STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019675	A. BUILDING: _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDENCOURT WAUKESHA	2330 W MICHIGAN AVE WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 05/08/2024, with information gathered through 05/31/2024, Surveyor conducted 2 complaint investigations at LindenCourt Waukesha. Six deficiencies were identified. One complaint was unsubstantiated. One complaint was substantiated. Census: 36	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's right to receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. From approximately 03/07/2024-04/24/2024, Resident 5 did not receive daily physician ordered clozapine resulting in hallucinations, a manic schizophrenic episode, and hospitalization. Due to facility staff inaccurately documenting administration of Resident 5's clozapine 250 MG from 03/07/2024-04/24/2024 on Resident 5's electronic medication administration record (eMAR), s/he was administered clozapine 250 MG in the ED resulting in acute respiratory	N 352		

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

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suppression, intubation, and transfer to ICU for ventilator support. S/he was extubated and discharged to a skilled nursing facility.

Findings include:

On 05/08/2024, the Department received a complaint regarding medication administration.

According to the Food and Drug Administration, " ...The Clozapine REMS [Risk Evaluation and Mitigation Strategy] is a shared system REMS for all approved clozapine products. The Clozapine REMS ensures appropriate patient monitoring for and management of clozapine-induced severe neutropenia and provides a centralized system for prescribers and pharmacists in managing patient risk, ...Clozapine is an antipsychotic drug used to help improve the symptoms of schizophrenia in patients who do not respond adequately to standard antipsychotic treatment ...pharmacies will need to contact the REMS Program by phone or online to verify safe use conditions ...Changes were also made to improve the process for a prescriber to submit absolute neutrophil count (ANC) results. Depending on the patient's monitoring frequency, this could require daily, weekly, biweekly, or monthly documentation of the ANC. In order to reduce the burden on prescribers and minimize unintended treatment interruption for patients, the documentation of ANC will now be submitted monthly ..." (Source: https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/frequently-asked-questions-clozapine-rems-modification (retrieval date 05/23/2024)).

From 05/17/2024-05/23/2024, Surveyor received (via email from Administrator A) and reviewed Resident 5's record.

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N 352	Continued From page 2 Resident 5 was admitted 01/05/2024. Diagnoses included: major depressive disorder, recurrent, unspecified; generalized anxiety disorder; and schizoaffective disorder, bipolar type. Physician orders included: CBC monthly on the last day of the month for CBC neutrophil count related to clozapine use due to schizoaffective disorder, unspecified. (Start date 07/11/2023); CBC with Diff every 2 weeks for medication management (start date 03/13/2024); Clozapine 150 MG every morning (start 07/11/2023, discontinued 03/13/2024) and 200 MG at bedtime (start 07/11/2023) for schizoaffective disorder, unspecified. Advanced Practice Nurse Prescriber (APNP) M note (summarized): Date of visit: 03/12/2024. Medications- clozapine 100 MG take 1 ½ tablets every morning and clozapine 200 MG take 1 tablet at bedtime. Assessment and Plan- Schizophrenia: continue clozapine. Labs- Lab results dated 04/01/2024. The record did not contain additional lab work. Pharmacy Packing Slip Proof of Delivery dated 02/06/2024 identified 30 tablets of clozapine 200 MG tablets were delivered and Pharmacy Packing Slip Proof of Delivery dated 02/09/2024 identified 45 tablets of clozapine 100 MG tablets were delivered (to equal 30 days at 150 MG). MAR dated 03/01/2024-04/24/2024: Staff documented administration of clozapine 150 MG in morning- 03/09/2024- blank 03/10/2024- administered	N 352		

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N 352	Continued From page 3 03/11/2024- code 16, Med Unavailable/Pharmacy Contacted 03/12/2024- code 16, Med Unavailable/Pharmacy Contacted 03/13/2024- code 16, Med Unavailable/Pharmacy Contacted Medication was discontinued on 03/13/2024. Staff documented administration of clozapine 200 MG at bedtime- 03/07/2024- 03/18/2024- administered 03/19/2024- code 16, Med Unavailable/Pharmacy Contacted 03/20/2024- administered 03/21/2024- code 9, Other/See Progress Notes 03/22/2024-03/24/2024- administered 03/25/2024- code 16, Med Unavailable/Pharmacy Contacted 03/26/2024 and 03/27/2024- administered 03/28/2024- code 9, Other/See Progress Notes 03/31/2024- code 16, Med Unavailable/Pharmacy Contacted 04/01/2024- code 9, Other/See Progress Notes 04/02/2024- and 04/03/2024- administered 04/04/2024- blank 04/05/2024- administered 04/06/2024- blank 04/07/2024- administered 04/08/2024- code 16, Med Unavailable/Pharmacy Contacted 04/09/2024- and 04/10/2024 administered 04/11/2024- code 9, Other/See Progress Notes 04/12/20/24- administered 04/13/2024- code 16, Med Unavailable/Pharmacy Contacted 04/14/2024 and 04/15/2024 administered 04/16/2024- code 16, Med Unavailable/Pharmacy Contacted 04/17/2024 administered 04/18/2024 code 16, Med Unavailable/Pharmacy	N 352		

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Contacted
04/19/2024 code 16, Med Unavailable/Pharmacy Contacted
04/20/2024 administered
04/21/2024 code 16, Med Unavailable/Pharmacy Contacted
04/22/2024 blank
04/23/2024 administered
(hospitalized 04/24/2024)

Facility Progress Notes:
04/01/2024 5:52 PM by Agency RN H- "Note Text : per report from ADON, order for stat labs for CBC [with] DIFF [and] valporic acid level received [related to] clonzapine [and] depakote therapy. Lab faxed [and] called and given [LindenCourt's address] and [Resident 5's] room number. pt [sic] notified. Also, paperwork received [and] signed by [physician] that pt is now [his/her] own person and is capable of making [his/her] own decisions and POA is no longer activated ..."

