STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235016	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Jackson	434 W North Street Jackson, MI 49202

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2747784Based on interview and record review, the facility failed to notify the family of one of one resident (R106) nor the on-call provider of a change in condition requiring to be sent out to the hospital. Findings Include;Resident #106 (R106)Review of the medical record reflected that R106 was admitted to the facility on [DATE]. Diagnoses of Pneumonitis due to inhalation of food and vomit, severe protein-calorie malnutrition, non-pressure related ulcers in the lower extremities, Dementia and peripheral vascular disease.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/11/2026 revealed R106 had a Brief Interview of Mental Status (BIMS) of 03 (Severe cognitive impact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R106 needed substantial assistance with showering and personal care. R106 was dependent on toileting and perineal hygiene.During an interview on 02/24/2026 at 10:15 AM, R106's family member M stated R106 was only at that facility for three weeks and he didn't have a call light that worked, they said they would work on it, but it still didn't work. R106's family member M stated they gave R106 a bell to ring if he needed help, but nobody could hear this bell, so what's the sense in that. R106's family member M stated she wasn't sure R106 knew how to use it. Record review revealed a nursing progress note regarding the non-working call light. Nursing Progress Note dated 01/11/2026 at 4:34PM .Resident's wife was upset that patient's call light did not work and the bell that he was given to call for assistance with was not loud enough because resident was at the end of the hall. Received permission to move resident into room [ROOM NUMBER]-2, with working call light and closer to the nurse's station. Wife stated, He has received the worst care here She was worried about his safety and stated it was neglectful that no one could hear when he needed help. Spoke with wife and she was upset about someone stating it was fixed on Friday, and it was not. She seemed to calm down after the room change and staff responding to all requests. Notified DON and Unit Manager.During an interview on 02/24/2026 at 10:15 AM, R106's family member M stated she questioned a change in his condition due to him responding a little differently than usual. R106's female nurse LPN E told her R106 wasn't dying. R106's family member M asked LPN E if he/R106 should go to the hospital, LPN E stated they wouldn't do anything for him but send him back to the facility. R106's family member M stated he/R106 was showing signs of decline, told staff they needed to check his vital signs. R106 seemed to have perked back up a little, so R106's family member M ended her visit with R106 and went home for the day.During this same interview on 02/24/2026 at 10:15 AM, R106's family member M stated the hospital called her to let her know that her husband was there and he had been there a couple of hours. R106's family member M stated the facility did not call her with this change in condition, she had checked her cell phone and home landline, no calls from the facility, no message left. R106's family member M stated she was very upset over this especially after her asking LPN E if he should had been sent in earlier that day.During an interview on (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/24/2026 at 11:30 AM, Licensed Practical LPN E stated she had been a rehire employee and had been there approximately 6 weeks. Writer asked LPN E to describe in detail how R106 was while in her care the night he was sent to the emergency room. LPN E stated R106 was good, stated he was alert to person, place and time, he was a nice gentleman, had wounds on his legs. LPN E stated earlier that day R106 was fine, around dinner time he was not fine, she got his vital signs, he was not stable, she hooked R106 up to oxygen and called 911. LPN E stated he was not alert, nor talkative, she went back down to R106's room, but once EMS got there, she left his room. LPN E stated R106's wife had left midafternoon, stated she called his wife. LPN E stated she sent the transfer/discharge paperwork with the resident to the hospital, and documented it in the nursing progress notes, then stated she don't know if she had done that or not. LPN E then stated maybe they didn't send it, then stated it was kind of crazy at that time and it was the end of her shift. Writer asked if she called the provider about this change in condition, stated she couldn't remember. Writer asked if she had documented all the events that took place during this change in condition for R106, LPN E stated I think so and left at the end of her shift.Record review of the nursing progress notes did not reflect that LPN E had called the primary provider nor the on call provider was notified of this emergency, prior to LPN E leaving at the end of her shift while EMS was still in house. Nor did it reflect that R106 had been given the bed hold