STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235653	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Capital Area	2100 E Provincial House Dr Lansing, MI 48910

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 27446 Based on observation, interview, and record review the facility failed to immediately report an injury of unknown origin for one out of six residents (Resident #25), resulting in the potential for further injuries of unknown origin to not be reported, and facility corrective action to not be taken. Findings Included: Per the facility face sheet R25 had been a resident at the facility since 11/16/2023 with a recent readmission on 1/24/2024. Review of an incident report dated 6/20/2024, revealed R25 was noted to have a small bruise that measured 0.5 inches by 0.5 inches on her forehead at her hairline. The report revealed R25 preferred to rest her head on the wall when standing in the bathroom while being changed. It was documented on the report, resident often leans forward and places head on wall. The report also revealed R25 was not able to give a description or stated what had happened that caused the bruising. The incident report did not describe the color of the bruise or the stage of healing the bruise was in. Further review review of the report revealed Certified Nurse Aid (CNA) L gave a statement that when R25 was changed in the bathroom she would lean her head on the wall and would sometimes does it (leans it) a little harder on the wall while standing up. Another statement documented on the incident report from Licensed Practical Nurse (LPN) M revealed R25 would rest her head on the wall in the bathroom and tap her head on the wall. The incident report, under notes revealed that Director of Nursing (DON) B observed a 0.5 by 0.5 inch bruise at R25's hairline on her forehead. DON B documented R25 would stand in the bathroom and rest her head on the wall while being changed and tap her head repeatedly against the wall while standing. The report revealed that Administrator A and DON B were notified at 4:01 PM of the bruise. Record review of R25's progress notes dated 6/20/2024 at 2:45 PM, revealed R25 had a bruise that was yellow in color on her left forehead with no redness in the surrounding area. There was no other documentation related to the bruise in R25's electronic medical record (EMR). (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 6/26/2024 at 2:45 PM, R25 was observed in the activity room up in her wheelchair. R25 was observed to have an approximately six centimeter (or approximately 2 inches) round yellow, (with no blue, purple green color that would indicate it was a newer bruise, but rather a healing bruise) bruise above her left eye. R25 was not able to state how the bruise occurred. In an interview on 6/26/2024 at 2:51 PM, Administrator A stated that the bruise on R25's forehead was not reported to the state agency because it was determined the bruise was caused from R25 leaning and tapping her head on the bathroom wall. Administrator A said DON B watched the CNA's perform toileting and peri care in the bathroom with R25 and determined that was how the bruise occurred. Administrator A said DON B reported her investigation outcome to her at 3:56 PM. Administrator A then stated that it was not DON B who reported it to her and she could not recall who it was that reported it to her. Administrator A stated she would confirm who the staff member was and the timeline of events and provide that information. As of 6/27/2024 at 4:00 PM at the time of exit Administrator A had not provided the information. In an interview on 6/27/2024 at 8:45 AM, CNA N stated that when she toileted R25 she never saw R25 rest her head on the wall in the bathroom when receiving assistance for toileting. In an interview on 6/27/2024 at 8:55 AM, CNA O stated it was about a week ago R25 started to rest her head on the wall in the bathroom when standing while receiving toileting assistance. CNA O said R25 never tapped her head on the wall, and said if R25 did lean her forehead on the wall she always put her hand in between R25's head and the wall for protection. CNA O also stated that about one week ago was when the bruise first showed up, and said it was a purple/blue in color. In an interview on 6/27/2024 at 9:16 AM, LPN M, who was the Unit Manager of the 100 hall, stated that the bruise on R25's forehead happened about two weeks ago. LPN M said R25 would rest her head on the wall while being assisted with toileting. In an interview on 6/27/2024 at 9:42 AM, CNA L said few CNAs noticed about a week ago a yellow bruise under R25's hairline on her left forehead. CNA L said she never observed a purple or blue bruise on R25's forehead, and said R25 had the habit of resting her head on the bathroom wall for at least the past month. CNA L said she had know idea what the cause of the bruise was, and said we (CNAs) were all trying to figure it out. In an interview on 6/27/2024 at 9:53 AM, Registered Nurse (RN) H said she was told about the bruise when it was noted on 6/20/2024 and when she observed the bruise she saw a yellowish greenish light purple fresher bruise about 0.5 X 0.5 inch at R25's hairline, and said she asked the CNAs how the bruise occurred. RN H said the CNAs told her that R25 would lean her head against the wall in the bathroom. RN L said she then reported the bruise right away to Administrator A and DON B because the bruise was an injury of unknown origin which was required to be reported. RN H said she did an investigation and reported to Administrator A and DON B that she thought the origin of R25's bruise was from leaning her head on the bathroom wall. RN H said Administrator A and DON B then agreed with her. In an interview on 6/27/2024 at 12:08 PM, DON B said she went to look at R25, and upon interviewing the CNA's she discovered R25 would lean her forehead on the bathroom wall. DON B said she thought the bruise was from the bathroom wall, and said staff reported to her R25 would sort of bang her head on the wall when she was being changed in the bathroom.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 27446 Based on observation, interview, and record review the facility failed to ensure a thorough investigation was conducted for one out of six residents (R25) sampled for alleged abuse resulting in the potential for abuse to occur, and necessary actions to not take place for resident protection. Findings Included: Per the facility face sheet R25 had been a resident at the facility since 11/16/2023 with a recent readmission on 1/24/2024. Review of an incident report dated 6/20/2024, revealed R25 was noted to have a small bruise that measured 0.5 inches by 0.5 inches on her forehead at her hairline. The report revealed R25 preferred to rest her head on the wall when standing in the bathroom while being changed. It was documented on the report, resident often leans forward and places head on wall. The report also revealed R25 was not able to give a description or stated what had happened that caused the bruising. The incident report did not describe the color of the bruise or the stage of healing the bruise was in. Further review review of the report revealed Certified Nurse Aid (CNA) L gave a statement that when R25 was changed in the bathroom she would lean her head on the wall and would sometimes does it (leans it) a little harder on the wall while standing up. Another statement documented on the incident report from Licensed Practical Nurse (LPN) M revealed R25 would rest her head on the wall in the bathroom and tap her head on the wall. The incident report, under notes revealed that Director of Nursing (DON) B observed a 0.5 by 0.5 inch bruise at R25's hairline on her forehead. DON B documented R25 would stand in the bathroom and rest her head on the wall while being changed and tap her head repeatedly against the wall while standing. The report revealed that Administrator A and DON B were notified at 4:01 PM of the bruise. Record review of R25's progress notes dated 6/20/2024 at 2:45 PM, revealed R25 had a bruise that was yellow in color on her left forehead with no redness in the surrounding area. There was no other documentation related to the bruise in R25's electronic medical record (EMR). In an observation on 6/26/2024 at 2:45 PM, R25 was observed in the activity room up in her wheelchair. R25 was observed to have an approximately six centimeter (or approximately 2 inches) round yellow, (with no blue, purple green color that would indicate it was a newer bruise, but rather a healing bruise) bruise above her left eye. R25 was not able to state how the bruise occurred. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/26/2024 at 2:51 PM, Administrator A stated that the bruise on R25's forehead was not reported to the state agency because it was determined the bruise was caused from R25 leaning and tapping her head on the bathroom wall. Administrator A said DON B watched the CNA's perform toileting and peri care in the bathroom with R25 and determined that was how the bruise occurred. Administrator A said DON B reported her investigation outcome to her at 3:56 PM. Administrator A then stated that it was not DON B who reported it to her and she could not recall who it was that reported it to her. Administrator A stated she would confirm who the staff member was and the timeline of events and provide that information. As of 6/27/2024 at 4:00 PM at the time of exit Administrator A had not provided the information. In an interview on 6/27/2024 at 8:45 AM, CNA N stated that when she toileted R25 she never saw R25 rest her head on the wall in the bathroom when receiving assistance for toileting. In an interview on 6/27/2024 at 8:55 AM, CNA O stated it was about a week ago R25 started to rest her head on the wall in the bathroom when standing while receiving toileting assistance. CNA O said R25 never tapped her head on the wall, and said if R25 did lean her forehead on the wall she always put her hand inbetween R25's head and the wall for protection. CNA O also stated that about one week ago was when the bruise first showed up, and said it was a purple/blue in color. In an interview on 6/27/2024 at 9:16 AM, LPN M, who was the Unit Manager of the 100 hall, stated that the bruise on R25's forehead happened about two weeks ago. LPN M said R25 would rest her head on the wall while being assisted with toileting. In an interview on 6/27/2024 at 9:42 AM, CNA L said few CNAs noticed about a week ago a yellow bruise under R25's hairline on her left forehead. CNA L said she never observed a purple or blue bruise on R25's forehead, and said R25 had the habit of resting her head on the bathroom wall for at least the past month. CNA L said she had know idea what the cause of the bruise was, and said we (CNAs) were all trying to figure it out. In an interview on 6/27/2024 at 9:53 AM, Registered Nurse (RN) H said she was told about the bruise when it was noted on 6/20/2024 and when she observed the bruise she saw a yellowish greenish light purple fresher bruise about 0.5 X 0.5 inch at R25's hairline, and said she asked the CNAs how the bruise occurred. RN H said the CNAs told her that R25 would lean her head against the wall in the bathroom. RN L said she then reported the bruise right away to Administrator A and DON B because the bruise was an injury of unknown origin which was required to be reported. RN H said she did an investigation and reported to Administrator A and DON B that she thought the origin of R25's bruise was from leaning her head on the bathroom wall. RN H said Administrator A and DON B then agreed with her. In an interview on 6/27/2024 at 12:08 PM, DON B said she went to look at R25, and upon interviewing the CNA's she discovered R25 would lean her forehead on the bathroom wall. DON B said she thought the bruise was from the bathroom wall, and said staff reported to her R25 would sort of bang her head on the wall when she was being changed in the bathroom. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no other staff interviews, or statements, there were no other resident interviews or assessments of other residents for injuries of unknown origins, there was no documentation prior to 6/20/2024 and no further documentation of bruise after 6/20/2024. The incident report was the only document received regarding the bruise on R25's forehead above her left eye, and only had two staff witness statements, one from the Unit Manager and one from the restorative CNA.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 45038 Based on observation, interview, and record review the facility failed to accurately complete a comprehensive assessment for one (Resident #254) of twenty residents reviewed resulting in the potential for unmet care needs. Finding Included: Resident #254 (R254) Review of the medical record demonstrated R254 was admitted to the facility 06/10/2024 with diagnoses that included Parkinson's Disease, type 2 diabetes, chronic obstructive pulmonary disease (COPD), Epilepsy (disorder of the brain characterized by repeated seizures), schizoaffective disorder, atrial fibrillation, anxiety, insomnia, dementia, hypertension, depression, anemia (low red blood cells), orthostatic hypotension, and stroke. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/16/2024, revealed R254 had a Brief Interview for Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. Section M (skin conditions) of the MDS, with the same ARD, demonstrated that R254 did not have a pressure ulcer. During observation and interview on 06/25/2024 at 01:14 p.m. R254 was observed lying in bed. R254 explained that he had pressure ulcer, and that the facility was performing the treatments to the area as directed by the physician. Review of R254 medical record demonstrated a facility assessment entitled Skin & Wound Evaluation V7.0 had been completed 06/11/2024 at 10:41 a.m. The assessment demonstrated that R254 had been admitted with a pressure ulcer, stage 3 (Full-thickness skin loss) to his right Ischial tuberosity. The pressure ulcer was documented to be 0.8 cm2 (centimeters squared) in surface area, 1.2 cm (centimeters) in length, and 0.9cm in length. R254's medical record also demonstrated that the pressure ulcer had been healed on 06/24/2024. In an interview on 06/26/2024 Minimum Data Set (MDS) Coordinator R explained that the MDS was to be completed after reviewing the medical record of the residents during the MDS assessment period. MDS Coordinator R confirmed that R254's medical record demonstrated a Skin & Wound Evaluation V7.0 had been completed 06/11/2024 and had identified that R254 was admitted with a stage 3 pressure ulcer to his right ischial tuberosity. MDS Coordinator R could not explain why R254's MDS, with an Assessment Reference Date (ARD) of 06/16/2024, section M (skin conditions) did not list the stage 3 pressure ulcer to his right ischial tuberosity. In an interview on 06/26/2024 at 03:00 p.m. Minimum Data Set (MDS) Nurse Q explained that she had completed section M (skin conditions) of the MDS, with an Assessment Reference Date (ARD) of 06/16/2024. MDS Nurse Q confirmed that R254's medical record demonstrated a Skin & Wound Evaluation V7.0 had been completed 06/11/2024 and had identified that R254 was admitted with a stage 3 pressure ulcer to his right ischial tuberosity. MDS Nurse Q could not explain why she had not documented R254's stage 3 pressure ulcer to his right ischial tuberosity.