04/24/2024 8:10 PM by Former Assistant Director of Nursing (FADON) L- "Patient appeared to be in a manic state this evening and was sent out 911 for psych services and to medically be evaluated. [Family Member J] was present and [Family Member K] was on the telephone. Patient was thinking people were trying to kill [him/her], [s/he] was yelling at [Family Member J]. It was reported to RN around 1400 [2:00 PM] that patient refused meds this AM was on the floor refused to get dressed, eat [sic] etc. RN will document this as an unwitnessed fall, patient had some swelling around right eye no bruising noted. [Family Member J] called EMS and patient was sent out 911 ..."

05/21/2024 11:18 AM by LPN I- " ...Note Text: After going through the eMAR [electronic

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N 352	Continued From page 5 Medication Administration Record] from Feb to April these are my findings: 2/6 clozapine 200 MG 30 delivered 2/7 clozapine 100MG 45 delivered 2/4-2/9 hospitalized 2/10 given all month 100 MG- 3/9 no signature 3/11-3/13 no med available code 16 (03/14/2024 med discontinued). 200 MG- 2/4-2/9 hospitalized. 2/10 given all month 3/19 code 16 no med available 4/1 med hold 4/4 no signature 4/6 no signature 4/8 code 16 no med available 4/9 med hold 4/13 no med available 4/16 no med available 4/18 no med available 4/18 no med available 4/19 no med available 4/21 no med available 4/22 no signature 4/24 no signature went out to hospital this day [sic] After counting meds that were delivered and comparing to med eMAR there is possible inaccurate documentation for med clozapine 200 MG from 3/18 to 4/24. Unable to determine if inaccurate documentation happened due to not having empty med packs, and not having access to the left-over meds from when resident left but is likely, education provided. Administrator will audit not administered med pass in PCC to ensure this does not happen again ..."	N 352		

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N 352	Continued From page 6 There was no documentation in the facility progress notes that: facility nurse, pharmacy or prescriber was notified that clozapine was unavailable for administration from 03/07/2024-04/24/2024; reason clozapine was not administered on dates when coded "9" on the eMAR; labs were drawn anytime other than 04/01/2024; and 04/01/2024 lab results were provided to primary care physician, psychiatrist, or pharmacy so clozapine could be refilled. ISP not dated or signed (earliest initiation date 01/08/2024): In the area of Medications- " ...Will be supported to take all medications safely and as ordered ...Has history of constipation. May take prn [as needed] meds as per MAR ...Requires assistance with ordering meds ...Requires daily supervision of medication ..." Fire Department/EMS) note dated 04/24/2024: On 05/29/2024 at 8:11 AM, Surveyor received Resident 5's Fire Department/EMS note dated 04/24/2024 from the fire department. The note stated that on 04/24/2024 at 4:48 PM emergency services arrived at the facility and patient was assessed to be oriented to person and disoriented to time and place, also noted head swelling. The note stated " ...On arrival EMS was directed to pt [patient] by staff. [Family Member J] was on scene and talked with EMS prior to pt contact. [Family Member J] stated that [s/he] arrived on scene at 1400 [2:00 PM] that afternoon where [s/he] located the pt lying prone on the floor. Pt appeared to have some swelling to [his/her] right eye and was stating that staff had not been giving [him/her] food or his/her] prescribed medications. Pt was noted to be having hallucinations during a manic schizophrenic episode. [S/he] also stated that the	N 352		

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N 352	Continued From page 7 pt had [his/her] medical POA discontinued about one month prior. Medical history was obtained from [Family Member J] as well as staff. Pt contact was made with the pt noted to be sitting on the floor with O2 [oxygen] via a NC [nasal canula] applied at 3 L/min. Pt stated that [s/he] did not feel safe and made several comments related to the swelling around [his/her] eye, stating, "They tried to take me! Don't let them kill me!" Pt continued to make comments about people who were not in the room and was afraid that people were present and trying to harm [him/her]. [Family Member J] stated that the pt would commonly have episodes where [s/he] felt in danger. The pt allowed EMS to assess [his/her] vitals which were charted. Pt also complained of pain in [his/her] abdomen. Pt had a noted history of UTIs [urinary tract infections]. EMS advised the pt that they could take [him/her] to the hospital to have [his/her] eye and abdomen looked at and the pt agreed. When EMS attempted to assist the pt to the cot, the pt became aggressive with EMS and pt movement was stopped. EMS worked to calm the pt down and assure [him/her] that no one was there to hurt [him/her], and that everyone wanted to make sure that [s/he] was healthy. After several more minutes EMS was able to get the pt onto the cot and EMS O2. Pt was secured and moved to the back of the ambulance. Once pt was in the back of the ambulance, EMS went enroute to [name of hospital] without lights or siren. While enroute the pt was monitored with no changes in condition noted. A report was called in to [name of hospital] ED via telephone, room on arrival. EMS arrived without incident. On arrival the pt was taken to the ED room ..." Hospital Note received 05/24/2024 at 1:26 PM via fax from hospital medical records department (summarized): Date 04/24/2024 time admitted	N 352		

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N 352	Continued From page 8 5:18 PM. " ...Principal Problem: ...Acute metabolic encephalopathy likely combination of possible UTI and patient not receiving clozapine at facility ...Per facility MAR, patient received 3 doses of clozapine in the past 7 days, family says [s/he] received no doses in the past 7 days ...Received clozapine 250 MG in ED ...Psychiatry consult for reinitiation and dose titration of clozapine ...Discharge Summary [dated 05/06/2024] ...Patient developed acute respiratory suppression, this was felt to be secondary to dose of Clozapen [sic] patient received in the ED. Patient was subsequently intubated and transferred to ICU for ventilator support. With time patient was successfully extubated was eventually transition [sic] to floor ...Patients [sic] ANC was reported to the REMS program for Clozapine [sic] for values obtained on 5/3/2024 and 5/6/2024 ..." On 05/21/2024 at 3:23 PM, Surveyor interviewed Pharmacist N who stated monthly lab work was required to refill clozapine due to risk of serious and fatal infections and when clozapine orders were received, the pharmacist checked the REMS data base for lab values. Pharmacist N stated because clozapine is a controlled substance it was not automatically refilled and someone needed to notify the pharmacy for refills. Pharmacist N stated because the pharmacy was not notified Resident 5's clozapine needed a refill it was not re-filled after 02/07/2024. On 05/24/2024 at 10:18 AM, Surveyor interviewed Pharmacy Tech O who stated there was no discharge order for Resident 5's clozapine 150 MG every morning and the pharmacy's system may have automatically discontinued it	N 352		

