STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235011	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iosco County Medical Care Facility	1201 Harris Avenue Tawas City, MI 48763

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement interventions to prevent pressure ulcer development for two residents(R9 and R22) of two residents reviewed, resulting in R9 developing an unstageable DTI and Resident R22 developing a stage II (partial thickness loss of first and second layer of skin) and unstageable DTI, unnecessary pain, and the likelihood for infection and decline in overall health status.Findings include: Resident #9 On 1/6/26 at 10:38 AM, Resident #9 was observed sitting in a wheelchair in the central area of the facility. Resident #9 was unable to provide meaningful responses to questions when asked. A pull tab alarm was observed on the Resident's wheelchair and was connected to the back of their shirt. Licensed Practical Nurse (LPN) I was in the common area of the unit and an interview was completed. When queried, LPN I revealed Resident #9 has a wound on their buttocks. When asked if the wound was a pressure ulcer, LPN I replied, Yes. Resident #9 was observed sitting in their wheelchair in the central area of the unit from 10:38 AM until 11:18 AM on 1/6/26. The Resident was not repositioned by facility staff during this timeframe. Record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses which included dementia, depression, anxiety, and left sided hemiplegia and hemiparesis (one sided paralysis) following cerebral infarction (stroke). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required total assistance to complete Activities of Daily Living (ADLs) with the exception of eating. The MDS further detailed the Resident was at risk for pressure ulcer development and had developed one unstageable DTI at the facility. Review of the facility provided CMS-802 Resident Matrix form detailed Resident #9 had a Stage 2 facility acquired pressure ulcer. Review of Resident #9's Electronic Medical Record (EMR) revealed a care plan entitled, I have actual for impairment to skin integrity r/t (related to) limited mobility. currently have a pressure ulcer to my left buttock. (Initiated: 4/3/24; Revised: 1/7/26). The care plan included the interventions: - I have a gel/foam cushion in my wheelchair to help offload pressure (Initiated: 11/12/24; Revised: 12/3/25) - I utilize an air mattress for increased pressure reduction (Initiated: 6/3/25) - Staff to lay me down after meals as I allow to help with position changes and offloading pressure. If I do not want to lay down please offer me to sit in a recliner (Initiated: 11/21/24: Revised: 10/2/25) (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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of documentation in Resident #9's EMR revealed the Resident had a history of pressure ulcers which had healed and was at risk for pressure ulcer development. Wound documentation revealed the following: - 9/17/25 at 7:43 PM: Health Status Note. CNA called writer to room regarding discolored area on left buttocks, CNA states redness was present yesterday but was worse today, writer observed bluish purple blanchable area to left buttocks, skin is still intact, writer notified wound care nurse this AM, CNA instructed to lay res down after meals and position from left to right, as tolerated by resident. - 9/17/25: Written Weekly Pressure Ulcer Report. Location: L (Left) gluteus. Stage. DTI. Wound measurements in centimeters (cm): 3.9 X 4.4. Care planned interventions: Air Bed, Roho, Lay down after meals. Nutritional Interventions: Milkshake TID (three times a day), Juven BID (twice a day), Boost (TID). - 10/15/25: Written Weekly Pressure Ulcer Report. Location: L (Left) gluteus. Stage. SDTI (Suspected Deep Tissue Injury) . Wound measurements in centimeters (cm): 1.7 X 1.5 . Wound healing. Improving. Care planned interventions: Air Bed, Roho, Reposition q (every) 2 hours, Lay down after meals. Nutritional Interventions: Milkshake TID (three times a day), Juven BID (twice a day), Boost (TID). - 10/22/25: Written Weekly Pressure Ulcer Report. Location: L (Left) gluteus. Stage. SDTI. Wound measurements in centimeters (cm): 2.9 X 4.7 . Wound healing. Deteriorating. Increased slough and eschar. Care planned interventions: Air Bed, Roho, Reposition q (every) 2 hours, Lay down after meals. Nutritional Interventions: Milkshake TID (three times a day), Juven BID (twice a day), Boost (TID). - 12/3/25: Written Weekly Pressure Ulcer Report. Location: L (Left) gluteus. Stage II. Wound measurements in centimeters (cm): 3.9 X 3.6 X 0.2 . Wound healing. Deteriorating. Care planned interventions: Air Bed, Roho, Reposition q (every) 2 hours, Lay down after meals. Nutritional Interventions: Milkshake TID (three times a day), Juven BID (twice a day), Boost (TID). - 12/23/25 at 7:20 AM: Skin & Wound Evaluation. Pressure. Stage II. Left Gluteus. In-House Acquired. Length: 3.2 cm. Width: 3.1 cm. Wound Bed. Slough. 100% . Evidence of Infection. Redness/inflammation. Stalled. Wound continues to show deterioration. Wound bed presents with 100% slough tissue. Peri wound presents as blanchable erythema with induration. Wound order updated today. continues with Milkshake TID, Juven BID and Boost TID for supplements. continues on air bed, gel cushion, and reposition Q 2 hr. - 1/7/26 at 7:05 AM: Skin & Wound Evaluation. Pressure. Unstageable. Left Gluteus. In-House Acquired. Length: 3.4 cm. Width: 4.2 cm. Wound Bed. Slough. 100% . Deteriorating . Review of Resident #9's Health Care Provider (HCP) orders revealed no new nutritional supplements were implemented following the pressure ulcer development. The supplement orders detailed: - Boost three times a day for Supplement. (Ordered and Start: 11/18/24) - Juven Oral Powder (Protein Nutritional Supplement) . every day and evening shift. (Ordered and Start Date: 11/29/24) On 1/7/26 at 3:06 PM, Resident #9 was not present in their room. Certified Nursing Assistant (CNA) II (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	was standing in the central area of the unit and asked where Resident #9 was. CNA II pointed out Resident #9 in the common area of the unit and stated, (Resident #9) is in a bad mood and indicated the Resident was having a rough day. Resident #9 was sitting in a recliner. The recliner chair was in the upright position with the Resident's feet on the floor. The recliner did not have a pressure reduction cushion in place on the seat. When asked what was going on, CNA II revealed Resident #9 has a girlfriend who would come visit them but due to inappropriate sexual behavior/acts, the girlfriend was no longer able to visit per Resident #9's representative. CNA II stated, I think that is part of the reason (Resident #9) is so upset. Upon approaching Resident #9 in the recliner, the Resident began yelling out. When asked questions, Resident #9's responses were unintelligible. A follow up interview was completed with CNA II on 1/7/26 at 3:25 PM. When queried regarding the Resident's pressure ulcer, CNA II revealed they were aware the Resident had a wound dressing in place but had not seen the ulcer. CNA II was asked if Resident #9 was dependent upon staff for repositioning and responded that they were. When queried regarding interventions for pressure prevention, CNA II stated, We put (Resident #9) in the recliner for a couple hours after lunch. When queried if the Resident is supposed to be reclined or sitting upright for pressure reduction, CNA II responded that the Resident is just supposed to sit in the recliner and a seating position was not specified in the care plan. CNA II was then queried how often Resident #9 is repositioned when they are sitting up in their wheelchair and replied, Every couple hours. When queried regarding the frequency Resident #9 is repositioned when they are sitting in the recliner, CNA II replied they do not really reposition Resident #9 when they are in the recliner. When asked how often the Resident was repositioned when in bed, CNA II responded that staff repositioned them every couple of hours. On 1/8/25 at 9:03 AM, Resident #9 was observed in their room in bed with their eyes closed. An interview was completed with LPN JJ on 1/8/26 at 9:08 AM. When queried if they had observed Resident #9's pressure ulcer, LPN JJ replied, No. A request was made to observe wound care at this time and LPN JJ replied, It is not dressing change day. A review of Resident #9's Treatment Administration Record (TAR) revealed the dressing had been changed by the night shift nurse at 2:25 AM. A task on the TAR, Please ensure dressing to L (left) gluteus is clean, dry, and intact. Replace if necessary. Every day and evening shift was documented as completed by LPN JJ on day shift 1/8/26. When queried if they had observed Resident #9's wound dressing that morning, LPN JJ replied, No. When asked why they documented they had observed the Resident's dressing if they had not, LPN JJ responded, I did? I don't know. LPN JJ was then asked to review Resident #9's TAR. LPN JJ confirmed they documented the task as completed but did not observe the dressing. LPN JJ then verbalized they documented the dressing was in place because the Resident's CNA had told them it was there. When asked if documentation of the task indicates they completed the task, LPN JJ did not provide a response. An interview was conducted with Registered Nurse (RN) A and RN F on 1/8/26 at 10:20 AM. When queried what stage Resident #9's pressure ulcer was, both RN A and RN F responded that it was unstageable due to the wound bed being obscured by slough. When asked why the provided CMS-802 form specified the pressure ulcer was a Stage II, RN F responded they thought that it had been corrected. RN F was then asked if a pressure ulcer is able to go from unstageable to a stage II in wound documentation, RN F responded that pressure ulcers can not be downgraded from unstageable to stage II. RN F was then queried why documentation in Resident #9's EMR detailed the pressure ulcer had went from unstageable to a stage II and then back to unstageable, an explanation was not provided. When queried regarding interventions in place related to Resident #9's pressure ulcer, RN F replied, Nutritional (supplements), turn program, different equipment. When asked what different (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	equipment meant, RN F revealed the Resident was to be in their bed, their wheelchair, and a recliner during the day. When queried Resident #9 was supposed to be positioned in a specific position/level of recline in the recliner to minimize pressure and shear, RN F responded, Not ordered. When asked if the position which Resident #9 sits in the recliner and the level of recline may contribute to pressure, RN A responded that it could add pressure and shearing forces. When queried how often Resident #9 is supposed to be repositioned in their wheelchair, RN F replied, Every hour. When asked how often the Resident should be repositioned when sitting in the recliner, RN F responded, Every hour. When queried if the recliner seat cushion was a pressure reduction cushion, both RN A and RN F responded it was not. RN A and RN F were asked why the Resident's care plan specified repositioning every two hours when sitting if they should be repositioned more frequently and responded they had educated staff regarding more frequent repositioning. When queried if repositioning every hour when sitting was best practice for pressure prevention/reduction, RN F indicated frequent repositioning is best. When asked what new interventions were implemented after Resident #9 developed the unstageable pressure ulcer on their left gluteus, RN F indicated wound care treatments were initiated. RN A and RN F were then informed of Resident observations and staff interviews. RN A and RN F both indicated staff had been educated regarding the importance of more frequent