on her all the time either. On 2nd shift there are 3 CNAs and 1 nurse and on 3rd shift there are only 2 CNAs and 1 nurse. The CNAs on 2nd shift are giving residents showers, toileting, dressing for bed, or helping other CNAs transferring residents. Staff cannot keep an eye on (R7). She almost needs a 1:1 person.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on interview and record review, the facility failed to follow up on pharmacist recommendations and ensure the physician documented review of pharmacy recommendations for one resident (Resident #6) of five residents reviewed for unnecessary medication use potentially resulting in incomplete monitoring of the use of medications for residents. Findings Include: Resident #6 (R6) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R6's admitted to the facility was on 10/17/2022 and she had diagnoses of hallucinations, cognitive communication deficit, depression, and anxiety. Brief Interview for Mental Status (BIMS) score was a 12 which indicated her cognition was moderately impaired (8-12 moderately impaired). During an interview on 6/25/2024 at 10:05 AM, resident was pleasant and confused. She was unable to answer some questions. Review of the Pharmacy Consultation Report recommendations dated 1/14/2024 revealed (R6) receives azathioprine and does not have a recent CBC (Complete Blood Count) with differential documented in the medical since June 2023. Azathioprine has a BOXED WARNING describing an increased risk of malignancy (e.g. lymphoma, leukemia, skin cancer). Last CBC has Hgb (hemoglobin low/normal at 12.3 but MCV (mean corpuscular volume, measures of the average volume of red blood cells) was elevated at 109. Anticonvulsants maybe depleting B12/folate but would like to follow up and see if Hgb is still WNL (within normal limits). Recommendation: Please consider 1. Monitor a CBC with diff. (differential) monthly. * Additionally, please ensure the individual's care plan includes monitoring for signs and symptoms of malignancy (e.g. skin changes) and limiting their exposure to sunlight by using sunscreen and wearing protective clothing. The facility physician agreed with the recommendations and signed the report on 1/16/2024. Review of R6's care plan revealed that the care plan wasn't updated with the pharmacy recommendations. Review of R6's chart under the laboratory tab showed that a CBC wasn't completed until 3/22/2024 and the next one after that was on 6/7/2024. Review of R6's chart revealed a Pharmacist Drug Regimen Review dated 2/19/2024 with multiple recs (recommendations). The Pharmacy Consultation Report recommendations sheet couldn't be located. Review of the Pharmacy Consultation Report recommendations dated 5/8/2024 revealed, (R6) has orders for labs, but at the time of the review they were not available in the medical record. The missing lab values include: 1. CBC monthly per standing order. Recommendation: Unless otherwise indicated, please ensure that ordered labs are obtained. Please disregard recommendation if these labs have been recently obtained. The signature where the Director of Nursing (DON) was to sign was left blank. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/2024 at 3:15 PM, Regional Clinical Nurse (RCN) Z stated that they couldn't find the Pharmacy Consultation Report form from 2/19/2024 that shows whether the facility physician agrees or disagrees with the pharmacy recommendations. RCN Z said she did get a Consultation Summary Report from the pharmacist with the recommendations and the physician did agree with the recommendations but there wasn't documentation of him agreeing to this. Review of the Medication Regimen Review Policy with an effective date of 12/1/2007 and a revision date of 8/17/2023 revealed, Procedure 8. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR (Monthly Regimen Review) and the Director of Nursing to act upon the recommendations contained in the MRR. 8.1 For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. 8.2 The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. 8.2.1 If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record. 9. Facility should alert the Medical Director where MRRs are not addressed by the attending physician in a timely manner. 11. If an irregularity does not require urgent action but should be addressed before the consultant pharmacist's next monthly MRR, the facility staff and the consultant pharmacist will confer on the timeliness of attending physician responses to identified irregularities based on the specific resident's clinical condition. 