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N 352	Continued From page 9 03/13/2024 due to no active prescription. Pharmacy Tech O stated they had an active prescription for clozapine 200 MG until after Resident 5's 04/24/2024 discharge from facility. On 05/24/2024 at 9:50 AM, Surveyor interviewed Resident Aide P regarding his/her coding "16 no med available" on Resident 5's MAR. Resident Aide P stated if s/he coded a "16" then the medication was not available. Resident Aide P stated s/he did not remember if s/he notified the facility nurse or pharmacy that the medication was unavailable. Resident Aide P stated when first admitted to facility Resident 5 was always talkative with staff and had some delusions that did not appear distressing to Resident 5. Resident Aide P stated 1 to 2 weeks prior to 04/24/2024 Resident 5 became agitated, talked to his/herself all the time, and kicked staff out of his/her room. On 05/24/2024 at 7:23 AM, Surveyor interviewed Family Member J and Family Member K. Family Member J stated on 04/24/2024 just after 2:00 PM s/he arrived at facility to meet the driver who was to transport Resident 5 to a scheduled appointment. Upon arrival to facility s/he found Resident 5 in his/her room and lying face down on the floor in a puddle of urine. [Note: (Photo 8 received from Family Member K at 05/24/2024 8:31 AM, taken by Family Member J date/time stamped 04/24/2024 at 2:13 PM) depicts Resident 5 wearing nightgown, lying uncovered face down on floor with face directly on carpet, a pillow lying on floor under bed just above Resident 5's head, dark spot on carpet protruding from under Resident 5 from groin area to lower thighs, feet crossed at the ankle and right hand resting near his/her neck, oxygen tubing on the floor and under Resident 5's head.] Family	N 352		

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N 352	Continued From page 10 Member J stated the oxygen concentrator was unplugged so s/he plugged it in and went to get staff. Family Member J stated Resident 5 appeared extremely fearful, stated s/he thought Family Member J was going to kill her, and would not allow Family Member J to touch him/her. Family Member J stated Resident Aide P assisted Family Member J to sit Resident 5 up. Family Member J stated Resident 5 was shaking and making repetitive vocalizations with some intermittent words. Family Member J stated Resident 5's eye appeared swollen, and lips appeared very dry. [Note: (Photo 9 received from Family Member K at 05/24/2024 8:31 AM taken by Family Member J and date/time stamped 04/24/2024 at 3:04 PM) depicts Resident 5's right eye lid swollen, a crusty brown matter on his/her lips, and both nasal canula prongs that deliver oxygen into the nasals situated under the right nasal.] Family Member J stated s/he called Family Member K who then called 911. Family Member J stated FADON L implied staff did not want to call 911 because Resident 5's usual behavior consisted of lying him/herself on the floor. Family Member J and Family Member K stated they were not aware of Resident 5's behavior of lying on the floor. Family Member J stated s/he was a pharmacist and per his/her request, staff provided him/her with a copy of Resident 5's April 2024 MAR with a 2nd copy provided to paramedics. Family Member J stated upon arrival to the ED, s/he told ED staff Resident 5's MAR was inaccurate, and Resident 5 had not received clozapine, however ED staff administered a full dose of clozapine and Resident 5 ended up on a ventilator for a couple of days. On 05/24/2024 at 2:00 PM, Surveyor discussed concern of Resident 5 not receiving clozapine	N 352		

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N 352	Continued From page 11 with Administrator A, Nurse Consultant B and LPN I. Administrator A stated if upon admission, Resident 5 brought medications in a pill packet they may have accepted them but if they were brought in a pill bottle they would have had to be repackaged. Administrator A stated they did not know if Resident 5 brought clozapine with her upon admission. Administrator A stated FADON L was responsible for notifying the prescriber or pharmacy when medication refills were needed. Administrator A stated s/he did not know why Resident 5's labs were not drawn at end of February 2024 or during March 2024, and there was a change in leadership around that time which may have potentially attributed to it. Administrator A stated the nurse manager was responsible for sending the 04/01/2024 lab results to Psychiatrist R or APNP M, and s/he did not see any evidence that Psychiatrist R or APNP M were notified of the 04/01/2024 lab results. Administrator A stated after a prescriber writes an order the nurse manager inputs the order into PCP (computer system) and the pharmacy automatically receives it. On 05/30/2024 at 9:04 AM, Surveyor interviewed Resident Aide S who stated on 04/24/2024 when s/he arrived for his/her PM shift, AM caregivers told him/her Resident 5 had refused medications and cares and was lying on the floor in his/her room. Resident Aide S stated s/he went to Resident 5's room and observed Resident 5 lying face down on the floor so s/he assisted Family Member J to help Resident 5 sit up. Cross Reference: N0389 83.35(3)(d) Service Plans Updated Annually Or On Changes N0431 DHS 83.38(1)(g) Health Monitoring	N 352		

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N 387	Continued From page 12	N 387		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident or resident's legal representative signed the individual service plan (ISP) acknowledging their involvement in, understanding of and agreement with the plan for 4 of 4 residents reviewed. Findings include: On 05/08/2024, Surveyor requested Resident 1's, Resident 2's and Resident 3's records including ISP signature sheets from Administrator A. Example 1- Resident 1 Resident 1 was admitted 03/11/2024. His/her	N 387		

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LINDENCOURT WAUKESHA	2330 W MICHIGAN AVE WAUKESHA, WI 53188

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Power of Attorney for Health Care was activated. Resident 1's ISP was not signed or dated.