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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** 30337 Based on observation, interview, and record review, the facility failed to develop and implement resident care plans in two of 20 residents reviewed for care plans, resulting in the likelihood for the development of pressure ulcers and injuries (Resident #34) and a delay in dental care (Resident #36). Findings Include: Resident #34 (R34): R34's Minimum Data Set (MDS), with assessment reference date of 3/22/24 revealed she was admitted to the facility on [DATE], and her cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The same MDS assessment revealed R34 was dependent in activities of daily living (ADL) care and, at the time of the assessment, had a facility acquired Stage 3 pressure ulcer (full tissue thickness loss; subcutaneous fat may be visible, but bone, tendon or muscle was not exposed; slough [devitalized tissue] may be present but does not obscure the depth of tissue loss; may include undermining [erosion under wound edges] and tunneling [passageways underneath the skin]). The same MDS assessment indicated R34 had the diagnoses of non-traumatic brain dysfunction, dementia, anxiety, depression, arthritis, and history of a hip fracture. In review of R34's ADL care plan dated 10/25/23 and risk for impaired skin integrity dated 12/08/23; interventions included: transfer with mechanical lift and 2 person assist with a shower sling, orthotic boot to the right heel for off-loading and protection; pillow placed between her knees, and soft boots at all times. The same care plan instructed to document all refusals. On 6/25/24 at 3:48 PM, R34 was observed sitting in a specialty wheelchair in the television room, a lift sling with green binding (not a shower sling) was observed under the resident. R34 was wearing socks on both feet. R34 did not have a pillow between her knees. On 6/26/24 at 8:44 AM, R34 was observed sitting in a specialty wheelchair in the dining room; socks were noted on both feet, no pillow was observed between her legs, and a lift sling with green binding (not a shower sling) was noted under the resident. On 6/27/24 at 8:35 AM R34 was observed lying in bed with her legs crossed at her knees. R34 had a raised bruise on the right side of her forehead. Resident Aide (RA) J and Certified Nurse Aide (CNA) I provided morning ADL care. Staff Development Registered Nurse (SDRN) C entered R34's room to perform a competency check-off for the mechanical lift transfer while surveyor was observing care. RA J placed a transfer sling with green binding under R34. RA J was guided by CNA I on how to don the sling and attach the sling to the mechanical lift transfer device (Maxi Lift). R34 was lifted from her bed in the sling without her head supported and her lower trunk was not fully supported in the sling. RA I and CNA J lowered R34 back to her bed, readjusted the sling, and attempted the transfer again. R34's head was not supported and middle of sling was not in line with R34's spine. R34 was transferred into a Broda chair (specialty wheelchair). R34's forehead was touching the spreader bar when she was seated into the Broda chair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SDRN C was interviewed on 6/27/24 following the observation of R34's transfer and stated she had concerns regarding correctly donning the transfer sling and spreading of the lift legs. SDRN C stated she had not observed the transfer technique with R34 after a hematoma/bruise were discovered on 6/21/24 until after surveyor requested observation of R34's transfer on 6/27/24. SDRN C stated there were no assessments completed regarding correct sling size, and it was up to the CNA to select the correct size. SDRN C was not sure of the sling size that was used during the transfer with R34 that she had just observed. SDRN agreed R34 was not transferred with a shower sling. SDRN C stated R34 was 57.5 inches (4.79 feet). R34's Activities of Daily Living (ADL) care plan dated 10/25/23, and intervention initiated 12/08/23, instructed to transfer with assist of two persons and use of Hoyer lift with shower sling. There was no shower sling size recommended or torso size on R34's care plan. In review of the ARJO Slings User Guide dated March 2005, the maxi lift, sling sizing guide was only an approximation, other factors considered when selecting the appropriate sling were distribution of body weight, i.e. hips; thighs, upper body, height, torso length and physical condition. The same manual indicated the green binding color sling was a size large, appropriate for a weight range of 154 to 264 pounds. In review of R34's progress note dated 6/20/23 at 1:00 AM, her weight was 129.8 pounds. Incident Report titled Injury of Unknown Cause dated 6/19/24 at 8:30 AM revealed a CNA reported to the nurse that R34 had a bump on her right forehead which was not observed previously. The bump on R34's forehead was 5.0 centimeters (cm) by 4.0 cm. The nurse performed a full skin assessment and noted a red fresh bruise on R34's right ear lobe and blanchable redness on her right knee. The same report indicated R34 was crossing her legs and redness was likely from crossing legs. Nursing Home Administrator (NHA) A and Director of Nursing (DON) B were interviewed on 6/27/24 at 11:08 AM. NHA A stated R34 had a bump on her forehead and bruising to her ear that was observed on 6/19/24; and it was determined R34's injury could have been caused by a staff member not following the mechanical lift transfer policy. The staff member transferred R34 without 2 persons, was suspended and had not returned to work. DON B stated they audited staff using mechanical lifts, but was not able to confirm R34's transfer was evaluated after injuries were noted and before surveyor observation. In review of Facility Past Non-Compliance Checklist dated 6/27/24, description of deficient practice (why and how did it happen); transfer with mechanical lift, incorrect sling size. Staff just completed the CNA class did not have mechanical lift competency validated upon beginning training on the floor. In review of R34's electronic medical record from 6/25/24 through 6/27/24 at 8:04 AM, there were no documented refusals of orthotic boot, pillow between knees, soft boots, or floating heels. Certified Nurse Assistant (CNA) I stated during an observation/interview on 6/27/24 at 8:35 AM a lot of staff forget to don R34's boots, and she previously had a sore on her heel that smelled bad. Resident #36 (R36) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R36 was observed sitting in his bed on 6/26/24 at 8:27 AM and stated he had sores in his mouth, like blisters, that caused him pain. R36 complained that he was supposed to see another dentist but was not aware if an appointment had been scheduled. R36's MDS with ARD dated of 3/07/24, revealed he was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS, cognitive screener) score of 10 (08-12 Moderate Impairment). In review of R36's care plans on 6/26/24, there were no care plans regarding dental issues or oral care. R36's Dental visit notes dated 3/28/24 revealed R36 had the diagnoses of dementia, obstructive sleep apnea, and lung disease. R36 had generalized soreness in his mouth, including burning sensations. R36 had a very low attached maxillary anterior frenum (tissue connecting upper lip to the upper gums and attached too close to the teeth) and had two round, 1 millimeter (mm) by 1 mm, indurated (hardened areas) nodules (growth or lump). The same visit notes indicated the nodules get very sore at times, but don't seem to drain. The soreness seemed to start after R36 had eye surgery that found a cancerous lesion. It