repositioning when out of bed. When asked if lack of repositioning may contribute to the pressure ulcer development and deterioration, both RN A and RN F confirmed it could. When queried regarding the status of Resident #9's pressure ulcer during the last assessment completed, RN F stated the wound was a little deteriorated again from last time and that the pressure ulcer had not improved since it had first been identified. Upon request for the facility policy/procedure pertaining to Pressure Ulcers and Skin Management Program, the facility provided a policy/procedure entitled, Wound Treatment Management (Reviewed/Revised: 1/7/26). This policy did not include information pertaining to interventions for pressure prevention and/or reduction. Resident #22: In an interview on 01/06/2026 at 10:34 AM with the Resident #22's family member revealed that Resident 22 got a pressure ulcer here at the facility, they have a bandage on the bottom, and they are changing it every other day. She came from Saginaw hospital after surgery on her left leg fracture and then she got cellulitis. Observation on 01/06/2026 at 10:38 AM the state surveyor observed a heel up device/pad to end of bed, the family member removed the socks and the state surveyor observed the left heel had a large brown/purple deep tissue injury noted. The family member stated that the Registered Nurse W, who stopped working at the facility back in December, before Christmas she stopped working, found the dark spot on the heel and put the foot/leg cushion (Hells-up device) on the bed and said to keep her heels off the bed. Record review on 1/6/2026 of resident #22's medical record/admission assessment and there was no mention of left heel deep tissue injury. No mention of pressure ulcer or deep tissue skin injury in care plans. In an interview and record review in 01/07/2026 at 10:58 AM with Registered Nurse (RN)/wound care (F) management explanation of Resident #22's Pressure ulcer identified on the CMS 802 matrix form. RN F stated that Resident #22 developed a facility acquired stage II pressure ulcer to the right gluteus. RN F stated that she had performed the treatment this morning and that the wound healed (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	the ulcer was resolved. RN F stated that a new order to leave right gluteus covered for 7 days more just to protect the skin area. When we identified the pressure ulcer, we implemented an air bed and Juven (Supplement) twice daily and added gel cushion to Wheelchair. The state surveyor inquired why the pressure ulcer developed? RN F stated Resident #22 was having pain in her leg and did not want to move, post-surgical. Resident #22 was working with therapy to an extent, but would request to get back in bed often, not wanting to move, that's how the pressure ulcer developed. The state surveyor inquired how did the pressure ulcer become stage II before any staff noticed? RN F stated that she did not know how the pressure ulcer went undetected from a red area to an opened wound with drainage. It was stage II when she was first notified. RN F stated that Resident #22 is sometimes incontinent with bowel & bladder. The state surveyor identified that Resident #22 was a 2 assistant from staff for Activities for Daily Living (ADLs), staff should have been aware when redness or changes occur. RN F stated that she was not sure what happened that it went unnoticed till a stage II with open area, with serosanguinous drainage noted. The state surveyor requested to observe the wound today. Observation and interview on 01/07/2026 at 2:01 PM with Registered Nurses A Infection Control and F Wound care entered the room with wound care supplies of wound wash and dry gauze. The Resident #22 was rolled to the right side and observation of the right gluteus revealed an open area pinpoint with slight serosanguinous drainage noted, wound care of wound wash and pat dry, a 2x2 Allevyn foam border dressing applied. The RN's A and F were requested by the state surveyor to remove Resident #22's socks to observe bilateral heels. Observation of Resident #22's left heel was noted with a large dark area, non-blanchable. RN A and F both were surprised and stated that they just found the deep tissue injury with the state surveyor today. The family member was in the room during observation and stated that the left heel sore had been there over 3 weeks, when Registered Nurse W the nurse does not work here anymore she found it and placed the heels-up device/pad to her bed. In an interview and record review on 01/07/2026 at 2:15 PM with Registered Nurse A Registered Nurse/Infection Control Preventionist/In-service director stated Resident #22 has a new left heel has a Deep Tissue Injury (unstageable pressure injury with unknown depth) that is purple/brown in color, that means it been there a while. The DTI is new today. RN A stated that there was nothing on the heels on admission assessment, RN A stated that he had been in the resident's room at least 1 or 2 times to assess her or transfer her. That deep tissue injury to the heel is newfound today during the dressing change. In an interview and Record review on 01/07/2026 at 3:02 PM with Human Resource director X of Registered Nurse W's resignation letter noted her last date of duty was 12/19/2025. In an interview and record review on 01/07/2026 at 3:48 PM with Registered Nurse F RN/Wound Care during an interview related to Resident #22's left heel Deep Tissue Injury. RN F stated that the left heel deep tissue injury she did not know about it. The left heel injury was new to her. RN F stated that she was Resident #22's room doing dressing changes at least once a week and was not aware of the left heel injury. RN F stated that there is a big communication issue between the Certified Nursing Assistance (CNA) and nurses. Each Resident gets two showers or baths weekly, and skin assessments are done once a week by the floor nurses, it is unfortunate to have the state surveyor find a new injury. Deep Tissues Injuries take a very long time to heal, a minimum of a couple of months, if they open it becomes an unstageable or stage II or greater depending on the depth of the wound. It has been there a while; it's dark brown in color. RN F stated that she notified physician/Nurse Practioner on call and the treatment is to keep heels up, while resident is up in Wheelchair to use an Allevyn heel cup to the left heel. RN F stated that she did a photo of the left heel (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	injury it is measured by photo app, length 0.9 x width 2.3, no depth until it opens. Record review of the facility 'Wound Treatment Management' policy, the only policy received for pressure ulcers care, revealed to promote wound healing of various types of wounds, it is the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. (8.) The effectiveness of treatments will be monitored through ongoing assessment of the wound In an interview and record review on 01/08/2026 at 7:55 AM with Registered Nurse F RN/Wound care state that there is no mention of the left heel Deep Tissue Injury of any interventions. RN F reviewed the medical record and did not find any deep tissue injury care plan. RN F stated that the care plans are performed by an off-site service provider contracted service and that they recommended that we only identify that a pressure area developed. Not identify the location, stage or treatment. We used to identify all the locations because more than one can develop. In an interview and record review on 01/08/2026 at 8:03 AM with the Director of Nursing related to care plan development. The DON stated that when a resident admits or comes in, we initiate care plans based on diagnosis and needs. record review of Resident #22's care plans pages 1 through 11 revealed no Deep Tissue Injury to left heel. The DON stated that there was no what, where, or when or how to treat. The DON stated that we put in/created a pressure ulcer care plan on the 1/6/2026 and then (stage II) then resolved it on 1/7/2025. I looked in the care plans and there was no pressure ulcer care plan, so I created one on 1/6/2025 and then they said that it resolved so I went back into the care plans on 1/7/2025, that's what I did. We do have an MDS contracted service that does our care plans, and we follow their recommendations.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to have policies and procedures for data collection, analysis and feedback procedures for 21 residents sampled of 49 residents, resulting in only one sheet of paper policy for the quality assurance program when the surveyor requested the program to review and the contracted pharmacy services failed to attend the quality assurance quarterly meetings for the last six months. Findings include: Quality assurance Task: Record review of the facility 'Quality Assurance Program' policy dated 12/13/2016 signed by a previous nursing home administrator, revealed that it is the policy of the facility to actively participate in a formalized and written Quality Assurance (QA)/ Quality Assurance Process Improvement (QAPI) program. The program is to be comprehensive (involving all departments) and coordinated, will include monitoring, evaluation, and appropriate follow-up action as needed. (5.) Implementation of an ongoing monitoring system that will provide data about actual care/services provided. (6.) Analysis of data to determine the quality of care/services provided. In an interview and records review on 01/08/2026 at 11:33 AM with the Nursing Home Administrator (NHA)/Quality Assurance coordinator revealed that the facility only has one policy for the QA program from the previous administration signed on 12/13/2016. The NHA stated that there were no other policies for the QA program. The NHA revealed that she had been at the facility for the last year and had not updated the policy. The NHA stated that there were no other policies for data collection/analysis or feedback on QA issues/concerns that could be found. The state surveyor inquired if there were any Process improvement plans (PIPs) in progress? The NHA stated that the facility has one PIP on call lights currently. NHA revealed that last year the facility did one on pressure ulcers, and it improved and we moved it to the back burner and stopped the PIP on that, but I heard that we had an issue yesterday with pressure ulcers. Our identified concerns prior to survey included: Pressure Ulcers, call lights, antibiotic stewardship, infection control, and falls. The state surveyor asked what about survey team concerns of:Certified Nursing Assistances working without pagers- or pagers are not alarming/sounding? The NHA stated that as of yesterday 1/7/25, we will be adding the pagers to the Medication Administration Record (MAR) or assignment sheets and holding the nurses accountable, because staff keep losing them, leaving them at home, not changing the batteries. The state surveyor explained to the NHA that residents are stating that the CNAs come in and shut the call lights off because they are being timed and do not provide the service and state they will come back and do not come back. The NHA stated that she is not aware of situation. Antibiotic stewardship Program- NHA was aware that the program was cited last year at annual survey and will be again at this year's survey. There was no documented antibiotic education given to the physician or nurse practitioners. The QAPI team meets monthly- Committee members list reviewed. Quality Assurance monthly meeting sign-in sheets reviewed from May 2025 through December 2025, revealed that in June 2025 the Pharmacist consultant attended on 6/26/2025 and there was not another pharmacist consultant that attended any QAPI meeting for over 6 months. The state surveyor inquired that the antibiotic stewardship program being discussed at QAPI meetings with pharmacist? Physicians are ordering the antibiotics and not doing any risk vs benefits for prophylactic antibiotics. There are no policies.