Example 2- Resident 2
Resident 2 was admitted 04/01/2024. His/her Power of Attorney for Health Care document was activated. Resident 4's ISP was not signed or dated.

Example 3- Resident 3
Resident 3 was admitted 02/19/2024. His/her Power of Attorney for Health Care document was activated. Resident 4's ISP was not signed or dated.

On 05/08/2024 at 4:24 PM, Surveyor discussed concern of ISP's not signed by legal representatives with Administrator A, Nurse Consultant B, and Admissions C. Administrator A stated s/he did not know why the ISPs were not signed. Administrator A stated they would look for the ISP signature sheets and submit to Surveyor by 4:30 PM on 05/09/2024. As of 5:00 PM on 05/10/2024 no additional information was received.

On 05/17/2024 at 8:58 AM, Surveyor began a complaint investigation and emailed Administrator requesting Resident 5's ISP and signature sheet.

On 05/21/2024 12:25 PM, Surveyor received via email from Administrator A, Resident 5's record. Resident 5 was admitted 01/05/2024. His/her Power of Attorney for Health Care document was activated at time of admission until 04/01/2024 when activation was rescinded.

Resident 5's ISP was not dated or signed.

On 05/24/2024 at 2:00 PM, Surveyor discussed

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N 387	Continued From page 14 concern of Resident 5's ISP not signed by Power of Attorney prior to 04/01/2024 or by Resident 5 after 04/01/2024 with Administrator A, Nurse Consultant B and LPN I. Administrator A stated Resident 5's Power of Attorney for Health Care agent missed the care plan meeting appointment and was unsure if the ISP was mailed to him/her for signature or not. Cross Reference: N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 387		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure Resident 2's individual service plan was followed as written. Resident 2 did not receive his/her glasses when s/he requested them, s/he was unshaven and his/her fingernails were overgrown and dirty with a brown substance. Findings include: On 05/08/2024 at 9:15 AM, Surveyor observed Resident 2, other residents, Caregiver D and Activities E in the dining room during breakfast. Resident 2 was eating breakfast. Resident 2 asked twice "Where are my glasses?" Resident 2 did not receive a reply.	N 388		

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N 388	Continued From page 15 On 05/08/2024 at approximately 9:30 AM, Surveyor followed Resident 2 and Caregiver D as Caregiver D accompanied Resident 2 to his/her private room. Upon arrival to Resident 2's room, Surveyor observed Resident 2's glasses on his/her bedside table, Resident 2 was unshaven and his/her fingernails were overgrown and dirty with brown substance. On 05/08/2024 at approximately 9:30 AM, Surveyor interviewed Caregiver D. Caregiver D stated s/he did not know if the glasses on Resident 2's bedside table were his/hers because s/he was just moved to Resident 2's unit from another unit. On 05/08/2024 at 9:39 AM, Surveyor interviewed Caregiver D who stated s/he was working alone as caregiver and med passer. On 05/08/2024 at 12:14 PM, Surveyor observed Resident 2 in the dining room. S/he was unshaven, and fingernails were overgrown and dirty with a brown substance. On 05/08/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted 04/01/2024. Diagnoses included dementia in other diseases classified elsewhere, unspecified severity with agitation, and Alzheimer's disease with late onset. ISP (not dated) earliest initiated date 04/04/2024: In the area of Grooming/Oral Hygiene- " ...Will be able to maintain appropriate grooming and hygiene with assistance ...Report any changes in ability to maintain grooming and hygiene to Nurse [sic] ...Requires assistance with grooming needs ..."	N 388		

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N 388	Continued From page 16 In the area of Vision- "Will be supported to maintain appropriate assistive devices for vision ...Wears glasses ..." On 05/08/2024 at 4:24 PM, Surveyor discussed concern of Resident 2's ISP not followed as written with Administrator A, Nurse Consultant B, and Admissions C. Administrator A stated "Okay." Cross Reference: N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure when there was a change in a resident's needs, abilities or physical or mental condition, the individual	N 389		

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service plan (ISP) was reviewed and revised for 3 of 4 residents reviewed.

Resident 2's ISP was not updated to include need for wander guard bracelet.

Resident 3's ISP was not updated to include need for wander guard bracelet and assistance with urinal.

Resident 5's ISP was not updated to include need for monthly labs necessary to refill physician ordered clozapine, psyche services or behavior of putting self on floor.

Findings include:

On 05/08/2024 at 9:05 AM, Surveyor observed Resident 3's room. Resident 3's fitted sheet on bed was saturated with urine. Two urinals containing approximately 1 cup of urine each were set on the over-the-bed table and on the floor next to the bed (Photo 1).

On 05/08/2024 at 9:36 AM, Surveyor interviewed Caregiver D who stated staff assisted Resident 3 to the bathroom when s/he required assistance.

On 05/08/2024 at 10:58 AM, Surveyor interviewed Resident 3 who stated s/he needed assistance with the urinal, periodically spilled the urinal, and at 6:00 AM on 05/08/2024 s/he missed the urinal.

On 05/08/2024 at 1:45 PM with Caregiver D, Surveyor observed Resident 2 wearing a wander guard bracelet on his/her left ankle.

On 05/08/2024 at 1:58 PM, Surveyor observed Resident 3 wearing a wander guard bracelet on

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his/her right wrist.

On 05/08/2024 at 1:58 PM, Surveyor interviewed Caregiver D who stated all the residents wore wander guard bracelets so staff knew if the residents were getting out.

On 05/08/2024, Surveyor reviewed Resident 2's and Resident 3's records.

Example 1- Resident 2
Resident 2 was admitted 04/01/2024. Diagnoses included dementia in other diseases classified elsewhere, unspecified severity with agitation, and Alzheimer's disease with late onset.