12. The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, either 30 or 60 days per applicable regulation.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on interview and record review the facility failed to ensure that residents of the facility were free from unnecessary psychotropic medication by completing gradual dose reductions for two residents (Resident #6, Resident #22) of five residents reviewed for unnecessary medication use resulting in incomplete monitoring of medications. Findings include: Resident #6 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R6's admitted to the facility was on 10/17/2022 and had diagnoses of hallucinations, cognitive communication deficit, depression, and anxiety. Brief Interview for Mental Status (BIMS) score was a 12 which indicated her cognition was moderately impaired (8-12 moderately impaired). During an interview on 6/25/2024 at 10:05 AM, resident was pleasant and confused. She was unable to answer some questions. Review of the June Medication Administration Record (MAR) revealed that one of the medications R6 received was citalopram (celexa) for depression, 20 mg (milligrams) 1 tab (tablet), oral at bedtime. Citalopram started on 10/17/2022. Review of R6's chart revealed there was no documentation regarding GDR attempts for citalopram. Review of the GDR Tracking Report provided by the facility revealed that R6 did not have a GDR completed for citalopram in 2023 and so far in 2024. On 6/27/2024 at 3:07 PM, Nursing Home Administrator (NHA) A stated in an email that R6 didn't have a GDR done for Celexa in 2023. During an interview on 6/27/2024 at 3:15 PM, Regional Clinical Nurse (RCN) Z stated that a GDR wasn't completed in 2023 for Celexa. Resident #22 (R22) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R22's admitted to the facility was on 5/31/2022 and he had diagnoses of dementia with behavioral disturbances, depression, and cognitive communication deficit. Brief Interview for Mental Status (BIMS) score was a 15 which indicated his cognition was intact (13-15 cognitively intact). Review of the June Medication Administration Record (MAR) revealed that one of the medications R22 received was trazodone, which is an antidepressant and sedative, tablet, 50 mg (milligram); amount to administer: 0.5 tablet; oral at bedtime. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the GDR Tracking Report provided by the facility revealed that R22 started on Trazadone on 6/28/2022. The last GDR attempt was 3/7/2024 and the next GDR was scheduled for 12/12/2024. Review of 22's chart revealed there was no documentation in physician notes regarding GDR attempts for trazadone. During an interview on 6/26/2024 at 4:12 PM, Social Services Manager (SSM) D stated that she doesn't keep track of GDRs for residents. She said that GDR recommendations come from the Pharmacist not from Neuropsychologist Services SSM D stated that GDR notes may be under the QAPI notes since the pharmacist attends QAPI. During an interview on 6/27/2024 at 8:08 AM, Director of Nursing (DON) B stated that the pharmacy sends recommendations for GDRs to the facility. Prior to exit, no further information was provided regarding GDRs for Trazadone in 2023. Review of the Gradual Dose Reduction of Psychotropic Drugs Policy with a review date of 3/2023 revealed, Policy Explanation and Compliance Guidelines: 2. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. 3. After the first year, a GDR will be attempted annually, unless clinically contraindicated. 4. The timeframes and duration of attempts to taper any medication shall depend on factors including the coexisting medication regimen, the underlying causes of symptoms, individual risk factors, and pharmacologic characteristics of the medications. a. Tapering shall be consistent with accepted standards of practice. b. Some medications (e.g., antidepressants, sedative/hypnotics, opioids) require more gradual tapering so as to minimize or prevent withdrawal symptoms or other adverse consequences. c. Opportunities during the care process to consider whether the medications should be continued, reduced, discontinued, or otherwise modified include: i. During the monthly medication regimen review by the pharmacist. ii. When the physician or prescribing practitioner evaluates the resident's progress. iii. During the quarterly MDS review by the interdisciplinary team. 5. GDR will be documented in the medical record. 9. Use of psychotropic medications, other than antipsychotics, should not increase when efforts to decrease antipsychotic medications are being implemented, unless the other types of psychotropic medications are clinically indicated.