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, interview and record review, the facility failed to sustain a system to ensure corrective measures for 49 of 49 residents residing in the facility, related to prevention and treatment of pressure ulcers/injuries had been monitored, evaluated, and were effective as evidence by repeated deficiencies on pressure ulcers and antibiotic stewardship during the past two annual surveys. Findings include: In an interview and records review on 01/08/2026 at 11:33 AM with the Nursing Home Administrator (NHA)/Quality Assurance coordinator revealed that the facility only has one policy for the QA program from the previous administration signed on 12/13/2016. The NHA stated that there were no other policies for the QA program. The NHA revealed that she had been at the facility for the last year and had not updated the policy. The NHA stated that there were no other policies for data collection/analysis or feedback on QA issues/concerns that could be found. The state surveyor inquired if there were any Process improvement plans (PIPs) in progress? The NHA stated that the facility has one PIP on call lights currently. NHA revealed that last year the facility did one on pressure ulcers, and it improved and we moved it to the back burner and stopped the PIP on that, but I heard that we had an issue yesterday with pressure ulcers. The state surveyor asked what about survey team concerns of:Pressure ulcer/injuries- Observation and interview on 01/07/2026 at 2:01 PM with Registered Nurses A Infection Control and F Wound care entered the room with wound care supplies of wound wash and dry gauze. The Resident #22 was rolled to the right side and observation of the right gluteus revealed an open area pinpoint with slight serosanguinous drainage noted, wound care of wound wash and pat dry, a 2x2 Allevyn foam border dressing applied. The RN's A and F were requested by the state surveyor to remove Resident #22's socks to observe bilateral heels. Observation of Resident #22's left heel was noted with a large dark area, non-blanchable. RN A and F both were surprised and stated that they just found the deep tissue injury with the state surveyor today. The family member was in the room during observation and stated that the left heel sore had been there over 3 weeks, when Registered Nurse W the nurse does not work here anymore she found it and placed the heels-up device/pad to her bed. Certified Nursing Assistances working without pagers- or pagers are not alarming/sounding? The NHA stated that as of yesterday 1/7/25, we will be adding the pagers to the Medication Administration Record (MAR) or assignment sheets and holding the nurses accountable, because staff keep losing them, leaving them at home, not changing the batteries. The state surveyor explained to the NHA that residents are stating that the CNAs come in and shut the call lights off because they are being timed and do not provide the service and state they will come back and do not come back. The NHA stated that she is not aware of situation. In an interview on 01/08/2026 at 10:37 AM with facility Controller W was auditing the call lights. The state surveyor inquired about the silence of the pagers not heard while on the nursing floor. Controller W stated that the aides are not bringing the pagers back to work, yesterday 1/7/26 I was told by Certified Nurse Assistants (CNA's) H and M that there were no working pagers. Controller W stated that she went to the main nursing station and there were 4 pagers on the desk in plain sight. The batteries were dead, so I took the pagers back to my office, changed the batteries, and checked the programing to make sure they were set for CNAs. I walked the pagers back to CNA H and M who were working on the floor with no pagers. The lights above the residents' doors do not light up, that is our old call system and do not work. I am watching CNAs call light times in audits, but I am not aware that they are shutting off the call lights and not coming back. That is not acceptable. Antibiotic stewardship Program- NHA was aware that the program was cited last year at annual survey and will be again at this year's survey. There was no documented antibiotic education given to the physician or nurse practitioners. The QAPI team meets monthly- Committee members list reviewed. Quality Assurance monthly meeting sign-in sheets reviewed from May 2025 through December 2025, revealed that in June 2025 the Pharmacist consultant attended on 6/26/2025 and there was not another (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	pharmacist consultant that attended any QAPI meeting for over 6 months. The state surveyor inquired that the antibiotic stewardship program being discussed at QAPI meetings with pharmacist? Physicians are ordering the antibiotics and not doing any risk vs benefits for prophylactic antibiotics. There are no policies. Record reviews of the facility 'Antibiotic Stewardship Policy' dated 10/26/2024 revealed that improving the use of antibiotics in healthcare to protect residents and reduce the threat of antibiotic resistance. An increase in drug-resistant organisms across the country coupled with a decrease in new antimicrobials on the market. The CDC recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. The Director of Nursing provides support and oversight and ensures adequate resources for carrying out the program. The Nursing Home Administrator provides adequate resources for carrying out the program and ensures review of the antibiotic use and resistance data at Quality Assurance Performance Improvement meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Deficient Practice Statement (DPS) One:Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive infection control program, encompassing outcome surveillance, accurate data collection/documentation/analysis and failed to ensure infection control measures during meal service for all residents residing in the Woodland 400 dementia and the Little House units, resulting in lack of accurate and comprehensive infection control tracking, surveillance and data monitoring/analysis, hand hygiene and Personal Protective Equipment (PPE) use during meal service, and the likelihood for cross contamination, spread of microorganisms and illness to all 49 facility residents. Findings include: DPS Two: Based on interview and record review, the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among all residents in the facility. 2.) Hand hygiene for 7 of 7 residents residing in the Woodland 400 dementia unit with meal service, resulting in the likelihood for the spread of organisms with cross contamination. Findings include: Hand Hygiene with meal service: Observation on 01/07/2026 at 7:51 AM of the woodland dementia 400 dementia unit with breakfast has a meals of scrambled/eggs, meat/ground sausage, Danish, oatmeal with brown sugar, wheat toast, milk/coffee Observed no hand washing by Certified Nurse assistant (CNA) AA between meal tray service set up from green hot box, to resident, and back to hot box and then to the next resident. Passed brown sugar from resident to resident's bowls of oatmeal, touching the bowls and stirring in the brown sugar and then moved on to the next resident. No hand hygiene observed. Record review of the facility 'Handwashing/Hand Hygiene' policy dated 10/3/2023 revealed all employees and volunteers at the facility will practice proper hand washing techniques. In conjunction with standards (universal) Precautions, to provide the best means of preventing and controlling infection. hand Hygiene is practiced at the following times: before touching a resident, after touching a resident, after touching a resident surrounding environment, before assisting a resident with feeding. Dietary is not included in using alcohol-based hand disinfectants, they are to wash their hands using soap and water. Resident #1: Review of the Face Sheet, physician orders dated 12/25, and care plans dated 9/22 to 1/26, revealed Resident #1 was [AGE] years old, admitted to the facility on [DATE] and re-admitted on [DATE], was his own person, and required extensive assistance from staff for all Activities of Daily Living/ADL's. The residents diagnosis included, myocardial infarction, anemia, pneumonia, back pain, malignant neoplasm of kidney, chronic lung and heart failure, acute kidney failure with a urinary catheter in place, shortness of breath, history of falling, and stroke. Review of the residents Urinary Catheter care plan dated 12/10/25, stated Ensure indwelling urinary catheter drainage bag is not touching floor. Observation made on 1/6/26 at 10:54 a.m., revealed the resident sleeping in bed with his catheter bag sitting on the floor next to his bed; no barrier was under the bag. During an interview done on 1/6/26 at approximately 10:00 a.m., Infection Control nurse, RN A stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	it (the urinary catheter bag) should not be on the floor, they needed a barrier under it). On 01/06/2026 at 9:16am-9:54am during the initial kitchen tour with Certified Dietary Manager R, observed a spigot near the two-compartment sink that appeared to be unused. When interviewed on whether the spigot is used, CDM R answered no. On 01/06/2026 at 10:38am-11:15am during the housekeeping tour with Housekeeping Supervisor S, observed an out of order hopper located in the main soiled utility room. When interviewed on how long the hopper hasn't been working, Housekeeping Supervisor S stated it has been out of order for over a year. On 01/06/2026 at 10:38am-11:15am observed an out of order hair sink in the barber shop. When interviewed on how long the sink hasn't been working, Housekeeping Supervisor S stated it's been out of order for at least a year. On 01/06/2026 at 10:38am-11:15am observed an out of order hopper located in the soiled utility room in the 400 unit. When interviewed on how long the hopper hasn't been working, Housekeeping Supervisor S stated it's been out of order for a year. On 01/06/2026 at 10:38am-11:15am observed an out of order drinking fountain located in the dining room. When interviewed on how long the drinking fountain hasn't been working, Housekeeping Supervisor S stated it hasn't been working for as long as she's been working there. On 01/06/2026 at 12:26pm during lunch observation with CDM R, observed what appeared to be three unused spigots hanging from pipes in the ceiling, located in the kitchen. When interviewed on whether the spigots are being used for anything, CDM R stated she doesn't know what they were used for. On 01/06/2026 at 1:00pm-1:45pm during the environmental tour with Maintenance T and Maintenance Director U, when interviewed on whether chlorine residual is being monitored, they both answered that chlorine residual is not being tested. On 01/06/2026 at 1:00pm-1:45pm when interviewed on whether the three unused spigots hanging from the ceiling in the kitchen are used or flushed, Maintenance T stated that the spigots have never been turned on. On 01/06/2026 at 1:00pm-1:45pm when interviewed on whether the unused spigot near the two-compartment sink in the kitchen is ever flushed, Maintenance T stated the spigot hasn't been flushed. According to the facility's Water Management Plan on stagnation, dead legs, and abandoned piping, Remove or routinely flush accessible piping that is no longer used. and Conduct survey for abandoned piping yearly and ensure all applicable piping is scheduled for removal or monthly flushing. According to the facility's Water Management Plan on disinfection and chlorine testing, Monitor disinfectant level in the water supply and distal faucets. and Record at least five readings monthly. Take one of the incoming water supply. Take another four from faucets -- hot and cold water at two faucets, one of which is located near the end point of the system. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Eliminate dead legs, which are sections of no- or low-water flow. and Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Ensure disinfectant residual is detectable throughout the potable water system.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a functional Antibiotic Stewardship program including monitoring to prevent unnecessary and inappropriate antibiotic use for three residents (#'3, #10, and #35) of three residents reviewed for antibiotic use and failed to ensure that antibiotics met criteria for use resulting in the potential for the development of antibiotic-resistant organisms and infections.Findings include:A review of facility Infection Control (IC) Data for December 2025 was completed. The documentation provided did not include documentation revealed two separate line listings titled, CAI (Community Acquired Infection) and HAI (Healthcare Acquired Infection). The CAI line list included five infections including one carry over infection from November 2025 and one prophylactic antibiotic related to a surgical incision infection. The HAI line list included 14 antibiotics including two carry-over infections and four prophylactic antibiotics. Neither line list specified if the infections/antibiotics listed met criteria for use. A review of the provided Infection Control Summary for December 2025 did not include any infection related to antibiotic stewardship including appropriateness of antibiotic use and/or follow-up for any inappropriate antibiotic treatment. An interview was conducted with Infection Control (IC) Registered Nurse (RN) A on 1/8/26 at 11:08 AM. When queried what criteria the facility utilized in their antibiotic stewardship program, RN A replied, McGeer. When queried if the antibiotic meet McGeer Criteria was included on the line list form, RN A replied it was not. RN A was asked how many residents received antibiotics during December 2025 which did not meet criteria and revealed they would need to review each resident's chart to answer. RN A then revealed they had included a comment on two residents listed on the line list that the Provider chose to treat empirically (treat before a specific causative organism is identified). Review of one of the residents with the comment revealed they were treated for Urethral drainage around indwelling catheter with Cipro (antibiotic) for seven days. Signs/Symptoms included on the line list specified, Observed upon assessment. When asked if wound cultures of the drainage were obtained, RN A revealed they were not. When asked if the infection meet criteria for treatment, RN A replied, Did not. With further inquiry, RN A revealed there were several other residents who received antibiotic treatment but did not meet McGeer criteria. When queried regarding follow-up with the Health Care Provider (HCP) when antibiotics do not meet criteria, RN A indicated the HCP is not consistently receptive to feedback. When queried if there was a specific HCP who frequently prescribed antibiotics which do not meet criteria, RN A indicated there was. When asked why antibiotic stewardship information was not included in the Monthly Summary information and how they track antibiotic stewardship data, RN A revealed they had not but would incorporate the information going forward. Review of policy/procedure, Antibiotic Stewardship Policy (Reviewed: 10/9/25) revealed, Policy: Improving the use of antibiotics in healthcare to protect residents and reduce the threat of antibiotic resistance. Record review of the facility 'Antibiotic Stewardship Policy' dated 10/26/2024 revealed the that improving the use of antibiotics in healthcare to protect residents and reduce the threat of antibiotic resistance. An increase in drug-resistant organisms across the country coupled with a decrease in new antimicrobials on the market. The CDC recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. The Director of Nursing provides support and oversight and ensures adequate resources for carrying out the program. The Nursing Home Administrator provides adequate resources for carrying out the program and ensures review of the antibiotic use and resistance data at Quality Assurance Performance Improvement meetings. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Antibiotic use protocols: Laboratory testing shall be in accordance with current standards of practice and CDC guidelines. Resident #3: Record review of Resident #3's Minimum Data Set (MDS) 12/29/2025 revealed an elderly female with Brief Interview of Mental status (BIMs) score of 12 out of 15 cognitive impairments. Medical diagnosis included: anemia, coronary artery disease, heart failure, hypertension, renal insufficiency diabetes, chronic obstructive pulmonary disease, anxiety, and depression. Section H: bladder & bowel noted frequent incontinence. Record review on 01/07/2026 at 12:54 PM of Resident #3's Medication Administration Record (MAR) for October 2025 revealed on 10/29/25 was started on Trimethoprim 100 MG Tablet by mouth one time a day for UTI (Urinary Tract Infection) prevention. Record review of the residents' medical record had no risk vs benefit documentation of the use of prophylactic antibiotic. Record review of the 'Infection Surveillance Monthly Reports' from July 2025 through October 2025 for Resident #3 revealed: May 2025- on 5/6/25 Antibiotic Cefdinir (Omnicef) oral capsule 300mg for 6 days for urinary tract infection. August 2025- on 8/16/25 Antibiotic cephalexin (Keflex) oral tablet 500mg for 9 days for insect bite to left forearm. September 2025- on 8/8/25 through 8/11/25 antibiotic Macrobid oral capsule 100mg by mouth two times daily for urinary tract infection for 10 days then switched 8/11/25 to antibiotic ceftriaxone (Rocephin) 1 gram injection intramuscularly for 7 days for urinary tract infection. On 9/23/2025 Clotrimazole 3 vaginal cream 2% for itching and burning sensation in genitals vaginal symptoms (vaginal yeast infection). October 2025- on 10/2/25 antibiotic Trimethoprim (Bactrim) oral tablet 100mg one-time daily urology recommended prophylactic for chronic urinary tract infection. On 10/6/25 antibiotic Trimethoprim (Bactrim) oral tablet 100mg one-time daily and antibiotic ciprofloxacin (Cipro) 250mg tablet by mouth two times a day for urinary tract infection for 7 days. On 10/28/25 antibiotic Trimethoprim (Bactrim) oral tablet 100mg one-time daily and Antibiotic cephalexin (Keflex) oral tablet 500mg give 1 tablet by mouth 3 times a day for urinary tract infection for 7 days. In an interview and record review on 01/08/2026 at 8:38 AM with Registered Nurse/Infection Control Preventionist/In-service education A was asked about the doubling up on antibiotic use and risk vs benefits documentation. Record review of the 'Infection Surveillance Monthly Reports' from July 2025 through October 2025 for antibiotic usage. Record review of Resident #3's repeated antibiotic usage. Registered Nurse (RN) A was quired about the use of on 9/23/2025 clotrimazole 2% vaginal cream started and why not Diflucan oral? RN A stated it was the physician's choice. Record review of the Trimethoprim Bacterium empirical treatment is an indefinite treatment, with no risk vs benefits found (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in the medical record. RN A stated that the facility has no policy about the prophylactic use of antibiotics or risk vs benefits, there should be a risk vs benefits as a standard of care. RN A was asked about the development of multi-drug-resistant organisms (MDRO's) created how. RN A stated by treating with multiple antibiotics, resident #3 has had different antibiotics. We do refer to specialist urologists. The residents come back with a script from urology with no culture, and some do come with a culture. Record review of the October 2025 line listing for Resident #3 noted on 10/28/2025 cephalexin oral 500mg tablet by mouth three times daily for 7 days for UTI and at the same time Trimethoprim oral 100mg tablet by mouth one time a day for UTI. RN A stated that it was double antibiotic therapy. Resident #35: Record review of Resident #35's Minimum Data Set (MDS) dated [DATE] revealed an elderly female with Brief Interview of Mental status (BIMs) score of 7 out of 15 cognitive impairments. Medical diagnosis included: anemia, atrial fibrillation, hypertension, gastro-esophageal reflux disease, renal insufficiency, thyroid disorder, hip fracture, chronic obstructive pulmonary disease, non-Alzheimer's dementia and anxiety. Section H: bladder & bowel noted frequent incontinence. Record review of Resident #35's December 2025 Medication Administration Record (MAR) noted that on 12/12/25 antibiotic trimethoprim oral tablet 100mg give 0.5 tablet by mouth in the evening for prophylactic. Did not identify a reason or infection. Record review of the residents' medical record had no risk vs benefit documentation of the use of prophylactic antibiotic. In an interview on 01/08/2026 at 10:54 AM with Registered Nurse/Infection Control Preventionist/In-service education A revealed that there was no risk vs benefit for antibiotic use prophylactic because the facility did not have a policy for that. Resident #35 had Urinary Tract Infections noted on History & Physical when she admitted on [DATE]. Record review of the Dec/Jan MAR TAR noted trimethoprim 100mg antibiotic started 12/12/2025 for infection with no stop date or site of infection. Resident #10: Review of the Face Sheet, minimum Data Set (resident assessment tool dated 2/23, physician orders dated 1/23 through 1/26, and care plans dated 1/17/23, revealed Resident #10 was [AGE] years old, interviewable with confusion, and required total assistance with all ADL's. The residents diagnosis included, heart disease, psychotic disorder, anxiety, anemia, stroke, Crohn's Disease, back pain, right shoulder pain and stage 3 kidney disease. Review of all of Resident #10's facility care plans (dated 10/17/23), revealed no care plan had been developed for antibiotic usage. Review of the residents physician orders dated 3/21/25, revealed two orders for two separate antibiotics (Gentamicin Sulfate Injection Solution 40 MG/ML, inject 4 ml intramuscularly one time a day for UTI for 7 days, and Nitrofurantoin Microcrystal Oral Capsule 100 MG, Give 1 capsule by mouth two times a day for UTI for 3 days), both ordered on 3/21/25, and both discontinued on 3/24/25 (after UA of no growth was sent to the facility). Review of the residents facility laboratory report dated 3/24/25, revealed a urine culture collected on 3/22/25 (a day after antibiotics were ordered), with a result of No growth. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the residents lab dated 3/24/25, had hand written note from Nurse Practitioner/NP stating (NP) ordered to discontinue all antibiotics and to review tomorrow during rounds prophylactic antibiotic r/t (related to) UTI's (urinary tract infections). During an interview done on 1/6/26 at 10:52 a.m., Resident #10 stated I was on an antibiotic and now I have diarrhea. The resident had no idea why she was on an antibiotic, and she said they then they just stopped it. Review of physician progress notes dated 3/21/25 through 3/24/25, revealed no documentation of notes regarding the residents ordered antibiotics or rational for use. During an interview done on 1/7/26 at 2:40 p.m., Infection Control Nurse, RN A stated (Resident #10) shouldn't' have been put on 2 antibiotics, and we should have waited for C&S (culture & sensitivity lab test) prior to antibiotics, there was a care plan for antibiotic usage but 2 days after it was started, and it was discontinued the same day.