Observation note dated 04/01/2024 5:30 PM- "[Resident 2] admitted to room [number] today. Since admission has been [sic] doors to leave. Has walked around unit almost entire time except when eating ...I did place a wander guard on [his/her] [left] ankle as [s/he] was restless and walking about the unit. At this point I felt [s/he] was at risk ..."

ISP (not dated) earliest initiated date 04/04/2024: In the area of Elopement Risk- " ...Attempt to engage resident in pleasant, meaningful, purposeful enjoyable, resident-centered activities, during episodes of constant wandering, by offering snacks and activities. Encourage being in communal areas for company ...Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television book, (specify residence preference) ...Document wandering behavior and attempted interventions to provide resident with meaningful activities, validation, and relationship based redirection in behavior log ...Identify resident's pattern of wandering: where does [s/he] walk to and does

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N 389	Continued From page 19 [s/he] go into other resident rooms ...observe resident for changes in gait/mobility/balance and notify the nurse of any changes ...observe resident location in the community ...provide structured activities ..." In the area of Behaviors: " ... wanders aimlessly or in undirected fashion without definable or obtainable purpose ..." In the area of Elopement Risk: " ...resides within locked unit ..." Resident 2's ISP did not identify need for or use of wander guard bracelet. Example 2- Resident 3 Resident 3 was admitted 02/19/2024. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Preadmission Assessment dated 02/12/2024 (summarized): Continent of bowel and bladder, requires assist with toileting, and " ...Additional Notes: Wander guard ..." ISP not dated (earliest initiation date 02/19/2024): In the area of Toileting: " ...Dependent in toileting activities or unable to recognize need to use toilet ...Needs regular or frequent assistance to/from bathroom ...Report any changes in toileting ability to Nurse [sic] ...Requires assistance with peri-care ...Uses incontinence products ..." In the area of Behaviors: "Exhibits normal, functional behavior patterns ..." In the area of Cognition- "... Demonstrates inappropriate judgment related to safety ... Displays deficits in judgment ... Has mild to moderate disorientation or difficulty recalling retaining information. Needs cueing ...Moderate dementia with significant short-term memory and possibly long-term memory loss ..."	N 389		

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N 389	Continued From page 20 In the area of Bladder- " ...Incontinence care needs to be provided ...Dribbles urine during the day ...Is continent of bladder ...Reminders/cues required to use toilet for voiding ..." Resident 3's ISP did not identify use of or need for urinal or wander guard bracelet. On 05/08/2024 at 4:24 PM, Surveyor discussed concern of ISP's not updated to reflect resident's current needs with Administrator A, Nurse Consultant B, and Admissions C. Administrator A stated it may have been an oversight by the new manager that the ISP's were not updated or resident specific enough. Example 3- Resident 5 On 05/17/2024 at 8:58 AM, Surveyor began a complaint investigation and emailed Administrator requesting Resident 5's record. On 05/21/2024 12:25 PM, Surveyor received Resident 5's record via email from Administrator A. Resident 5 was admitted 01/05/2024. Diagnoses included: major depressive disorder, recurrent, unspecified; generalized anxiety disorder; and schizoaffective disorder, bipolar type. Physician orders included: CBC monthly on the last day of the month for CBC neutrophil count related to clozapine use due to schizoaffective disorder, unspecified. (Start date 07/11/2023); CBC with Diff every 2 weeks for medication management (start date 03/13/2024); Clozapine 150 MG every morning (start 07/11/2023, discontinued 03/13/2024) and 200 MG at bedtime (start 07/11/2023) for schizoaffective disorder, unspecified. The record contained lab results dated	N 389		

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N 389	Continued From page 21 04/01/2024. The record did not contain additional lab work. Initial Psychiatric Evaluation dated 03/27/2024 which stated " ...Follow-Up Appointment: 2 weeks ..." and a Geropsychiatric Follow-Up note dated 04/16/2024 which stated " ...Follow-up Appointment: 1 month ..." Facility Progress Note: 04/24/2024 8:10 PM by Former Assistant Director of Nursing (FADON) L- "Patient appeared to be in a manic state this evening and was sent out 911 for psych services and to medically be evaluated. [Family Member J] was present and [Family Member K] was on the telephone. Patient was thinking people were trying to kill [him/her], [s/he] was yelling at [Family Member J]. It was reported to RN around 1400 [2:00 PM] that patient refused meds this AM was on the floor refused to get dressed, eat [sic] etc ...patient was sent out 911 ..." ISP not dated or signed (earliest initiation date 01/08/2024): In the area of Behaviors- "Will not act out in a way that is harmful to self or others ...Report changes from baseline behaviors to nurse ..." In the area of Medications- " ...Will be supported to take all medications safely and as ordered ...Has history of constipation. May take prn [as needed] meds as per MAR ...Requires assistance with ordering meds ...Requires daily supervision of medication ..." Resident 5's ISP did not address need for monthly labs, psychiatric services, or behavior management for lying self on floor. On 05/24/2024 at 9:50 AM, Surveyor interviewed	N 389		

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N 389	Continued From page 22 Resident Aide P who stated when Resident 5 was first admitted to facility Resident 5 was always talkative with staff and had some delusions that did not appear distressing to Resident 5. Resident Aide P stated 1 to 2 weeks prior to 04/24/2024 Resident 5 became agitated, talked to his/herself all the time, and kicked staff out of his/her room. On 05/24/2024 at 2:00 PM, Surveyor discussed concern of need for monthly lab work, psyche services and behavior of lying self on floor not addressed on Resident 5's ISP with Administrator A, Nurse Consultant B and LPN I. Administrator A stated Resident 5 had been lying self on floor for 15-20 minutes per episode since admission. Administrator A stated Resident 5 was able to get him/herself off the floor independently and staff would offer to assist him/her with getting off the floor. Administrator A stated s/he though monthly labs, psychiatric services and behavior of putting self on floor were addressed on Resident 5's ISP, that they may have been addressed on and accidently resolved off the temporary ISP. Cross Reference: N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0431 DHS 83.38(1)(g) Health Monitoring	N 389		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In	N 431		