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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. 38384 Based on observation, interview, and record review, the facility failed to ensure a double-lock system for a controlled substance in the facility's medication refrigerator resulting in the potential for diversion and/or misappropriation of medication. Findings include: Observed on 6/27/24 at 8:00 AM the medication room refrigerator unlocked through window of medication room. Observed on 6/27/24 at 8:05 AM MDS RN (Minimum Data Set Registered Nurse) C using RN H keys to enter medication room with supplies. RN did not watch MDS RN while in room. Medication room refrigerator unlocked. During an observation and interview on 6/27/24 at 8:20 AM, RN H entered medication room and observed medication refrigerator was unlocked. Inside of the refrigerator were vials and pens of insulin, vaccines, and a container that held doses of Lorazepam ((Ativan) a controlled substance (benzodiazepines) (sedative)). The RN stated, Myself, the DON (Director of Nursing), and ADON (Assistant Director of Nursing) have the keys to the medication refrigerator. I believe the person that stocks this supply room, the nurse in charge of the medication cart, the DON, and ADON have keys to this room. The refrigerator should be kept locked because of the narcotic (controlled substance) that is in it. During an interview on 6/27/24 at 8:30 AM, MDS RN C stated, I borrowed keys to the medication/supply room from (RN H) so I could put aspirin and Tylenol in there. You were standing there. During an interview on 6/27/24 at 8:40 AM, DON B stated, The medication refrigerator should be kept locked because there are narcotics/controlled substances stored in there. Only the nurse and I assigned to the medication cart(s) will have the key to the medication room and refrigerator. Review of facility policy, Control Substances Standards of Practice updated 9/2022, revealed, .It it is a refrigerated item, the controlled substance must be under a double lock system in the refrigerator .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22050 Based on observations, interviews, and record reviews, the facility failed to: (1) effectively clean and maintain food service equipment and (2) date mark all potentially hazardous ready-to-eat food products effecting 33 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and resident foodborne illness. Findings include: On 06/25/24 at 08:08 A.M., An initial tour of the food service was conducted with Dietary Manager G and Dietary [NAME] BB. The following items were noted: 1 of 2 hand sink faucet assemblies were observed loose-to-mount. Dietary [NAME] BB indicated she would contact maintenance for necessary repairs as soon as possible. The pre-wash sink overhead spray arm handheld valve assembly was observed invading the flood plane level of the sink basin. Dietary Manager G indicated he would have maintenance correct the issue as soon as possible. The 2017 FDA Model Food Code section 5-205.15 states: A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair. The Juice Machine (backsplash, undersplash, and dispensing spouts) were observed with accumulated and encrusted food residue. The interior machine surfaces were also observed with accumulated and encrusted food residue. Dietary Manager G indicated he would have staff thoroughly clean and sanitize the juice machine as soon as possible. The Nursing Station refrigerator interior was observed soiled with accumulated and encrusted food residue. The exterior refrigerator surfaces were also observed soiled with accumulated and encrusted food residue. Dietary Manager G indicated he would have staff thoroughly clean and sanitize the interior and exterior refrigerator surfaces as soon as possible. The 2017 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. One gallon of Country Fresh 2% milk approximately one-third full was observed without an effective open or use-by-date. The manufacturer's use-by-date was also observed to read 6-30-24. Dietary Manager G stated: We date mark milk the day of plus 2 for a total of 3 days. (continued on next page)

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	235637	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Ave Plainwell, MI 49080

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2017 FDA Model Food Code section 3-501.17 states: (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. The mop sink basin was observed heavily soiled with accumulated and encrusted dust and dirt deposits. The 2017 FDA Model Food Code section 4-602.13 states: NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 06/26/24 at 11:17 A.M., Record review of the Policy/Procedure entitled: Storage Procedures dated (no date) revealed under Refrigerated Storage: (11) Leftovers are refrigerated immediately and used within 5-7 days with a use-by-date clearly marked. Staff will follow Food Code Requirements for storage and dating. (12) All foods in the freezer are to be wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn. They are to be labeled and dated with use-by-dates clearly marked. Refer to Food Storage guideline chart. On 06/26/24 at 11:32 A.M., Record review of the Policy/Procedure entitled: Cleaning Reach-In Refrigerator and Freezer dated 08/23 revealed under Policy: Reach-in refrigerator and freezers will be cleaned and sanitized on a regular basis. Record review of the Policy/Procedure entitled: Cleaning Reach-In Refrigerator and Freezer dated 08/23 further revealed under Procedure Weekly: (2) Wipe out the box with a cloth dampened with detergent solution. (3) Wipe the sides of the box with a cloth dampened in non-food contact sanitizing solution; then wipe with a dry cloth. (4) Shelves can be washed at the pot sink, air dried, and returned to the reach-in.