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, interview and record review, the facility failed to ensure dignity regarding call light response times and accessibility for 4 resident's (Resident's #1, #10, #29, and #49), and 2 confidential Resident's from the Resident Group meeting (held on 1/7/26, at 11:00 a.m.), and 2 residents (Resident #4 and #44) not treated in a dignified manner by staff, resulting in 1 confidential resident being incontinent due to no one answering the call light, embarrassment, anger, fear of being left alone, with the potential for isolation. Findings Include:Review of the facility Call Light Policy dated June 30, 2012, stated A system to provide for the resident when in their rooms and toilet and bathing areas, have a means of directly contacting caregivers. If a call is not answered in a specified length of time (4 minutes), the initial group is re-paged. If the call continues to be unanswered; pages are escalated to back up and supervisory personnel (8 minutes). It is important to see that the resident's needs are met in a timely manner. Resident #1: Review of the Face Sheet, physician orders dated 12/25, and care plans dated 9/22 to 1/26, revealed Resident #1 was [AGE] years old, admitted to the facility on [DATE] and re-admitted on [DATE], was his own person, and required extensive assistance from staff for all Activities of Daily Living/ADL's. The residents diagnosis included, myocardial infarction, anemia, pneumonia, back pain, malignant neoplasm of kidney, chronic lung and heart failure, acute kidney failure with a urinary catheter in place, shortness of breath, history of falling, and stroke. Review of the residents Fall care plan dated 9/27/22, stated Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance. Observation made on 1/6/26 at 11:54 a.m., revealed the resident in bed sleeping with his call light coiled up and hanging on the wall by the silver plug (not within reach of the resident). During an interview done on 1/6/26 at 12:22 p.m., Nursing Assistant/CNA H stated He likes it (call light) like that, walked out of the room and left his call light hanging on the wall. Resident #10: Review of the Face Sheet, minimum Data Set (resident assessment tool dated 2/23, physician orders dated 1/23 through 1/26, and care plans dated 1/17/23, revealed Resident #10 was [AGE] years old, interviewable with confusion, and required total assistance with all ADL's. The residents diagnosis included, heart disease, psychotic disorder, anxiety, anemia, stroke, Crohn's Disease, back pain, right shoulder pain and stage 3 kidney disease. Review of the residents Anxiety care plan dated 12/5/25, stated monitor for safety.1as During an interview done on 1/6/26 at 10:54 a.m., when the resident was asked do staff answer her call light timely the resident stated, It takes them awhile to get in here (stated over 30 minutes). Resident #29: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Face Sheet, physician orders dated 12/25, and care plans dated 12/31/25, revealed Resident #29 was [AGE] years old, confused and required staff assistance with all ADL's. The residents diagnosis included, fracture with displacement of the neck (with a cervical color on), muscle weakness, unsteady gait, anxiety, anemia, heart disease, essential tremors, and high blood pressure. Review of the residents Fall care plan dated 12/3/25, stated I am in the falling start program (a program for close monitoring due to falls). I had a fall from bed after shift change. I wake easily so please re-round back right after report to ensure my needs are met. Nurse to ensure alarms are functioning every shift. Observation made on 1/6/26 at 10:27 a.m., revealed the resident in bed with her call light hanging over the bed on the right side, she was unable to locate it when asked. Resident #49: Review of the Face Sheet, physician orders dated 11/25, and care plans dated 7/23, revealed Resident #49 was [AGE] years old, confused and required total assistance from staff with all ADL's. The residents diagnosis included, Acute kidney failure, anxiety, anemia, diabetes, encephalopathy, altered mental status, weakness, fatigue and was born without eyes and was a fall risk. Review of the residents care plans dated 11/19/25, revealed he had behaviors, and staff were to anticipate his needs and check on him often. Observation made on 1/6/26 at 10:52 a.m., revealed the resident sitting in his rocker and his call light was dangling over the bedside night table; not within reach. During an interview done on 1/6/26 at 10:42 a.m., CNA J stated He is blind, he has behaviors, I just don't know what to do. The CNA walked out of the room, the call light remained out of reach. Review of the facility Resident Council Minutes dated 6/19/25, stated Call light-continue to monitor. Review of the Resident Council minutes dated 8/28/25, stated Call light wait time is too long. During the confidential Resident Group meeting held on 1/7/26 at 11:00 a.m., 2 resident's verbalized staff do not answer their call lights timely, stating It takes 45 minutes on days and nights, they don't have enough staff. I had an accident (incontinent) due to no one coming to answer my light, I was mad. Review of the facility Nursing In-Service held on 10/24/25, revealed Infection Control Nurse A included call lights (within reach and timely answering) in the meeting. Review of the facility call light response times for October, 25, revealed a total of 46 times resident's call light's were not answered for over an hour. There were 294 times it took over 20 minutes to answer residents call light, and 124 times it took 30 minutes to an hour to answer the call light. Review of room [ROOM NUMBER]'s call light response time on 10/8/25, revealed it was answered in 8 hours 22 seconds. During an interview done on 1/8/26 at 10:04 a.m., the facility Administrator stated it should not take (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	more then 20 minutes tops to answer a residents call light. During an interview done on 1/8/26 at 11:20 a.m., Account V stated They (staff) are supposed to have pagers, sometimes they are out of batteries; a lot of them put them (pagers) on vibrate. I started 9/25 monitoring call lights. During an interview done on 1/8/26 at 11:40 a.m., the Director of Nursing stated We are going to pinpoint staff and I am going to hold them accountable. Review of the facility Abuse, Neglect Exploitation & Misappropriation of Resident Property policy dated 2/27/25, stated Neglect: The failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress (including call light availability and prompt answering time). Resident #4: Record review of Resident #4's medical record revealed the residents were totally dependent on facility staff for all activities of daily living. Record review of Resident #4's Kardex care guide for staff revealed that activity: to take the resident to the activity room where he can look out the window and play music for him. Observation on 01/06/2026 at 9:35 AM of Resident #4 was Observed to be seated in the activity room across the hall from the main dining room, up in Broda chair and placed so that he is facing the wall next to the room entrance doorway. The surveyor walked into the room and noted that there were no tv, photos or anything of interest on the wall. No call device noted within reach. No staff in attendance. Will monitor. Observation on 01/06/2026 at 9:50 AM Resident #4 was still in the activity room in same position in chair facing a blank wall, still no call device within reach and no staff in attendance. The surveyor noted that staff passed the activity room doorway but did not look into the room or stop to check on the resident. Observation on 01/07/2026 9:40 AM Resident #4 was seated up in WC in his room placed in front of the TV with call light in reach. 01/07/2026 1:56 PM still seated in same spot in room up in Broda chair in the same position in front of TV. No activity observed with this resident

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure sufficient and adequate staffing levels were in place to meet residents' needs in a timely manner for Resident #39 and seven out of seven residents residing in the Little House (separate building from main facility) unit of the facility. Findings include: Review of the facility call light response times for October, 25, revealed a total of 46 times resident's call light's were not answered for over an hour. Review of room [ROOM NUMBER]'s call light response time on 10/8/25, revealed it was answered in 8 hours 22 seconds. On 1/6/26 at 11:50 AM, there were no Residents observed in the central area of the Little House unit of the facility. On 1/6/26 at 12:14 PM, Dietary Staff EE was observed standing beside an open cart with food plates covered with tin foil in the kitchen area of the Little House unit. When queried, Dietary Staff EE revealed they delivered the food trays to the unit from the main building kitchen but do not distribute the trays to the residents. Dietary Staff EE stated, I think it is a nurse who is supposed to serve the food. Three Residents along with several visitors/family members were observed sitting at the large table in the central area of the unit waiting for lunch to be served at this time. At 12:19 PM on 1/6/26, Certified Nursing Assistant DD entered the kitchen area of the Little House unit and began prepping beverages to go with each resident's food plate and putting them on a tray. When queried regarding other staff on the unit, CNA DD stated, The nurse is on north (in main building) and revealed they were the only staff in the Little House unit. CNA DD was observed temping the food on the plates. The temperatures were not within normal ranges and CNA DD microwaves the individual plates. When asked if they are responsible to prepare beverages and food daily, CNA DD revealed they do a couple days a week because they do not have a dedicated kitchen staff for the Little House seven days a week. When asked if CNA staff are responsible to prepare the resident trays alone on the days when a kitchen staff is not assigned to the Little House unit, CNA DD confirmed they were. CNA DD was then asked if other facility staff are in the unit to assist them and revealed staff assigned to work in the Little House include one CNA and one nurse. CNA DD explained the nurse is also assigned a unit in the main building of the facility and comes the Little House to pass medications. CNA DD was queried regarding their ability to provide care and meet resident needs in a timely manner, including serving meals, when they are the only staff member working on the unit and revealed they do the best they can do but cannot be everywhere at once. The first resident tray was served at 12:34 PM, after CNA DD prepared the beverages and microwaved the food to get it up to a safe temperature. On 1/6/26 at 1:40 PM an interview was completed with the facility Administrator. When queried regarding dining services and staff assist in the Little House, the Administrator revealed the facility has a dedicated, full-time dietary staff member for the Little House who is scheduled five days a week. The Administrator disclosed the dietary staff who had filled in and worked in the Little House when the full-time staff was off had vacated their position. The Administrator then stated they were not aware that the position had not been filled and the CNA was the only staff member providing dining assistance two days a week. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/26 at 3:30 PM to 3:54 PM, there were no residents and/or no nursing staff observed in the central area of the Little House unit of the facility. At 3:54 PM, CNA HH was observed exiting a resident room. When queried regarding staffing, CNA HH revealed the nurse assigned to the Little House also had a hall in the main building and they were the only nursing staff present in the Little House. When queried how frequently the nurse is present in the Little House, CNA HH indicated the nurse comes to pass medications and leaves as they have more residents in the main building of the facility. An interview was completed with CNA GG on 1/7/26 at 7:54 PM. When queried the lack of residents observed in the central area of the Little House unit of the facility, CNA GG replied, Yeah, everyone pretty much stays in their room all the time. When asked about activities to encourage the residents to come out of their rooms, CNA GG replied, The CNAs have to do activities over here, so it is hard. When to clarify, CNA GG revealed they were the only nursing staff currently working on the unit and were responsible for assisting and providing all ADL care including bathing/showering, responding to call lights, and planning/completing activities for all seven residents as no other staff were present on the unit all the time. CNA GG revealed the nurse assigned to the Little House is also assigned to a hall in the main building and indicated they come to the Little House pass medications and leave. CNA GG was asked staff emergency call lights in the resident rooms in case there is an emergency with a resident, such as a medical emergency or a fall, and replied, No. CNA GG revealed they have a walkie which they are supposed to use if they need assistance. CNA GG then stated, It only works if someone answers or remembers to get one. When asked if they have had instances where no one responded to the walkie, CNA GG responded they had. CNA GG verbalized safety concerns related to being the only staff member in the Little House of the facility. When queried regarding ADL care, CNA GG responded that they are often unable to answer call lights in timely manner when they are assisting another resident. CNA GG revealed they ask the other residents if they need anything prior to giving a resident a shower but it is concerning when they are unavailable and off the unit with no other staff present for 30 minutes to an hour providing a shower. CNA GG verbalized they do not consistently receive breaks and stated, No one to cover. With further inquiry, CNA GG revealed they maybe get a 10-minute break when the nurse comes to pass medications and indicated not receiving a break is very stressful. Review of Call Light Logs from 12/31/25 to 1/6/26 revealed the following call light times greater than 15 minutes in the Little House unit: - 12/31/25 at 8:03 AM; room [ROOM NUMBER]- Call light length: 20:06 minutes - 12/31/25 at 8:32 AM; room [ROOM NUMBER]- Call light length: 18:24 minutes - 12/31/25 at 8:15 PM; room [ROOM NUMBER]- Call light length: 19:14 minutes - 1/1/26 at 6:47 AM; room [ROOM NUMBER]- Call light length: 17:54 minutes - 1/1/26 at 3:36 PM; room [ROOM NUMBER]- Call light length: 16:23 minutes - 1/2/26 at 8:20 AM; room [ROOM NUMBER]- Call light length: 16:36 minutes - 1/4/26 at 12:38 AM; room [ROOM NUMBER]- Call light length: 18:15 minutes - 1/4/26 at 10:33 AM; room [ROOM NUMBER]- Call light length: 22:58 minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1/4/26 at 6:51 PM; room [ROOM NUMBER]- Call light length: 18:23 minutes - 1/4/26 at 7:57 PM; room [ROOM NUMBER]- Call light length: 20:09 minutes - 1/5/26 at 8:17 AM; room [ROOM NUMBER]- Call light length: 18:17 minutes - 1/5/26 at 4:10 PM; room [ROOM NUMBER]- Call light length: 19:54 minutes - 1/5/26 at 4:22 PM; room [ROOM NUMBER]- Call light length: 29:26 minutes - 1/5/26 at 6:53 PM; room [ROOM NUMBER]- Call light length: 31:33 minutes - 1/5/26 at 6:59 PM; room [ROOM NUMBER]- Call light length: 29:33 minutes - 1/5/26 at 8:12 PM; room [ROOM NUMBER]- Call light length: 26:06 minutes - 1/5/26 at 8:42 PM; room [ROOM NUMBER]- Call light length: 15:14 minutes - 1/6/26 at 9:20 AM; room [ROOM NUMBER] – Call light length: 1:02:24 (1 hour, 2 minutes, 24 seconds) An interview was conducted with the facility Administrator on 1/8/26 at 12:07 PM. When queried what staff member is responsible for staffing, the Administrator replied, No specific person does staffing. When asked who completes the schedule, the Administrator stated, The DON (Director of Nursing) does CNAs, (Registered Nurse [RN] F) does nurses, and Unit Managers schedule their own units. An interview was completed with the DON on 1/8/26 at 12:13 PM with the DON. When queried regarding facility staffing levels, the DON revealed there are typically three nurses and nine CNAs scheduled for the building. Review of the provided nurse schedule revealed there was not an RN scheduled to work each day during the week. When queried if a RN is always scheduled to work on a unit, the DON stated, No and revealed that either a Unit Manager or themselves are available when an RN is not scheduled. When queried regarding staffing in the separate building, Little House unit, the DON stated, Little House and Loop (main building unit) share nurse and one CNA out there (in Little House). When queried regarding the CNA responsibilities in the Little House, the DON revealed the CNA assigned is responsible for all resident care needs including ADL care, activities, etc. When queried regarding staffing for the Little House including observations of the only staff in the building being a CNA, the DON relayed there are only seven residents in the unit. The DON verbalized all residents who reside in the Little House require one assistance from staff. When queried regarding assistive devices including mechanical lifts, the DON revealed one resident in the Little House uses a one assist with a sit to stand lift (mechanical lift) for transfers. When queried if it was reasonable to assume one CNA would be able to provide adequate supervision to all residents while being alone and responsible for all ADL care, the DON reiterated there were only seven residents on the unit. When asked about activities, the DON stated, CNAs provide activities or they bring them to the main building. When asked if who provided supervision to the remaining residents in the Little House if the only assigned CNA took a resident to an activity in the main building, a response was not provided. When queried regarding CNA staff statements regarding lack of coverage for breaks, the DON indicated they were unaware of staff not getting breaks. No further explanation was provided. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident R39: Record review of Resident R39's Minimum Data Set (MDS) dated [DATE] revealed an elderly male resident with Brief Interview of Mental status (BIMs) score of 15 out of 15, cognitively intact. Medical diagnosis included: coronary artery disease (CAD), hypertension, peripheral vascular disease (PVD), renal insufficiency, obstructive uropathy, diabetes, depression and chronic obstructive pulmonary disease. Section GG physical function revealed impairment of one side of the body, use of wheelchair and/or walker. Toileting and showers/bath with substantial/maximal assistance of staff. In an interview on 01/06/2026 at10:10AM during the survey screening process on call light response. Resident #39 stated that the call lights take too long. The resident #39 stated that there have been changes in staffing with the shower aides being moved to floor aides and now the floor aides have to give the showers. On the afternoon and night shifts there is only one aide on the hallway. He stated that he had to wait over 15 minutes to use the bathroom. Observation on 01/07/2026 at 10:25AM of the 200-hallway revealed that the call lights above resident room doors do not work and the pagers are all on silent mode. Certified nurse assistants (CNAs) are observed in the hallways. How do aides know what room needs assistance? 01/08/2026 12:50 PM Record review of the call light audit forms from October 2025 revealed that the Resident of concern did not use the call light excessively, but when they did there were noted times that the call light was on for over 15 minutes. 10/3/25 at 8:10PM call light on for 17:16 minutes 10/5/25 at 10:33AM call light on for 20:09 minutes 10/8/25 at 8:06AM call light on for 9:59 minutes 10/8/25 at 11:09 AM call light on for 11:29 minutes 10/9/25 at 5:22PM call light on for 13:09 minutes 10/9/25 at 7:49 PM call light on for 11:46 minutes 10/11/25 at 7:47 AM call light on for 22:43 minutes 10/12/25 at 10:56 PM call light on for 18:46 minutes 10/14/25 at 9:15 AM call light on for 15:46 minutes 10/14/25 at 3:27 PM call light on for 11:25 minutes 10/15/25 at 7:35PM call light on for 21:48 minutes 10/17/25 at 9:31 AM call light on for 12:31 minutes 10/20/25 at 7:39 PM call light on for 35:48 minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/23/25 at 8:15 PM call light on for 46:53 minutes 10/27/25 at 7:46 AM call light on for 14:02 minutes 10/27/25 at 9:33 AM call light on for 15:07 minutes 10/27/25 at 5:11PM call light on for 35:27 minutes Only one month was reviewed due to the residents' complaint. In an interview on 01/08/2026 at 10:37 AM with the facility Controller W was auditing the call lights. The state surveyor inquired about the silence of the pagers not heard while on the nursing floor. Controller W stated that the aides are not bringing the pagers back to work, yesterday 1/7/26 I was told by Certified Nurse Assistants (CNA's) H and M that there were no working pagers. Controller W stated that she went to the main nursing station and there were 4 pagers on the desk in plain sight. The batteries were dead, so I took the pagers back to my office, changed the batteries, and checked the programing to make sure they were set for CNAs. I walked the pagers back to CNA H and M who were working on the floor with no pagers. The lights above the residents' doors do not light up, that is our old call system and do not work. I am watching CNAs call light times in audits, but I am not aware that they are shutting off the call lights and not coming back. That is not acceptable.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that documentation of discharge and communication of information with receiving health care facility was complete in the Electronic Medical Record (EMR) for one (#52) of one resident reviewed for hospitalization. Findings include: Record review revealed Resident #52 was admitted to the facility on [DATE] with diagnoses which included surgical site infection, right sided hemiplegia and hemiparalysis (one sided paralysis) following cerebral infarction (stroke) and history of kidney transplant. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required supervision to moderate assistance for hygiene and transferring. Review of census documentation revealed Resident #52 was discharged from the facility on 11/28/25. Review of Resident #52's EMR revealed no assessment documentation pertaining to transfer and/or discharge from the facility on 11/28/25.Review of progress note documentation in Resident #28's EMR revealed the last note in the EMR was dated 11/28/25 at 9:30 AM and detailed, Health Status Note. Resident admitted to facility for strengthening rehab r/t (related to) right hip fracture requiring surgical repair. Surgical incision to right hip noted to have copious amount of bright red blood-tinged serosanguinous drainage at this time, tissue surrounding incision site is bright red and hot to the touch down to knee. Resident is receiving Cefepime (antibiotic). for infection in incision and Zithromax (antibiotic) for pneumonia. An interview was completed with Registered Nurse (RN) A on 1/7/26 at 2:26 PM. When queried regarding Resident #52 and their discharge, RN A revealed they thought the Resident had a doctor appointment and were admitted to the hospital from the doctor's office. RN A verbalized that the Resident's spouse took them to a hospital in the city because they were tired of the (local hospital). When asked what documentation is supposed to be completed by nursing staff when a Resident is transferred or discharged , RN A responded that an assessment should be completed. RN A was asked to review Resident #52's EMR. After review, RN A confirmed an assessment had not been completed. RN A was then asked if an assessment should have been completed and responded yes. Further review of progress note documentation in Resident #28's EMR revealed the following:- 11/27/25 at 11:53 PM: Health Status Note. Called to resident room. moderate amount of bloody drainage on bed pad. Dressing to right hip saturated. Dressing removed, observed drainage coming from mid incision. Noted redness surrounding the incision halfway down the outer thigh with warmth.