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N 431	Continued From page 23 addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure services were provided or arranged adequately to meet the needs of the Resident 5 in the area of health monitoring. Resident 5's physician ordered monthly labs were not drawn in February 2024 and March 2024, and	N 431		

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N 431	Continued From page 24 lab results obtained 04/01/2024 were not sent to the prescriber so Resident 5's clozapine, a medication used to treat schizophrenia, could be refilled early March 2024 and early April 2024. From 03/07/2024-04/24/2024, Resident 5 did not receive clozapine resulting in a manic schizophrenic episode on 04/24/202 and subsequent hospitalization with intubation. On 04/24/2024 staff did not assess Resident 5 when was lying on the floor (documented as an unwitnessed fall) and his/her right eyelid was swollen during a manic episode. AM staff reported to PM staff that Resident 5 had been lying on the floor and refused medications and cares. On 04/24/2024, Resident 5 was found lying on floor in his/her room by Family Member J at approximately 2:00 PM, 911 was called by Family Member K at 4:35 PM, Resident 5 was transported via EMS to hospital at 5:10 PM and did not return to the facility. Resident 5's record contained a pain assessment due to swollen eye lid area documented at 8:00 PM on 04/24/2024. The record did not contain vitals, behavior assessment or unwitnessed fall assessment dated 04/24/2024. Findings include: According to the Food and Drug Administration, " ...The Clozapine REMS [Risk Evaluation and Mitigation Strategy] is a shared system REMS for all approved clozapine products. The Clozapine REMS ensures appropriate patient monitoring for and management of clozapine-induced severe neutropenia and provides a centralized system for prescribers and pharmacists in managing patient risk, ...Clozapine is an antipsychotic drug used to help improve the symptoms of schizophrenia in patients who do not respond	N 431		

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adequately to standard antipsychotic treatment ...pharmacies will need to contact the REMS Program by phone or online to verify safe use conditions ...Changes were also made to improve the process for a prescriber to submit absolute neutrophil count (ANC) results. Depending on the patient's monitoring frequency, this could require daily, weekly, biweekly, or monthly documentation of the ANC. In order to reduce the burden on prescribers and minimize unintended treatment interruption for patients, the documentation of ANC will now be submitted monthly ..." (Source: https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/frequently-asked-questions-clozapine-rems-modification (retrieval date 05/23/2024)).

From 05/17/2024-05/31/2024, Surveyor received (via email from Administrator A) and reviewed Resident 5's record.

Resident 5 was admitted 01/05/2024. Diagnoses included: major depressive disorder, recurrent, unspecified; generalized anxiety disorder; and schizoaffective disorder, bipolar type.

Physician orders included: CBC monthly on the last day of the month for CBC neutrophil count related to clozapine use due to schizoaffective disorder, unspecified. (Start date 07/11/2023); CBC with Diff every 2 weeks for medication management (start date 03/13/2024); Clozapine 150 MG every morning (start 07/11/2023, discontinued 03/13/2024) and 200 MG at bedtime (start 07/11/2023) for schizoaffective disorder, unspecified.
Labs- Resident 5's record contained 1 lab result dated 04/01/2024.

Facility Progress Notes:

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04/01/2024 5:52 PM by Agency RN H- "Note Text: Per report from ADON, order for stat labs for CBC [with] DIFF [and] valporic acid level received [related to] clonzapine [and] depakote therapy. Lab faxed [and] called and given [LindenCourt's address] and [Resident 5's] room number. pt [sic] notified ..."

04/24/2024 8:10 PM by Former Assistant Director of Nursing (FADON) L- "Patient appeared to be in a manic state this evening and was sent out 911 for psych services and to medically be evaluated. [Family Member J] was present and [Family Member K] was on the telephone. Patient was thinking people were trying to kill [him/her], [s/he] was yelling at [Family Member J]. It was reported to RN around 1400 [2:00 PM] that patient refused meds this AM was on the floor refused to get dressed, eat [sic] etc. RN will document this as an unwitnessed fall, patient had some swelling around right eye no bruising noted. [Family Member J] called EMS and patient was sent out 911 ..."

04/24/2024 at 8:39 PM by FADON L- "Note Text: case manager notified of incident RN left voicemail for [name of] case manager."

There were no additional progress notes regarding 04/24/2024 manic episode.

April 2024 Medication Administration Record (MAR):
On 04/24/2024, staff documented administration of Resident 5's AM medications.

05/31/2024 at 1:44 PM, Surveyor received Resident 5's Weights and Vitals Summary dated 04/24/2024 at 8:18 PM from Administrator A. Pain was rated an 8. No additional vitals were listed on

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the summary.

Individual Service Plan not signed or dated (earliest initiation date 01/08/2024):
In the area of Behaviors: "Date Initiated 01/08/2024 Will not act out in a way that is harmful to self or others ...Report changes from baseline behaviors to Nurse ...:
In the area of Falls: Poor safety Awareness "Will be encouraged to call for assistance when needed ...Education on use of call light and asking for assistance ...remind to call for assistance ..."