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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. 46999 Based on observation, interview, and record review the facility failed to ensure proper use of personal protective equipmen, during cares for 2 (Resident #26 and Resident #82), hand hygiene, labeling/dating IV tubing, and clean medication administration for 1 resident (Resident #82) of 12 residents reviewed for infection control, resulting in a potential for the transmission/transfer of pathogenic organisms and cross contamination between residents and staff. Findings include: Resident #26 During an observation on 6/26/24 at 1:21pm, Registered Nurse (RN) H completed a blood glucose test for Resident #26 as he sat in a common area outside the nurse's station, with 2 other residents nearby. RN H did not wear gloves during the testing as she used the lancet (a sharp medical instrument) to pierce the skin on Resident #26's finger and placed a drop of his blood on a test strip. RN H then handled the test strip with ungloved hands as she placed it in the glucometer. RN H disposed of the soiled test strip and the lancet, and assisted Resident #26 back to his room without completing hand hygiene. In an interview on 6/27/24 at 10:15am, Infection Preventionist (IP) C reported to avoid cross contamination and a potential blood borne pathogen exposure, nurses should wear gloves when performing blood glucose monitoring and should complete hand hygiene before and after the procedure. Review of Infection Prevention during Blood Glucose Monitoring and Insulin Administration published by the Center for Disease Control and Prevention, 2013, revealed: An underappreciated risk of blood glucose testing is the opportunity for exposure to bloodborne viruses (HBV, hepatitis C virus, and HIV) through contaminated equipment and supplies if devices used for testing . (e.g., blood glucose meters, fingerstick devices, insulin pens) are shared. Outbreaks of hepatitis B virus (HBV) infection associated with blood glucose monitoring have been identified with increasing regularity, particularly in long-term care settings, such as nursing homes . Unsafe practices during assisted monitoring of blood glucose and insulin administration that have contributed to transmission of HBV or have put persons at risk for infection include: . failing to change gloves and perform hand hygiene . 38384 Resident #82 (R82) According to R82's Admission Record, printed 6/27/24, indicated diagnoses that included a pilonidal cyst (a fluid-filled sac under the skin in the lower back, near the crease of the buttocks) without abscess. Review of R82's Order Summary dated: -6/19/24 indicated the resident was to receive an antibiotic intravenous through a PICC line (peripherally inserted central catheter) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-6/20/24 Intravenous (IV) tubing to be changed every 24 hours and PRN (as needed) once a day 07:00 AM-11:00 AM - 6/25/24 Enhanced Barrier Precautions (EBP) (targeted gown and gloves use) during high contact resident care activities During an observation and interview on 6/25/24 at 10:29 AM, R82's room had CDC (Center for Disease Control) Enhanced Barrier Precautions (EBP) signage on the door. The resident was awake in his bed with a PICC line in his upper left arm. At the resident's bedside was an IV pump attached to an IV pole with an empty bag of antibiotics hung with unlabeled/undated tubing attached to R82, stating, The bag was hung a while ago. I have a cyst that burst on my coccyx. Observed floor around bed area to be sticky. The stickiness was audible when walking. R82 stated, The nurse broke a bag of antibiotics this morning that spilled all over the floor. Housekeeping is supposed to come clean it up. Observed on 6/25/24 at 2:20 PM, R82 was awake in bed with a PICC line inserted in his upper left arm. The PICC line dressing date was smudged and not readable. The two bags of antibiotics hanging from the IV pole were both empty. An empty saline syringe was attached to one antibiotic bag. Neither IV tubing or bags were labeled or dated. During an interview on 6/26/24 at 8:20 AM, RN H stated, IV tubing to be labeled to keep track how old the tubing is for infection control. EBP During an observation on 6/26/24 at 8:20 AM, Registered Nurse (RN) H gathered supplies to administer IV antibiotics to R82. On the door of the resident's room was CDC signage identifying EBP and what PPE (personal protection equipment) should be worn when providing direct cares. Upon entering R82's room with IV supplies, the RN did not don gown or gloves. The RN prepped and primed IV tubing attaching the IV tubing to the antibiotic and the resident's PICC line without performing hand hygiene and without wearing gloves. During an interview on 6/26/24 at 8:50 AM, Medical Director T stated, PICC lines and open wounds should be on Enhanced Barrier Precautions with gown and gloves worn for infection control reasons. During an observation on 06/26/24 12:01 PM, Licensed Practical Nurse (LPN) J entered R82's room to set up and administer an IV antibiotic. The resident's room was identified as EBP with signage visible outside the door. The LPN donned gloves over nails that extended 1/4 past her fingertips but did not don a gown. During the prepping of IV tubing, IV pump, and attaching the tubing to the resident's PICC line, the LPN did not change gloves nor use hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hand hygiene is also indicated after contact with a patient's intact skin, contact with body fluids or excretions, non-intact skin, or wound dressings, and after removing gloves .Nail length is important because even after careful handwashing, HCWs often harbor substantial numbers of