was recommended R36 follow-up with an oral surgeon to remove the frenum nodules. The same note indicated after removal of the nodules, R36 would like to receive upper and lower dentures if possible. The same note indicated action required by nursing home staff included: (1) continue daily oral care and (2) refer to oral surgeon for the removal of the two nodules on the maxillary anterior frenum. Unit Manager Registered Nurse (UMRN) H was interviewed on 6/26/24 at 2:18 PM and stated when a resident had a referral, she would write a note, put in an order, print it out and give it to the scheduler. The care plan would be updated as needed. UMRN H confirmed the referral was sent to the scheduler on 5/28/24 and the dental appointment was not scheduled yet. UMRN H was not sure why R36's dental appointment was not attempted to be scheduled between 3/28/24 through 5/28/24. R36's dental/oral care plan, developed following surveyor interview, was dated 6/27/24 and revealed Resident has a dental problem related to missing teeth, no dentures. R36's nodules noted by the dentist were not included in the care plan. R36's goal was Resident will have reduced complications related to dental/oral issues through the next review; his goal to receive upper and lower dentures were not added to the care plan.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on observation, interview and record review, the facility failed to provide a meaningful, diverse, and engaging activity program for one resident (#44) of one resident reviewed for activities. Findings include: Resident #44 (R44) Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] reflected Resident # 44 (R44) was a admitted to the facility on [DATE] with diagnoses that included dementia and resided on the facility's secured memory care unit. R44 scored 00 on the Brief Interview for Mental Status indicating severe cognitive impairment. Review of R44's activity assessment dated [DATE] reflected R44 enjoys music, talk radio, walking and pet visits. The assessment reflected R44 had severe cognitive impairment and will make sounds but not normally words. Section 2 of the same assessments reflected materials would be provided as needed or requested. Section 4 of the assessment reflected R44 was cheerful, anxious/depressed and a passive observer. Review of R44's activity care plan initiated 8/16/23 with revisions dated 12/27/23 reflected R44 would maintain their current activity level and actively participate in diversional activities daily. Interventions included needs and wants must be anticipated due to cognition, provide R44 with an activity calendar, encourage participation in group activities, and Feeling others and objects, touching things on the wall. Walking. Being social. Playing with dolls and being social. On 06/25/24 at 10:03 AM, R44 was observed wandering up and down hall carrying a balloon. R44 was observed to make eye contact and smile at others. R44 was observed throughout the day ambulating alone on the memory care unit. On 06/26/24 at 12:48 PM, R44 was observed wandering around the memory care unit and approached the desk and started fumbling through papers. 06/27/24 09:09 AM Resident # 44 observed walking up and down hall. 06/27/24 at 10:32 AM the Activity Calendar scheduled activity titled Coffee and [NAME] at 10:30 R44 was observed ambulating up and down the hall there was no attempt by staff on the unit to encourage R44 to participate. On 06/27/24 01:28 PM Resident # 44 observed walking up and down hall on unit, the patio area had an activity of music playing, there was no attempt made by staff to involve R44. On 06/27/24 at 02:13 PM , during an interview with Activity Director D she reported working at the facility for 10 months. Activity Director D reported R44 liked to grab things from the wall and sensory things, along with pet visits. Review of R44 activity participation record for June 2024 did not reflect any pet visits in the last 30 days - nor does R44's activity care plan and most recent activity assessment reflect an interest in pet therapy. Activity Director D

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 27306 Based on observation, interview and record review the facility failed to ensure the Activities Director had minimum qualifications to perform the duties of the position effectively involving residents on the memory care unit with a current census of 20 residents. Findings include: On 06/25/24 at 10:03 AM during the initial tour of the facility's memory care unit, (census of 20) several residents were observed in bed. Nine residents were observed sitting in lounge/ TV area 7 of 9 residents were sleeping. No observed activity throughout the unit was in progress. On 06/26/24 at 12:48PM Eight residents were observed in day area, TV was on but residents were looking around and nodding off. On 06/27/24 at 09:09 AM, the day room area had the TV was on, 9 residents were present 4 were asleep and the other 5 residents were looking around the room. At 9:33 4 of the 6 residents continued to sleep the television was still on and none of the residents were watching it. The memory care Activity Calendar for 6/27/24 reflected a scheduled activity titled Coffee and Cocoa at 10:30 at 10:35am Activity Director D entered unit and addressed the 7 residents in the room (2 were sleeping) Hey Friends, where is the balloon at 10:36 am Activity Director D played balloon toss for a total of 2 minutes (balloon toss stopped at 10:38 am) and announced it was time to take a break, at this time she went around the circle of 7 asking if they would like coffee or cocoa. Activity Director D then left the unit, Activity Aide (AA) E was present watching the group drink their beverages, one resident addressed Activity Aide E stating she liked AA E jeans, AA E responded These aren't jeans. After the beverages were consumed the activity was over there was no attempt at conversation or attempts to engage with the group. On 06/27/24 at 11:40 am, the memory care unit activity calendar reflected Dance to Dine at 11:30 am, which did not occur, what was observed was the television on with a black and white movie on. On 06/27/24 at 01:36 PM, 8 residents were observed sitting on the patio listening to music, AA F was observed for several minutes sitting in a chair looking down on a cell phone, upon entering the patio area AA F put the phone in her pocket and at that time started to engage with the residents. On 06/27/24 at 02:13 PM , during an interview with Activity Director D she reported working at the facility for 10 months. When queried about the observations made throughout the week Activity Director D offered no explanation. When queried for additional information for things on the activity calendar such as church service that was explained as being on on television, when queried about coffee and cocoa or sparkling cider , Activity Director D stated hydration was important. When queried about how its determined for meaningful activities of interest and how that was individualized on the memory care unit, Activity Director D reported the residents like to sleep and watch a lot of television. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Activity Director D reported she was not a recreational or occupational therapist. When queried about her educational background she reported she was currently taking the MEPAP (Modular Education for Program Activity Professional) class to become certified in Activities but had not completed it as of yet. When queried if she held any certifications she reported no. When queried about experience in an Activities department she reported this was her first position as an Activity Director which (August of 2023) she had 3 months experience as an Activity Aide at a sister facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 Based on observation, interview, and record review, the facility failed to safely transfer Resident #34 with a mechanical lift, in one of four residents reviewed for accidents, resulting in a hematoma and bruises. Findings Include: Resident #34 (R34) On 6/27/24 at 8:35 AM R34 was observed lying in bed with her legs crossed at her knees. R34 had a raised bruise on the right side of her forehead. Resident Aide (RA) J and Certified Nurse Aide (CNA) I provided morning activities of daily living (ADL) care. Staff Development Registered Nurse (SDRN) C entered R34's room to perform a competency check-off for the mechanical lift transfer while surveyor was observing care. RA J placed a transfer sling with green binding under R34. RA J was guided by CNA I on how to don the sling and attach the sling to the mechanical lift transfer device (Maxi Lift). R34 was lifted from her bed in the sling without her head supported and her lower trunk was not fully supported in the sling. RA I and CNA J lowered R34 back to her bed, readjusted the sling, and performed the transfer again. R34's head was not supported and middle of sling was not in line with R34's spine. R34 was transferred into a Broda chair (specialty wheelchair). R34's forehead was touching the spreader bar when she was seated into the Broda chair. SDRN C was interviewed on 6/27/24 at 9:12 AM, following the observation of R34's transfer and stated she had concerns regarding correctly donning the transfer sling and spreading of the lift legs. SDRN C stated she had not observed transfer technique with R34 after a hematoma/bruise were discovered on 6/21/24 until after surveyor requested observation of R34's transfer on 6/27/24. SDRN C stated there were no assessments completed regarding correct sling size, and it was up to the CNA to select the correct size. SDRN C stated she was not sure what sling size was used during the transfer with R34 that she had just observed. SDRN agreed R34 was not transferred with a shower sling. SDRN C stated R34 was 57.5 inches (4.79 feet) tall. R34's ADL care plan dated 10/25/23, intervention initiated 12/08/23, instructed to transfer with assist of two persons with a Hoyer lift (mechanical total lift) with shower sling. There was no shower sling size recommended or torso size on R34's care plan. In review of the ARJO Slings User Guide dated March 2005, the maxi lift, sling sizing guide was only an approximation, other factors considered when selecting the appropriate sling were distribution of body weight, i.e. hips; thighs, upper body, height, torso length and physical condition. The same manual indicated the green binding color sling was a size large, appropriate for a weight range of 154 to 264 pounds. In review of R34's progress note dated 6/20/23 at 1:00 AM, her weight was 129.8 pounds. RA J was interviewed on 6/27/24 at 9:20 AM and stated she was not checked off for competency on mechanical lift transfer before surveyor observation and had just completed the CNA class last Friday (6/21/24). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R34's Minimum Data Set (MDS) assessment, with assessment reference date of 3/22/24 revealed she was admitted to the facility on [DATE], and her cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The same MDS assessment revealed R34 was dependent in ADL care and had a facility acquired Stage 3 pressure ulcer (full tissue thickness loss; subcutaneous fat may be visible but bone, tendon or muscle was not exposed; slough [devitalized tissue] may be present but does not obscure the depth of tissue loss; may include undermining [erosion under wound edges] and tunneling [passageways underneath the skin]). The same MDS assessment indicated R34 had the diagnoses of non-traumatic brain dysfunction, dementia, anxiety, depression, arthritis, and history of a hip fracture. Incident Report titled Injury of Unknown Cause dated 6/19/24 at 8:30 AM revealed a CNA reported to the nurse that R34 had a bump on her right forehead which was not observed previously. The bump on R34's forehead was 5.0 centimeters (cm) by 4.0 cm. The nurse performed a full skin assessment and noted a red fresh bruise on R34's right ear lobe and blanchable redness on her right knee. The same report indicated R34 was crossing her legs and redness was likely from crossing legs. Nursing Home Administrator (NHA) A and Director of Nursing (DON) B were interviewed on 6/27/24 at 11:08 AM. NHA A stated R34 had a bump on her forehead and bruising to her ear that was observed on 6/19/24; and it was determined R34's injury could have been caused by a staff member not following the mechanical lift transfer policy. The staff member transferred R34 without 2 persons, was suspended and had not returned to work. DON B stated they audited staff using mechanical lifts, but was not able to confirm R34's transfer was evaluated after injuries were noted and before surveyor observation. In review of Facility Past Non-Compliance Checklist dated the same date, 6/27/24, description of deficient practice (why and how did it happen); transfer with mechanical lift, incorrect sling size. Staff just completed the CNA class did not have mechanical lift competency validated upon beginning training on the floor.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility to ensure their medication error rate was below 5% when three medication errors were observed from a total of 27 opportunities for one resident (Resident #81) of seven reviewed resulting in a medication error rate of 11.11%. Findings include: On 06/26/24 at 9:05 AM, Licensed Practical Nurse (LPN) K was observed preparing and administering medications to R81. LPN K administered Metoprolol (used to treat hypertension/high blood pressure) 25 milligrams (mg) , two Senna Plus (senna 8.6 mg (laxative) with docusate sodium 50 mg (stool softener)) , and 25 milliliters (mL) of ClearLax (Miralax/laxative). LPN K measured the ClearLax in a plastic pill cup. When asked how much was being administered, LPN K reported 25 milliliters (mL). R81 was admitted to the facility on [DATE] with diagnoses that included thoracic spine injuries. Review of R81's Physician's Order dated 6/6/24 revealed R81 was ordered to receive Metoprolol 25 mg half tablet (12.5 mg) twice a day for hypertension. R81 received a whole tablet. Review of the Physician's Order dated 3/15/24 revealed an order for Senna 8.6 mg, two capsules twice a day for constipation. R81 did not have an order for docusate sodium. Review of the Physician's Order dated 5/15/24 revealed an order for Glycolax (Miralax) 17 grams (g) twice a day for constipation. Review of the ClearLax instructions revealed the bottle top is a measuring cap marked to contain17 grams of powder when filled to the indicated line (white section in cap). In an interview on 06/26/24 at 9:20 AM, LPN K was asked about R81's Metoprolol. LPN K pulled the medication out of the medication cart. The pills sent from pharmacy were full tablets of Metoprolol 25 mg. When asked about the order, LPN K confirmed that R81's order was for a half tablet and that they administered a full tablet. When asked about the Senna Plus, LPN K reported R81 preferred the Senna Plus versus the regular Senna. LPN K confirmed the order was for Senna and not Senna Plus. When asked about measuring the Miralax, LPN K reported they usually measured the Miralax in a plastic pill cup. When asked about using the top of the container to measure 17 g, LPN K reported they sometimes measured it that way. When asked how they knew the pill cup was 17 g, LPN K stated I just put it in the cup and look. In an interview on 06/26/24 at 1:32 PM, Director of Nursing (DON) B reported the facility completed medication error reports for R81 regarding the Metoprolol and Senna Plus. DON B reported the ClearLax/Miralax bottles had a measuring cup on the top of the container, and she was not aware of an instance where a plastic pill cup would be used to measure 17 grams.