EMS note dated 04/24/2024:
On 05/29/2024 at 8:11 AM, Surveyor received Resident 5's Fire Department/EMS note dated 04/24/2024 from the fire department which stated that on 04/24/2024 at 4:48 PM emergency services arrived at the facility and left facility with Resident 5 at 5:10 PM. The note stated "Head: Swelling ...On arrival EMS was directed to pt [patient] by staff. [Family Member J] was on scene and talked with EMS prior to pt contact. [Family Member J] stated that [s/he] arrived on scene at 1400 [2:00 PM] that afternoon where [s/he] located the pt lying prone on the floor. Pt appeared to have some swelling to [his/her] right eye and was stating that staff had not been giving [him/her] food or [his/her] prescribed medications. Pt was noted to be having hallucinations during a manic schizophrenic episode ...Pt contact was made with the pt noted to be sitting on the floor with O2 [oxygen] via a NC [nasal canula] applied at 3 L/min. Pt stated that [s/he] did not feel safe and made several comments related to the swelling around [his/her] eye, stating, "They tried to take me! Don't let them kill me!" Pt continued to make comments about people who were not in the room and was afraid that people were present

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and trying to harm [him/her]. [Family Member J] stated that the pt would commonly have episodes where [s/he] felt in danger. The pt allowed EMS to assess [his/her] vitals which were charted. Pt also complained of pain in [his/her] abdomen. Pt had a noted history of UTIs [urinary tract infections]. EMS advised the pt that they could take [him/her] to the hospital to have [his/her] eye and abdomen looked at and the pt agreed. When EMS attempted to assist the pt to the cot, the pt became aggressive with EMS and pt movement was stopped. EMS worked to calm the pt down and assure [him/her] that no one was there to hurt [him/her], and that everyone wanted to make sure that [s/he] was healthy. After several more minutes EMS was able to get the pt onto the cot and EMS O2. Pt was secured and moved to the back of the ambulance. Once pt was in the back of the ambulance, EMS went enroute to [name of hospital] without lights or siren ..."

Hospital Note received 05/24/2024 at 1:26 PM via fax from hospital medical records department (summarized): Date 04/24/2024 time admitted 5:18 PM.
" ...Principal Problem: ...Acute metabolic encephalopathy likely combination of possible UTI and patient not receiving clozapine at facility ...Per facility MAR, patient received 3 doses of clozapine in the past 7 days, family says [s/he] received no doses in the past 7 days ...Received clozapine 250 MG in ED ...Psychiatry consult for reinitiation and dose titration of clozapine ...Discharge Summary [dated 05/06/2024] ...Patient developed acute respiratory suppression, this was felt to be secondary to dose of Clozapen [sic] patient received in the ED. Patient was subsequently intubated and transferred to ICU for ventilator support. With time patient was successfully extubated was

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eventually transition [sic] to floor ...Patients [sic] ANC was reported to the REMS program for Clozapine [sic] for values obtained on 5/3/2024 and 5/6/2024 ..."

On 05/23/2024 at 9:46AM, Surveyor emailed Administrator A requesting all documentation dated 03/01/2024-04/25/2024 regarding any falls or injuries of unknown source for [Resident 5].
On 05/24/2024 at 9:57 AM, Surveyor received an email from Administrator A stating : ...I am not seeing any vitals from that day other than pain was assessed at 8 ..."
On 05/23/2024 at 11:52 AM, Surveyor received an email from Administrator A stating " ...Just for clarification she discharged on 4/24 to the hospital ...I do have one incident report that is linked to the progress note from 4/24 that I will pull and send as well but other than that I am not seeing any other falls or incident reports ..."
Attached to the email was an incident note dated 04/24/2024 at 8:10 PM that stated "Note Text: Patient appeared to be in a manic state this evening and was sent out 911 for psych services and to medically be evaluated."
On 05/23/2024 at 12:05 PM, Surveyor emailed Administrator A requesting investigation or additional assessment for the swelling around Resident 5's right eye noted in 04/24/2024 progress note.

On 05/23/2024 at 3:02 PM, Administrator A responded via email "There was not an additional "assessment" because [Resident 5] was sent out right away. I am looking for if there was a separate incident report done or just the incident note."
On 05/24/2024 at 9:57 AM, Surveyor received an email from Administrator A stating ". I am not seeing any vitals from that day other than pain

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was assessed at 8 ..."

On 05/31/2024 at 1:48?PM, Surveyor emailed Administrator A asking why the pain assessment was charted at 8:00 PM when Resident 5 left with the EMS at approximately 5:00 PM.

On 05/31/2024 at 2:18 PM, Administrator A replied via email "I would assume that [s/he] most likely did not chart it at the time of event but after but [s/he] does not work at the building anymore for me to ask [him/her]."
On 05/24/2024 at 9:50 AM, Surveyor interviewed Resident Aide P stated when first admitted to facility Resident 5 was always talkative with staff and had some delusions that did not appear distressing to Resident 5. Resident Aide P stated 1 to 2 weeks prior to 04/24/2024 Resident 5 became agitated, talked to his/herself all the time, and kicked staff out of his/her room.

On 05/21/2024 at 3:23 PM, Surveyor interviewed Pharmacist N who stated monthly lab work was required to fill monthly physician orders for clozapine due to the risk of serious or fatal infections with clozapine use.

On 05/24/2024 at 7:23 AM, Surveyor interviewed Family Member J and Family Member K. Family Member J stated on 04/24/2024 just after 2:00 PM s/he arrived at facility to meet the driver who was to transport Resident 5 to a scheduled appointment. Upon arrival to facility s/he found Resident 5 in his/her room and lying face down on the floor in a puddle of urine. [Note: (Photo 8 received from Family Member K at 05/24/2024 8:31 AM, taken by Family Member J date/time stamped 04/24/2024 at 2:13 PM) depicts Resident 5 wearing nightgown, lying uncovered face down on floor with face directly on carpet, a

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pillow lying on floor under bed just above Resident 5's head, dark spot on carpet protruding from under Resident 5 from groin area to lower thighs, feet crossed at the ankle and right hand resting near his/her neck, oxygen tubing on the floor and under Resident 5's head.] Family Member J stated the oxygen concentrator was unplugged so s/he plugged it in and went to get staff. Family Member J stated Resident 5 appeared extremely fearful, stated s/he thought Family Member J was going to kill her, and would not allow Family Member J to touch him/her. Family Member J stated Resident Aide P assisted Family Member J to sit Resident 5 up. Family Member J stated Resident 5 was shaking and making repetitive vocalizations with some intermittent words. Family Member J stated s/he requested staff take Resident 5's vitals but they were unable to find a pulse oximeter (for oxygen reading) so FADON L went to look for it. Family Member J stated Resident 5's eye appeared swollen, and lips appeared very dry. [Note: (Photo 9 received from Family Member K at 05/24/2024 8:31 AM taken by Family Member J and date/time stamped 04/24/2024 at 3:04 PM) depicts Resident 5's right eye lid swollen, a crusty brown matter on his/her lips, and both nasal canula prongs that deliver oxygen into the nasals situated under the right nasal.] Family Member J stated s/he called Family Member K who then called 911. Family Member J stated FADON L implied staff did not want to call 911 because Resident 5's usual behavior consisted of lying him/herself on the floor. Family Member J and Family Member K stated they were not aware of Resident 5's behavior of lying on the floor.