potential pathogens in the subungual spaces. Numerous studies have documented those subungual areas of the hand harbor high concentrations of bacteria, most frequently coagulase-negative staphylococci, gram-negative rods (including Pseudomonas spp.), corynebacteria, and yeasts. Natural nail tips should be kept to 1/4 inch in length. A growing body of evidence suggests that wearing artificial nails may contribute to transmission of certain healthcare associated pathogens. Healthcare workers who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than are those who have natural nails, both before and after handwashing. Therefore, artificial nails should not be worn when having direct contact with high-risk patients . https://www.cdc.gov/handhygiene/download/hand_hygiene During an observation and interview on 6/27/24 at 8:09 AM, RN H donned gown and gloves without performing hand hygiene stating, I forgot to wear a gown and gloves yesterday when I went to administer (R82's) Vanco (IV antibiotic). It is an infection control issue. Observed the RN prime IV tubing at pump, then attach to resident's PICC line while wearing gloves that were used to the thread tubing into the IV pump and back to PICC. During an interview on 6/27/24 at 8:40 AM, DON B stated, I watched yesterday when (RN H) administered (R82's) IV antibiotic and did not have on the PPE needed. A gown and gloves should be worn with EBP because the resident has a PICC line. When touching the end cap of the PICC clean gloves should be worn and not the same gloves used to touch other equipment. MEDICATION During an observation and interview on 6/27/24 at 8:09 AM, RN H was prepping medications to be administered to R82. Two tablets of different medications the RN popped out onto the top of the med cart. One of which was on the computer mouse pad. The RN used a glove to pick up each tablet and put in the med cup stating, What do you want me to do? The medications were then administered to the resident. During an interview on 6/27/24 at 8:40 AM, DON B stated, Medications that are dropped on top of the med cart without a clean barrier should be destroyed and a new medication pulled to be given to the resident. You do not know what germs are on that med cart.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 33 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased illumination. Findings include: On 06/25/24 at 12:46 P.M., A common area environmental tour was conducted with Director of Environmental Services E. The following items were noted: East Hall Housekeeping Closet: The overhead light assembly was observed non-functional. Director of Environmental Services E indicated he would replace the faulty bulb as soon as possible. Nursing Station Restroom: An active water leak was observed, adjacent to the overhead light assembly. The damaged ceiling surface measured approximately 12-inches in diameter. West Hall Clean Linen Room: Two acoustical ceiling tiles were observed stained from previous moisture exposure. South Hall Nursing Station: One of two chairs were observed (etched, scored, worn). The bi-lateral arm rests were also observed worn and torn, exposing the inner Styrofoam padding and metal support plate. Employee Lounge: The Insignia microwave oven was observed (etched, scored, corroded). The damaged surface measured approximately 2-inches-wide by 2-inches-long. Director of Environmental Services E indicated he would remove and replace the damaged microwave oven as soon as possible. Occupational/Physical Therapy: Two 24-inch-wide by 48-inch-long acoustical ceiling tiles were observed moist from an active water leak. Beauty Shop: The lockset hasp was observed broken on the double door storage cabinet. The floor broom head and dustpan caddy were also observed heavily soiled with accumulated and encrusted hair deposits. On 06/25/24 at 03:50 P.M., An environmental tour of sampled resident rooms was conducted with Director of Environmental Services E. The following items were noted: 4: 1 of 3 overhead light assemblies were observed non-functional. The restroom commode support was also observed loose-to-mount. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7: The oscillating floor fan was observed soiled with accumulated dust and dirt deposits. 8: 1 of 2 overhead light assemblies were observed non-functional. 27: 1 of 2 overhead light assemblies were observed non-functional. The commode support was also observed loose-to-mount. 29: The commode support was observed loose-to-mount. On 06/25/24 at 04:56 P.M., An interview was conducted with Director of Environmental Services E regarding the facility maintenance work order system. Director of Environmental Services E stated: We have a manual work order system. Director of Environmental Services E further stated: Staff record their concern in the maintenance logbook for review. On 06/26/24 at 08:23 A.M., Record review of the Maintenance Request Log Sheets for the last 120 days revealed no specific entries related to the aforementioned maintenance concerns. On 06/26/24 at 08:26 A.M., Record review of the Policy/Procedure entitled: Housekeeping and Laundry Staff dated (no date) revealed under Standard: Housekeeping and laundry staff will be responsible for meeting housekeeping and laundry services for each resident. The facility will provide effective housekeeping and maintenance services to ensure the resident has a clean, sanitary, orderly, comfortable, and home-like environment. Record review of the Policy/Procedure entitled: Housekeeping and Laundry Staff dated (no date) further revealed under Policy: The facility will be staffed with qualified personnel in sufficient quantity to meet each resident's housekeeping and laundry needs as required by state and federal law.