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 Based on observation, interview, and record review, the facility failed to promptly schedule a dental referral, in one of one resident reviewed for dental care (Resident #36), resulting in continued pain and a delay meeting resident goals. Findings include: Resident #36 (R36) R36 was observed sitting in his bed on 6/26/24 at 8:27 AM and stated he had sores in his mouth, like blisters, that caused him pain. R36 complained that he was supposed to see another dentist but was not aware if an appointment had been scheduled. R36's MDS with ARD dated of 3/07/24, revealed he was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS, cognitive screener) score of 10 (08-12 Moderate Impairment). In review of R36's care plans on 6/26/24, there was no care plans regarding dental issues or oral care. R36's Dental visit notes dated 3/28/24 revealed R36 had the diagnoses of dementia, obstructive sleep apnea, and lung disease. R36 had generalized soreness in his mouth, including burning sensations. R36 had a very low attached maxillary anterior frenum (tissue connecting upper lip to the upper gums and attached too close to the teeth) and had two round, 1 millimeter (mm) by 1 mm, indurated (hardened areas) nodules (growth or lump). The same visit notes indicated the nodules get very sore at times, but don't seem to drain. The soreness seemed to start after R36 had eye surgery that found a cancerous lesion. It was recommended R36 see an oral surgeon to remove the frenum nodules. After that R36 would like to receive upper and lower dentures if possible. The same form indicated action required by nursing home staff included: (1) continue daily oral care and (2) refer to oral surgeon for the removal of the two nodules on the maxillary anterior frenum. Unit Manager Registered Nurse (UMRN) H was interviewed on 6/26/24 at 2:18 PM and stated when a resident had a referral, she would write a note, put in an order, print it out and give it to the scheduler. The care plan would be updated as needed. UMRN H confirmed the referral was sent to the scheduler on 5/28/24 and the dental appointment was not scheduled yet. UMRN H was not sure why R36's dental appointment was not attempted to be scheduled between 3/28/24 through 5/28/24. R36's care plan dated 6/27/24 revealed Resident has a dental problem related to missing teeth, no dentures. R36's nodules noted by the dentist were not included in the care plan. R36's goal was Resident will have reduced complications related to dental/oral issues through the next review; his goal to receive upper and lower dentures were not added to the care plan.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 Based on observation, interview, and record review the facility failed to serve food at the preferred temperature for one resident (#57) and six residents (confidential resident group) and failed to provide condiments, food accuracy, preferred food palatability, preferred eating utensils, and preferred food items for six residents (confidential resident group) resulting in dissatisfaction during meals. Findings Included: Resident #57 (R57) Review of the medical record demonstrated that R57 was admitted [DATE] with diagnoses that included spinal stenosis, neoplasm (abnormal mass) related pain, malignant (cancer) neoplasm of the cervix, malignant neoplasm of bone, chronic obstructive pulmonary disease (CPOD), cognitive communication deficit, insomnia, mood disorder, depression, and back pain. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/30/2024, revealed R57 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. During observation and interview on 06/25/2024 at 10:02 a.m. R57 was observed lying in bed. She explained that every time she receives her meal it is cold. R57 explained that staff had explained to her that they could not re-heat her food. Review of R57's medical record demonstrated at R57 was to receive a regular diet with thin liquids. During observation and interview on 06/26/2024 at 08:33 a.m. R57 was observed to be lying in bed. It was observed that Certified Nursing Aide (CNA) J brought in R57's breakfast tray. The tray was uncovered and was observed to be sausage gravy over a biscuit and hash browns. R57 placed her finger in the food and told CNA J that the food was cold. CNA J explained to R57 that she could not re-heat her food but could go to the kitchen and have a new tray provided or she could have an alternative morning breakfast. R57 explained that she would like a new tray to be provided. CNA J removed the entire tray with metal silverware observed. In an interview on 06/26/2024 at 08:38 a.m. Certified Nursing Aide (CNA) J explained that direct care staff was not allowed to re-heat food for the residents if they had ben informed that the food was cold. She explained that residents could be provided an alternative or staff would need to get a new tray from the kitchen. In an interview on 06/26/2024 at 08:46 a.m. Dietary Manager (DM) G explained that direct staff were not allowed to re-heat food if a resident had a concern that the food was cold. He explained that direct staff must take it back to the kitchen, at which time the food would be destroyed and a new food tray would be prepared. When asked how long a tray replacement was provided, he explained it usually took between five and ten minutes. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/26/2024 at 08:53 a.m. it was observed that Certified Nursing Aide (CNA) J returned with the food tray for R57. The food tray was observed to contain sausage gravy on a biscuit and a plastic spoon. R57 proceeded inquire about the hash browns. CNA J explained that the kitchen did not have any more hashbrowns. R57 also inquired why she was given a plastic spoon and requested metal silverware. R57 placed her finger in her food and explained that it was warm enough now. CNA J left the room and did not offer R57 any replacement for the hashbrowns. At the end of the observed interaction between R57 and CNA J, CNA J exited the room. On 06/26/2024 at 08:59 a.m. Certified Nursing Aide (CNA) J returned to R57's room and provided her with metal silverware. It was observed that because of the above listed events R57 was not able to initiate consumption of her breakfast tray for 27 minutes from when she first received her breakfast tray. 27306 During the confidential group meeting help on 6/27/24 at 11:00 am, 6 of 6 confidential group participants reported they had chronic food concerns ranging from cold food temperatures, to soggy bread/rolls from vegetables not being drained and accuracy. All six participants reported that on a daily basis there is an issue with tray accuracy, preferences not being followed. One participant presented her meal ticket from last nights dinner and the ticked read add 2 packets of mayo the confidential group member reported she received 0 packets of mayonnaise. Another resident reported she will get toast but no butter or jelly and on another day will get jelly and butter but no toast, another resident reported that last week she did not receive any silverware. All 6 group participants reported things had been a long standing ongoing issue with some improvement but not enough. On 06/27/24 at 01:58 PM, during an interview with Dietary Manager G stated he was aware of the issues and was taking measure to correct things such as audits which he thought were going well. 39083 On 6/26/24 at 12:25 PM, Resident 99 lunch tray was aquired as a test tray while staff were approximately half way through distributing the lunch trays from the rolling cart. The following temperatures were noted using a digital probe thermometer: Meatloaf - 113 degrees F, Mashed potatoes - 133 degrees F, Corn - 125 degrees F. The meatloaf was observed to be luke warm.