- 11/28/25 at 9:12 AM: Health Status Note. Resident's (spouse) came in to see resident this morning and looked at resident's hip while writer was changing dressing. (Resident spouse) stated . was taking (Resident #52) down to (hospital system) on this day because felt the (local hospital) did not do the surgery correctly. Writer notified no-call provider of family request to take resident by private vehicle down to [NAME] Ford Hospital. Received okay by provider. Notified on-call supervisor of discharge. An interview was conducted with the facility Administrator on 1/8/26 at 9:19 AM. When queried what is sent with a resident when they go to an appointment at an external provider, the Administrator replied, Med list, x-rays, labs, face sheet, whatever they need. When queried if the information sent with the resident is documented, the Administrator indicated it should be. The Administrator was then queried regarding Resident #52 including where the Resident was discharged and what was sent with them. The Administrator reviewed the Resident's EMR and called the Director of Nursing (DON) to join the interview. The DON entered the interview at 9:22 AM. When queried regarding Resident #52's discharge, the DON verbalized that the Resident's husband took them to see a doctor at a different hospital. When asked how the facility knew the Resident was admitted to the hospital, the DON revealed they thought the Resident's spouse called and informed the facility. When queried regarding documentation in the EMR, the DON referred to the Health Status note dated 11/28/25 at 9:12 AM in the EMR. When asked if Resident #52's spouse took them to see a doctor or to (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iosco County Medical Care Facility	1201 Harris Avenue Tawas City, MI 48763

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Emergency Department at the other hospital, the DON did not provide a response. When queried what information was sent with the Resident, the DON was unable to provide documentation of any information being sent with the Resident and/or any follow up communication. When asked if they understood the concern related to lack of documentation of discharge and communication for continuation of care with upon discharge/transfer, the Administrator verbalized understanding. No further explanation was provided. A policy/procedure related to transfer/discharge including documentation was requested at this time but not received by the conclusion of the survey.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and operationalize policies and procedures to ensure Pre-admission Screening and Resident Review (PASARR) completion for one resident (Resident #8) of one resident reviewed for PASSAR completion resulting in lack of annual evaluation completion and the potential for lack of comprehensive assessment and care coordination. Findings includeRecord review revealed Resident #8 was originally admitted to the facility on [DATE] with diagnoses which included dementia, anxiety, depression, psychosis, and adult personality and behavior disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required substantial to moderate assistance to complete Activities of Daily Living (ADLs) with the exception of eating. Review of Resident #8's Electronic Medical Record (EMR) revealed the Resident was receiving antianxiety, antidepression, and atypical antipsychotic medications. Review of Resident #8's Electronic Medical Record (EMR) revealed PASSAR Level I and Level II screenings were completed prior to admission by the hospital on 6/17/24. An interview was completed with Social Services Director C on 1/7/26 at 10:41 AM. When queried regarding Resident #8's PASSAR assessments, Director C reviewed the EMR and provided the PASSAR Level I and Level II assessments dated 6/17/24. When asked if the PASSAR assessment had to be completed annually at the facility, Director C stated, (Director of Nursing- DON) does those now. Director C continued, I think they are annually and we are behind on those. An interview was completed with the facility 1/8/26 with the facility Administrator. When asked how frequently PASSAR assessments should be completed, the Administrator responded annually. The Administrator revealed the facility had a change in staff and stated they knew the assessments were behind and the DON was receiving education related to PASSAR form completion. A facility policy/procedure related to PASSAR completion was requested from the facility Administrator on 1/7/26 at 12:53 PM but not received by the conclusion of the survey.

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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** Based on interview and record review, the facility failed to ensure that 1 resident (Resident #1) of 1 resident sampled for implementing indwelling urinary catheter care plan, resulting in cross contamination due to catheter bag being on the resident's floor. Findings Include: Resident #1:Review of the Face Sheet, physician orders dated 12/25, and care plans dated 9/22 to 1/26, revealed Resident #1 was [AGE] years old, admitted to the facility on [DATE] and re-admitted on [DATE], was his own person, and required extensive assistance from staff for all Activities of Daily Living/ADL's. The residents diagnosis included, myocardial infarction, anemia, pneumonia, back pain, malignant neoplasm of kidney, chronic lung and heart failure, acute kidney failure with a urinary catheter in place, shortness of breath, history of falling, and stroke.Review of the residents Urinary Catheter care plan dated 12/10/25, stated Ensure indwelling urinary catheter drainage bag is not touching floor.Observation made on 1/6/26 at 10:54 a.m., revealed the resident sleeping in bed with his catheter bag sitting on the floor next to his bed; no barrier was under the bag.During an interview done on 1/6/26 at approximately 10:00 a.m., Infection Control nurse, RN A stated it (the urinary catheter bag) should not be on the floor, they needed a barrier under it).Review of the facility Care Planning policy dated 1/8/26, stated The comprehensive care plan is designed to : Incorporate identified problem areas, identify risk factors associated to the identified problems, focus and build on the residents strengths, reflect goals and objectives in measurable outcomes, identify responsibility for each element of care, prevent or minimize decline in functional status.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, the facility failed to update care plan interventions for 1 resident (R22) of two residents reviewed, resulting in the likelihood for missed interventions in treatment and unmet needs. Resident #22:In an interview on 01/06/2026 at 10:34 AM with the Resident #22's family member revealed that the Resident #22 got a pressure ulcer here at the facility, they have a bandage on the bottom, and they are changing it every other day. She came from Saginaw hospital after surgery on her left leg fracture then she got cellulitis. Observation on 01/06/2026 at 10:38 AM the state surveyor observed a heel up device/pad to end of bed, the family member removed the socks and the state surveyor observed the left heel had a large brown/purple deep tissue injury noted. The family member stated that the Registered Nurse Z, who stopped working at the facility back in December, before Christmas she stopped working, found the dark spot on the heel and put the foot/leg cushion (Hells-up device) on the bed and said to keep her heels off the bed. Observation of Resident #22's closet door Kardex/care guide noted no mention of the heels up device in place to the bed, or of the deep tissue injury to left heel. Record review on 1/6/2026 of resident #22's medical record/admission assessment and there was no mention of left heel deep tissue injury. No mention of pressure ulcer or deep tissue skin injury in care plans. Record review of facility 'Care Planning' policy dated 10/2/2024 noted each resident will have a care plan developed and maintained by the interdisciplinary team, in coordination with the resident and the family/representative . The individualized care plan includes measurable objectives and timetables established to meet resident's medical, nursing, mental, social, and psychological needs. (9.) Revised care plans as dictated by changes in condition. (10.) Care plan changes are made in point-click-care and a new Kardex is printed and placed in resident closets. Observation and interview on 01/07/2026 at 2:01 PM with Registered Nurses A Infection Control and F Wound care entered into the room with wound care supplies of wound wash and dry gauze. The Resident #22 was rolled to the right side and observation of the right gluteus revealed an open area pinpoint with slight serosanguinous drainage noted, wound care of wound wash and pat dry, a 2x2 Allevyn foam border dressing applied. The RN's A and F were requested by the state surveyor to remove Resident #22's socks to observed bilateral heels. Observation of Resident #22's left heel was noted with a large dark area, non-blanchable. RN A and F both were surprised and stated that they just found the deep tissue injury with the state surveyor today. The family member was in the room during observation and stated that the left heel sore had been there over 3-weeks, when Registered Nurse W the nurse does not work here anymore she found it and placed the heels-up device/pad to her bed. In an interview and record review on 01/07/2026 at 2:15 PM with Registered Nurse A RN/ICP/In-service director- Her left heel has a deep tissue injury, purple/brown in color, it new today. there was nothing there on admission assessment, I have been in there at least 1 or 2 times to assess her or transfer her. That deep tissue injury is newfound today. In an interview and Record review on 01/07/2026 at 3:02 PM with Human Resource director X of Registered Nurse Z's resignation letter noted her last date of duty was 12/19/2025. Record review on 1/8/2026 at 8:45 AM with Registered Nurse A Infection control/In-service education of Resident #22's physician order on 1/2/2026 at 1:17PM revealed 'Ensure that heels up device is in place while in bed. In an interview and record review on 01/08/2026 at 8:03 AM with the Director of Nursing related to care plan development. The DON stated that when a resident admits or comes in, we initiate care plans based on diagnosis and needs. record review of Resident #22's care plans pages 1 through 11 revealed no Deep Tissue Injury to left heel. The DON stated that there was no what, where, or when or how to treat. The DON stated that we put in/created a pressure ulcer care plan on the 1/6/2026 and then (stage II) then resolved it on 1/7/2025. I looked in the care plans and there was no pressure ulcer care plan, so I created one on 1/6/2025 and then they said that it resolved so I went back into the care plans on 1/7/2025, that's what I did. We do have an MDS contracted service that does our (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plans, and we follow their recommendations. Record review with the DON of Resident #22's care plan changes presented by the Director of Nursing during the interview revealed that Resident #22 had potential for pressure ulcer development on 12/19/2025, and pressure ulcer development dated 1/6/2026 and revised on 1/7/2026.