On 05/24/2024 at 2:00 PM, Surveyor discussed concern lack of health monitoring with Administrator A, Nurse Consultant B and LPN I.

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N 431	Continued From page 32 Administrator A stated s/he did not know why Resident 5's labs were not drawn at end of February 2024 or during March 2024, and there was a change in leadership around that time which may have potentially attributed to it. Administrator A stated the nurse manager was responsible for sending the 04/01/2024 lab results to Psychiatrist R or APNP M, and s/he did not see any evidence that Psychiatrist R or APNP M were notified of the 04/01/2024 lab results. Administrator A stated no vitals were documented for Resident 5 on 04/24/2024 because the nurse immediately thought they would send him/her out (via 911) and they could only go by what FADON L charted. Administrator A stated Resident 5 began putting him/herself on the floor at admission, could get him/herself up independently and would lie on the floor maybe 15-20 minutes at a time. Administrator A stated s/he did not know how often Resident 5 put him/herself on the floor. On 05/30/2024 at 9:04 AM, Surveyor interviewed Resident Aide S who stated on 04/24/2024 when s/he arrived for his/her PM shift, AM caregivers told him/her Resident 5 had refused medications and cares and was lying on the floor in his/her room. Resident Aide S stated s/he went to Resident 5's room and observed Resident 5 lying face down on the floor so s/he assisted Family Member J to help Resident 5 sit up. Resident Aide S stated Family Member J was requesting vitals taken but they were unable to find the blood pressure cuff and pulse oximeter so someone went to the attached skilled nursing facility to get them. Resident Aide S stated vitals were usually documented on the eMAR. Cross Reference: N0352 83.32(3)(h) Rights Of Residents: Receive	N 431		

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N 431	Continued From page 33 Medication N0389 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 431		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident rooms were clean and free from odors. Resident 1's carpet was heavily littered with food crumbs and paper debris. Resident 2's room was not tidy or organized. Resident 3's room smelled heavily of urine. The bed was saturated with urine and there was a large dark spot on the carpet. Resident 4's carpet was soiled. Findings include: The facility is licensed as a Class CNA non-ambulatory CBRF able to serve up to 48 residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, advanced age, and terminally ill. The facility is divided into 2 units, a locked memory care unit referred to as Michigan and a unit referred to as University. Example 1- Michigan	N 489		

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N 489	Continued From page 34 On 05/08/2024 at 9:05 AM, Surveyor observed Resident 3's room. The bed was unmade and saturated with urine (Photo 1). There was a large dark spot approximately 3' x 2' on the carpet (Photo 2). The room smelled heavily of urine. On 05/08/2024 at 9:14 AM, Surveyor observed Resident 2's room. Clothes and linens were piled on the floor next to the recliner, a (clean) incontinence pad was lying on the floor next to the bed, the pillows were missing pillowcases, a large maroon fabric item was lying on the floor and a large, opened box containing incontinence products was on set on the floor near the wall (Photo 3). On 05/08/2024 at 10:47 AM, Surveyor observed Resident 1's room. Resident 1's carpet was heavily littered with debris including food crumbs and paper. The debris was concentrated in front of the desk (Photo 4) and recliner (Photo 5) and between the bed and recliner (Photo 6). On 05/08/2024 at 9:35 AM, Surveyor observed Caregiver D changing and cleaning Resident 3's bed and room. On 05/08/2024 at 9:35 AM, Surveyor interviewed Caregiver D who stated s/he was working on Michigan alone as caregiver and med passer. Caregiver D stated s/he started at 6:00 AM and did rounds at 6:00 AM on 05/08/2024. On 05/08/2024 at 9:51 AM, Surveyor interviewed Housekeeper F who stated s/he did not normally work on Michigan but was requested to do so on 05/08/2024. Housekeeper F stated maintenance staff normally cleaned the carpets. On 05/08/2024 at 10:48 AM, Surveyor	N 489		

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N 489	Continued From page 35 interviewed Resident 1 who stated staff cleaned weekly "If I'm lucky" and "No one's vacuumed forever, it drives me nuts". On 05/08/2024 at 10:58 AM, Surveyor interviewed Resident 3 who stated s/he needed assistance with the urinal, periodically spilled the urinal, and at 6:00 AM on 05/08/2024 missed the urinal while urinating. Example 2- University On 05/08/2024 at 11:17 AM, Surveyor observed Resident 4's. The carpet was soiled with 4 quarter sized red spots (Photo 7). On 05/08/2024 at 11:17 AM, Surveyor interviewed Caregiver G who stated s/he did not know how long the spots had been on Resident 4's carpet. Caregiver G stated there was no consistent housekeeper on University unit. On 05/08/2024 at 4:24 PM, Surveyor discussed concern of unclean rooms and odors with Administrator A, Nurse Consultant B, and Admissions C. Administrator A stated they would take care of it as soon as possible. On 05/10/2024, Surveyor reviewed the Department's facility file. The facility was issued a regular license effective 12/ 01/2023 following a change of ownership. The facility's Program Statement stated, " ...Our program goal is to provide the highest quality of life in a supervised setting, including ...housekeeping ..."	N 489		