policy, transfer/discharge paperwork.During an interview on 02/20/26 at 3:10 PM, Social Worker H stated she thought she did some of those, unsure as she described an unplanned discharge and her role in those. Social Worker H stated she did not see a progress note in his chart, then stated when she did the bed hold/transfer/discharge paperwork, she puts her progress note under regular progress note tab. Writer asked if R106's wife was notified that he was being sent out to the hospital, and she stated it didn't look like it.During an interview 02/24/2026 at 11:54 AM, prior Director of Nursing (DON) B stated R106's wife stopped her and told her she had concerns on his/R106's care. Writer asked prior DON B if she was notified of the change in condition on R106 prior to sending him out to the hospital, prior DON B stated she didn't get an update until after they sent him out, after the fact. Prior DON B stated they did talk to the nurse about the course of events that took place and what could they have done differently. Writer asked prior DON B if the on-call provider had been notified of this change in condition needing to be sent out. Prior DON B stated she wasn't sure as she found out about this after the fact.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure grievances were promptly documented, investigated, tracked and resolved for four residents of four resident reviewed for grievances (R107, R111, R112, and R113). Findings include: Resident #107 (R107)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/10/26, reflected R107 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included severe morbid obesity, cervical disc degeneration, muscle wasting and atrophy, major depression and anxiety. The MDS reflected that R107 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for transfers, showering and toileting.During an interview on 2/19/26 at 8:45 a.m., Nursing Home Administrator (NHA) A reported had been employed at the facility for about five months. This surveyor requested all allegations of abuse for review for past 30 days. NHA A reported R107 recently alleged no care for 14 hours and was not reported because determined did not happen prior to two hours.During an interview and record review on 2/19/26 at 11:34 a.m., Director of Nursing (DON) C reported had additional staff interview statements for R107 allegation of abuse provided and had additional to provide.Review of R107 concern form, 2/16/26, for care concern from 2/14/26. The form indicated concerns were reported during a care conference that included, R107 was left 14 hours with no staff checking on resident (allegation of neglect), not enough staff, told resident had to go to bed. Continued review of form reflected facility response included, reviewed by management staff in facility at the time who had spoken with staff who reported had gotten R107 up multiple times and changed when needed. The form reflected action taken was investigation complete and educated staff (no evidence provided including no evidence allegation of neglect was reported to State of Michigan). Form signed by NHA A 2/23/26. Provided witness statements received 2/26/26, did not include evidence of dates of times.Review of R107 Electronic Medical Record, dated 2/14/26, reflected no evidence to support R107s allegation of neglect did not occur. During an observation and interview on 2/20/26 at 12:15pm, R107 was sitting in room in recliner and appeared calm, pleasant and able to answer questions without difficulty. R107 reported staff often want to transfer R107 into bed early and R107 reported does not want to around 730 pm and stated that was too early. R107 reported facility had staffing issues with not enough staff to meet resident needs timely including on nights that is why staff try to put residents to bed before leaving day shift around 7:00 p.m. R107 reported staff had assisted her transfer to bed around 11-1130 pm one night and staff were unable to get R107 up until after 3:00 p.m. next day because takes two staff to use mechanical lift. R107 reported when that incident occurred reported to staff that she was unhappy with long length of time soiled brief and reported recent skin breakdown with no follow up. Resident #105(R105)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 1/9/26, reflected R105 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included cerebral vascular event(stroke) effecting right dominate side and depression. The MDS reflected that R105 had a BIM (assessment tool) score of 11 which indicated her ability to make daily decisions was moderately impaired, and she was dependent on staff for transfers, bed mobility, hygiene, dressing, showering and toileting.During an observation and interview on 2/20/26 at 12:37 pm, R105 was observed in bed in room. R105 appeared to have difficulty expressing words and able to clearly answer yes, no questions. R105 verified had care concerns, not enough staffing to meet resident needs, call light response times and lack of dignity and respect.Review of R105 tasks report, dated 2/1/26 through 2/26/26, (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected multiple