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 45038 Based on observation, interview, and record review the facility failed to provide adaptive equipment for one resident (#30) out of twenty residents, resulting the potential for decrease independence with preparing meals and eating. Findings Included: Resident #30 (R30) Review of the medical record demonstrated R30 was admitted to the facility 04/30/2024 with diagnoses that included osteomyelitis (inflammation of bone caused by infection) of left ankle an foot, type 2 diabetes, arthritis, myocardial infarction (hear attack), heart disease, uropathy (disease affecting urinary flow), absence right leg below knee, urinary retention, cognitive communication deficit, depression, atherosclerosis (build-up of fats, cholesterol in and on the artery walls), peripheral vascular disease (PVD), hypertension, hyperlipemia (high fat content in blood), insomnia, and stroke. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/05/2024, revealed R30 had Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 06/26/2024 at 08:18 a.m. R30 was observed lying down in bed. He explained that facility was supposed to provide him with built up eating utensils. He explained that they are providing a fork and spoon but that never provide him with a knife. He explained that a knife was necessary to prepare his food prior to him eating. He explained that he had repeatedly asked for a built up knife but had not been provide one yet. Review of R30's medical record demonstrated a plan of care stating Resident has an ADL (Activity of Daily Living) self-care performance deficit related to multiple CVA (stroke). Care plan intervention list the intervention Built up handles for utensils at meals. During observation and interview on 06/27/24 at 08:26 a.m. R30 was observed sitting up in bed. Observed his breakfast tray to include scramble eggs, a piece of toast, butter, jam, and a drink. It was also observed that a built up handle spoon and fork were present on the resident's tray. No built up knife was present on his tray. R30 explained that he had to use his spoon and fork to butter his toast and apply jam on his toast. In an interview on 06/27/2024 at 08:33 a.m. Dietary Manager (DM) G explained that residents at the facility are provided adaptive silver if a resident needs those devices to assist them with eating their food. He was asked if this included knives and he responded that the facility also had adaptive knives to be provided to the residents. He explained that dietary staff would review the meal ticket, which would inform the dietary staff if adaptive eating utensils or devices should be provided. DM G was asked if R30 required built up utensils for eating to be provide on his dining tray. He explained that he would have to review R30's meal ticket. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/27/2024 at 08:40 a.m. Dietary Manager (DM) G returned with R30's meal ticket. R30's meal ticket was observed to state Built up utensils. DM G could not explain why R30 had not received a built up knife on his meal tray. He explained that it was his expectation that a built up knife should be provided on his meal tray every meal.

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	235653	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Capital Area	2100 E Provincial House Dr Lansing, MI 48910

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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. 39083 Based on observation, interview, and record review, the facility failed to maintain plumbing and refrigeration equipment, resulting in the potential for an increased risk of foodborne illness, affecting all residents that consume food from the kitchen. Findings include: On 6/25/24 at 9:58 AM, water was observed to be leaking from the in-line water filter provided for the coffee maker. At this time, water accumulation was observed on the floor. According to the 2017 FDA Food Code Section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; P and (B) Maintained in good repair. On 6/25/24 at 10:19 AM, the Arctic Air reach-in cooler was observed to be holding temperature at around 52 degrees Fahrenheit, read from the internal ambient air thermometer. At this time, Certified Dietary Manager (CDM) G stated that staff were just in the cooler and that the temperature hasn't dropped down yet since the door was open. Peanut butter jelly sandwiches, individually portioned salads, and meat and cheese sandwiches were observed in the cooler. During an interview on 6/25/24 at 11:24 AM, CDM G stated that they discarded the food from the warm reach-in cooler, as the temperature was not coming down. According to the 2017 FDA Food Code Section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or (2) At 5 C (41 F) or less. P . According to the 2017 FDA Food Code Section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened. On 6/25/24 at 10:21 AM, the atmospheric vacuum breaker (AVB) (a device commonly used in plumbing that prevents backflow/backsiphonage of contaminated water into the potable water supply), was observed to be provided for the mop sink. At this time, the water supply was in the open position with a shutoff valve below the AVB, leaving the AVB under constant pressure. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code Section 5-202.14 Backflow Prevention Device, Design Standard. A backflow or backsiphonage prevention device installed on a water supply system shall meet American Society of Sanitary Engineering (A.S.S.E.) standards for construction, installation, maintenance, inspection, and testing for that specific application and type of device. P

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 45038 Based on observation, interview, and record review the facility failed to ensure proper communication/documentation of Hospice services provided to one resident's responsible person (Resident #56) of one resident reviewed for Hospice services, resulting in a lack of coordination of comprehensive services and care provided. Findings Included: Resident #56 (R56) Review of the medical record demonstrated R56 was admitted to the facility 02/15/2024 with diagnoses that included dementia, traumatic subdural hemorrhage (brain bleed), type 2 diabetes, osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down), atrial fibrillation, urine retention, gastro-esophageal reflux, Alzheimer's Disease, depression, hyperlipidemia (high fat content blood), and hypertension. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/26/2024, revealed R56 had a Brief Interview for Mental Status (BIMS) of 00 (sever cognitive impairment) out 15. The same MDS demonstrated section O-Special, Treatments, Procedures, and Programs demonstrated that R56 was receiving hospice care. In a telephone interview on 06/25/2024 at 11:35 a.m. R56's Durable Power of Attorney (DPOA) P explained that she was aware that she had approved R56 to receive hospice services. She explained that she was told that someone would contact her regarding which disciplines were providing services and the frequency of those services but that she had not been contacted. Review of R56's medical record demonstrated a physician order that hospice services were to be started 05/22/2024. Review of R56's plan of care demonstrated that he was to receive Hospice Aide two times weekly, Nurse one time weekly and as needed, Social Services one time weekly and as needed, and a Chaplin two times monthly and as needed. During observation and attempted interview on 06/25/2024 at 10:04 a.m. R56 was observed lying down in bed. R56 did not respond to verbal questions. No hospice calendar, which would explain which disciplines would visit and what days those services were to be provide, was observed in R56's room. Review of R56's medical record did not demonstrate that R56's Durable Power of Attorney (DPOA) P received any notification of what hospice disciplines were to be involved in R56's hospice services or when those services were to be provided. R56's medical record demonstrated one Care Plan Conference Summary V5 that was conducted 06/24/2024 but did not include any information of hospice services and did not demonstrate that R56's DPOA P was provided the information discussed at the conference. In an interview on 06/27/2024 at 08:10 a.m. Licensed Practical Nurse (LPN) V explained that nursing staff knew which residents received hospice services because it is listed in the residents' medical record. She explained that each resident who was receiving hospice services had a Hospice Notebook at the nurses station. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R56's Hospice Notebook, which was located at the nurses station, did not demonstrate a calendar of when the disciplines visits were to occur. In an interview on 06/27/2024 at 09:41 a.m. Nurse Manager (NM) H explained that when a resident starts on hospice services, they or their responsible party would be informed in an admission meeting for the hospice services. She explained that it would be explained which hospice disciplines and frequency of those visits would be explained at that meeting. NM H could not locate any documentation that a hospice admission meeting had occurred with R56's Durable Power of Attorney (DPOA) P. NM H could not verbalize or provide documentation demonstrating when hospice services where to be provided. In an interview on 06/27/2024 at 10:15 a.m. Social Worker (SW) W explained that she was involved in monthly meetings with the hospice agency that occurred monthly. She explained that those meetings were recorded in the resident's medical record. She explained that the hospice visit calendar was in a resident's medical record. SW W could not demonstrate that a hospice meeting had been conducted with R56 in which his Durable Power of Attorney (DPOA) had been involved. During this interview R56's medical record demonstrated a hospice calendar for the week of 05/26/2024 but was not scanned into the medical record until 05/28/204, a hospice calendar for the week of 06/16/2024 but was not scanned into the medial record until 06/18/2024, and a hospice calendar for the week of 06/23/2024 but was not scanned into the medical record until 06/27/2024. No hospice calendar was present for the week of 06/03/2024 or 06/10/2024. SW W' explained that the hospice agency would forward the calendar to medical records and then medical records would scan it into the residents medical record. SW W could not explain why the calendar was not scanned into the medical record prior to the hospice visits. SW W could not explain if R56's DPOA P had received any hospice calendar of visits that were provided. Review of provided facility policy entitled Hospice, implemented 10/20/2020 and a last revision date of 10/26/2023, demonstrated #2 which stated The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goal, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 45038 Based on interview and record review the facility failed to administer pneumococcal immunizations in accordance with the Center for Disease Control and Prevention (CDC) recommendations for one resident (#25) of five residents reviewed resulting in the potential for server illness and complications from pneumococcal disease Findings Included: Resident #25 (R25) Review of the medical record demonstrated that R25 was admitted to the facility 11/18/2023 with diagnoses that included dementia, chronic kidney disease, anxiety, hyperlipidemia (high fat content in blood), sever protein-calorie malnutrition, hypertension, depression, muscle weakness, insomnia, irritable bowel syndrome, and spinal stenosis. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/25/2024, revealed R25 had a Brief Interview for Mental Status (BIMS) of 2 (severe cognitive impairment) out of 15. Review of R25's medical record demonstrated a date of birth of 09/16/1951. R25's medical record demonstrated that she had received Pneumococcal Conjugate Vaccine (PCV)13 05/23/2017 and PCV23 12/05/2018. No documentation was present that PCV20 had been given. According to Center for Disease Control and Prevention (CDC) guidelines on PneumoRecs Vax Advisor, for person over the age of 65, one dose of PCV20 at least 5 years after last pneumococcal vaccination dose. In an interview on 06/27/2024 at 02:50 p.m. Infection Preventionist (IP) C explained that pneumococcal vaccinations are offered to the residents based on the guidelines that are provided by Center for Disease Control and Prevention (CDC). IP C confirmed that R25 had not offered or received Pneumococcal Conjugate Vaccine (PCV)20 at least 5 years after her last pneumococcal vaccination. IP C explained that she was not aware of the CDC guidelines suggested that R25 receive PCV20. Review of facility policy entitled Pneumococcal Vaccine (Series), with an implementation date of 03/01/2022 and last revised 10/30/2023, demonstrated #5 which stated: The type of pneumococcal vaccine (PCV15, PCV20, or PPSV23/PPSV) offered will depend on recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 39083 Based on observation, interview, and record review, the facility failed to control pests in the kitchen and reduce harborage conditions, resulting in uncontrolled pests in the facility, affecting all residents in current facility census of 99 residents. Findings include: On 6/25/24 at 10:03 AM, a swarm of gnats were observed in the dry storage room, surrounding the bread rack, which is located directly next to a drainage pipe. At this time, Certified Dietary Manager (CDM) G stated that the pest control operator has provided them with floor and drain cleaner which is supposed to help with the gnats. On 6/25/24 at 10:15 AM, a swarm of gnats were observed flying around the grease trap by the three-compartment sink. On 6/25/24 at 11:35 AM, gnats were observed to be flying around the dish machine area. On 6/25/24 at 11:44 AM, a cart in the dining room was observed to be holding breakfast trays, while residents were in the dining room waiting for their lunch trays. The breakfast trays were observed to be attracting gnats, with multiple gnats observed on the leftover breakfast foods. On 6/26/24 at 1:51 PM, countless gnats were observed to be crawling on the wall adjacent to the hand sink. At this time, CDM G stated they cleaned the grease trap area which may have made the gnats move to a different area of the kitchen. According to the 2017 FDA Food Code Section 6-501.111 Controlling Pests. The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: (A) Routinely inspecting incoming shipments of FOOD and supplies; (B) Routinely inspecting the PREMISES for evidence of pests; (C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under SS 7-202.12, 7-206.12, and 7-206.13; Pf and (D) Eliminating harborage conditions. A review of the Pest Control Operator's, Service Report, dated for 6/5/24 and 5/2/24, notes no mention of gnats/drain flies/fruit flies or treatment applications thereof.