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the provision of services, treatment and assistive devices to maintain vision and hearing abilities for one resident (Resident #15) of one resident reviewed for vision/hearing resulting in lack of equipment, audiology services, and Resident verbalization of difficulty and discontentment.Findings include:On 1/6/26 at 12:06 PM, Resident #15 was observed in their room sitting in a recliner. An interview was completed at this time. When spoke to, Resident #15 was noted to be very hard of hearing, and they did not make eye contact nor track movement with their eyes. When asked about their vision, Resident #15 stated, I can't see. Resident #15 was asked if they had seen an eye doctor while at the facility and indicated they had but stated the glasses they got did not help them to see. Resident #15 was then asked if they had hearing aids and responded they don't work. When queried if they had seen an audiologist while at the facility, Resident #15 replied they had not. The Resident then stated, I crocheted and did stuff all my life. Now I can't do anything. Record review revealed Resident #15 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, depression, anxiety, and heart disease. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required partial/moderate staff assistance with transfers and hygiene. Review of Resident #15's Electronic Medical Record (EMR) revealed a care plan entitled, I have impaired visual function r/t (related to) macular degeneration. I have stated I am legally blind (Initiated and Revised: 10/2/24). The care plan included the intervention, Ensure my glasses are available to support my participation in activities (Initiated and Revised: 10/2/24). A second care plan entitled, I have a communication problem r/t (related to) Hearing deficit (Initiated: 10/2/24) was also present in Resident #15's EMR. The care plan included the intervention, Ensure availability of my hearing aids and that they are working properly (Initiated and Revised: 10/2/24). Review of Resident #15's EMR revealed the following progress note documentation: - 9/30/24 at 4:01 PM: MDS Note. This nurse entered resident room to find resident sitting up in wheelchair. answered all questions appropriately with this nurse. stated. utilizes glasses and is legally blind. moderate difficulty hearing without hearing aids.- 10/17/24 at 10:10 AM: Medicare Note. Resident reports is legally blind and has moderate difficulty hearing without hearing aids.- 7/30/25 at 11:50 AM: Social Service. This writer delivered resident's new glasses to staff at resident's building No further documentation was noted Resident #15's care plan/ progress note documentation pertaining to vision and/or hearing services/equipment. No documentation pertaining to audiology consultation was noted in the EMR. On 1/7/26 at 3:41 PM, a second interview was completed with Resident #15. The Resident was observed sitting in the recliner in their room. The Resident was not wearing glasses and there were no glasses observed in the Resident's room. With further inquiry regarding their vision, the Resident explained they had got new glasses, but the glasses did not help them to see, and they were unsure of where the glasses are now. When asked if they saw the followed up with the eye doctor after receiving the new glasses which did not help their vision, Resident #15 verbalized they did not. When asked about their hearing aids, Resident #15 indicated they had not been working for quite some time but did not provide further information. An interview was conducted with Certified Nursing Assistant (CNA) Y on 1/7/26 at 3:50 PM. When queried regarding Resident #15's hearing, CNA Y confirmed the Resident was very hard of hearing. CNA Y was asked if the Resident has hearing aids and stated, Not that I'm aware of. When queried if the Resident had glasses, CNA Y replied, I think they have them but doesn't use them. She just uses the magnifying glass. When asked why the Resident doesn't use their glasses, CNA Y indicated they were not sure. CNA Y was then asked if Resident #15 leaves their room and stated, No. (Resident #15) says they can't hear and can't see so it's too hard. CNA Y continued, The last time I seen (Resident #15) out was on Halloween. An interview was completed with the facility Administrator on 1/8/26 at 8:48 AM. When queried regarding Resident #15's hearing impairment, the (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator confirmed the Resident had impaired hearing. When asked about the Resident's hearing aids, the Administrator revealed they did not know and asked the Director of Nursing (DON) to join the interview. When queried regarding the location of Resident #15's glasses, their new glasses not assisting their vision, and lack of documentation of follow up, the DON responded that the Resident is blind and not improving the Resident's vision, the DON responded that Resident #15 says they are legally blind and glasses will probably not help. When queried regarding the Resident's hearing and audiology services, the DON stated, (Resident #15) refuse ancillary services. Documentation of refusal related to audiology services was requested at this time.At 9:20 AM on 1/8/25, the DON provided a printed copy of the EMR MDS Note dated 9/30/24 at 4:01 PM. The note specified the Resident wore glasses, was legally blind, and was moderately hard of hearing without hearing aids. An interview was conducted with the Administrator and DON at this time. When asked, the DON revealed they were unable to locate any other information pertaining to ancillary vision and/or audiology services. When queried if Resident #15 had refused audiology services, the DON responded they had not. The DON then stated, (Resident #15) has a consult for audiology. The DON was asked when the audiology consult was placed and stated that a consult was sent on 9/30/24 and again in January 2025. When asked if the Resident had been seen by audiology, the DON replied, No. With further inquiry, the DON revealed they contacted the company the facility has a contract with for ancillary services, including audiology, and were informed that there is not an audiologist available. Both the DON and Administrator verbalized they were unaware that audiology was unavailable through the contracted company. When asked if alternative audiology providers had been contacted, the Administrator and DON revealed they had not. The Administrator verbalized they would address the concern. No further explanation was provided. Review of facility policy/procedure entitled, Hearing and Vision Services (Reviewed/Revised: 10/1/25) revealed, It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. 4. assist the resident by making appointments and arranging for transportation. 5. Employees will assist the resident with the use of any devices or assistive equipment needed to maintain vision or hearing.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure monitoring for anticoagulation (blood thinner) medication side effects for one resident (#37) of five residents reviewed for unnecessary medications. Findings include:Record review revealed Resident #37 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included atrial fibrillation (irregular heart rhythm), respiratory failure, and anxiety. Review of Resident #37's Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required partial/moderate assistance with toileting and bathing. An interview was completed with Resident #37 on 1/6/26 at 11:35 AM in their room. The Resident was sitting in a recliner in their room. When queried if they take an anticoagulant medication, Resident #37 responded they do. Resident #37 was asked the name of the medication and revealed they did not know. Review of Resident #37's Health Care Provider (HCP) orders and Medication Administration Record (MAR) in the Electronic Medical Record (EMR) revealed the Resident was currently receiving Apixaban (Eliquis- oral anticoagulant) 2.5 milligram (mg) one tablet twice a day. Review of MAR and progress note documentation in Resident #37's EMR revealed no documentation of monitoring for bleeding and/or side effects of anticoagulation medications. Resident #37 did not have a care plan in place related to anticoagulant medication therapy. An interview and record review was completed with the facility Administrator and Director of Nursing (DON) on 1/8/26 at 9:32 AM. When queried regarding facility policy/procedure related to monitoring for side effects of anticoagulation medications, the DON revealed a task for side effect monitoring is initiated on the MAR when a Resident takes an anticoagulant medication. When asked if Resident #37 is receiving an anticoagulant medication, the DON reviewed the Resident's EMR and confirmed they were. When asked if they should have anticoagulant medication monitoring in place, the DON stated, Should be. When queried where anticoagulation monitoring is documented in Resident #37's EMR, the DON reviewed the Resident's EMR and confirmed the Resident did not have monitoring in place. When asked why Resident #37 did not have anticoagulant monitoring in place, the DON indicated the monitoring task was not reordered when the Resident was readmitted to the facility and it should have been. No further explanation was provided. A facility policy related to anticoagulation medication monitoring was requested at this time but not received by the conclusion of the survey.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen.Findings include: On 01/06/2026 at 9:16am-9:45am during the initial kitchen tour with Certified Dietary Manager R, observed a carton of Lactaid with a discard date of 12/30/25, located in the walk-in refrigerator in the kitchen. According to the 2022 Food Code, 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date. On 01/06/2026 at 9:16am-9:45am observed the slicer visibly soiled with a substance caked to the blade and accumulating rust, located in the kitchen. When interviewed CDM R on how often the slicer is cleaned, she stated that the slicer hasn't been used in 2 years. On 01/06/2026 at 9:16am-9:45am observed the mixer visibly soiled with a white substance, located in the kitchen. When interviewed CDM R on how often the mixer is cleaned, she stated that the mixer is supposed to be clean every time they use it. On 01/06/2026 at 9:16am-9:54am observed crumbs accumulating on top of pans stored under the counter near the 2-compartment sink, located in the kitchen. According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the facility's policy on sanitation of food preparation areas, All kitchenware and food contact surfaces used in the preparation of or serving of food and drink will be cleaned and sanitized after each use and thoroughly cleaned and sanitized after each meal. On 01/06/2026 at 9:45am observed the microwave visibly soiled in the interior walls and ceiling, located in the kitchen in the Small House. When interviewed CDM R on the cleaning schedule of the microwave, and she stated that she hasn't looked inside the microwave lately, but it's supposed to be cleaned daily. On 01/06/2026 at approximately 9:45am observed the inside of the oven visibly soiled with grease, located in the kitchen in the Small House. On 01/06/2026 at approximately 9:45am observed the toaster visibly soiled with a large number of crumbs collecting at the top and bottom of the toaster, located in the kitchen in the Small House. On 01/06/2026 at noon-12:45pm observed [NAME] Q remove one glove and proceeded to don another glove without washing hands while serving food in the kitchen. On 01/06/2026 at noon-12:45pm observed [NAME] Q remove both gloves and don gloves without washing hands while preparing trays in the kitchen. According to the 2022 Food Code, 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms .immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and . Before donning gloves to initiate a task that involves working with food. According to the facility's policy on handwashing and hand hygiene, All employees and volunteers at Iosco County Medical Facility will practice proper hand washing techniques, in conjunction with standard (universal) precautions, to provide the best means of preventing and controlling infection. Hand hygiene is practiced at the following times .Before putting gloves on .after removing gloves.