holes with no documentation of care provided including hygiene, activities of daily living, toileting and several missed showers. During an observation and interview on 2/27/26 at 10:23 a.m., R105 family could be overheard in room with raised voices that appeared upset. LPN X entered room and R105 family member reported sheets soiled and resident leaning in bed almost falling out. R105 family AA reported was R105 daughter and does not like to visit because causes her to get upset and stated, Every time, every time. R105 family AA reported speaks with staff about R105 care concerns every time she visits and nothing every changes and was not aware of concern form process. Resident #110(R110)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/3/26, reflected R110 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included respiratory failure, post-traumatic stress disorder, anxiety and depression. The MDS reflected that R110 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was intact, and she required maximum to moderate assist from staff for toileting and bathing.During an interview on 2/20/26 at 1246 pm, observed R110 in bed appeared reported complaint that had not received shower for two weeks, and then several weeks prior to that. R110 reported had reported several complaints to staff and concern form completed without follow-up or improvement. Review of R110 task reports, dated 1/1/26 through 2/26/26, reflected multiple holes with no documentation of care provided including hygiene, activities of daily living, toileting and several missed showers. Further review reflected that R110 had received one shower in past 2 months. Resident #111(R111)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 1/20/26, reflected R111 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included multiple sclerosis, functional quadriplegia, and anxiety. The MDS reflected that R110 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was intact, and she required maximum to moderate staff assist for toileting, bathing and dependent on staff for transfers. Resident #112(R112)Review of the Face Sheet reflected R112 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included dementia and repeat falls.Review of R112 Care plans, dated 4/4/25, reflected R112 required two person assist with transfers, toileting and one person assist with showering and personal hygiene. Resident #113(R113)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/9/26, reflected R113 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included chronic spinal pain, Alzheimer's disease, anxiety and depression. The MDS reflected that R113 had a BIM (assessment tool) score of 13 which indicated her ability to make daily decisions was intact, and she was dependent on staff for transfers, toileting and showers.During a telephone interview on 2/26/26 at 4:49 p.m. Certified Nurse Aid (CNA) W reported worked the past weekend and reported there were no CNA staff on Saturday night into Sunday night shift on second floor. CNA W reported R111 was not laid down entire night, and grievance form was completed for resident and given to the NHA A. CNA W reported R113 was also left up in chair all night and remained in the chair the following morning when day shift arrived. CNA W reported R112 was heavily soiled with urine and stool and required shower after being left up in chair entire 12 hour night shift. CNA W' reported no CNA staff arrived during the night shift or were present on Sunday morning when she arrived. CNA W reported two nurses were present on Saturday night shift. CNA W reported when one CNA is scheduled cannot perform every 2-hour check and change timely for all residents, not enough staff. CNA W reported potential allegations of neglect related to care concerns and condition of resident were reported to nursing staff on 2/22/26 around 7:00 a.m.During an interview on 2/27/26 at 10:10 a.m., Licensed Practical Nurse (LPN) X verified no CNA staff worked Saturday 2/21/26 into 2/22/26 night shift on second floor. LPN X (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported called on call manager, Prior Director of Nursing (PDON) B to inform and told to call Nurse Y to cover. LPN X reported Prior DON C never comes in to work if she is on call. LPN X reported CNA Z stayed over late 2/21/25 to get most residents to bed and left three residents up in chairs. LPN X reported same three residents remained up in chairs and with same clothing on upon return in morning for 7am day shift. LPN X reported management staff informed because potential allegation of neglect and resident care needs were not met. LPN X reported two nurses worked 2/21/26 into 2/22/26 night shift 7pm to 7am and second nurse was called in to work as CNA staff but was older and not physically able and was passing medications working as nurse.During an interview on 2/27/26 at 10:58 am NHA reported did not have any concern forms for R105 and verified no care concern forms for R110, R111, R112, or R113 in past 30 days.During an interview on 2/27/26 at 11:10 NHA A reported no knowledge of three resident who remained up all shift on 2/21/26 evening. NHA A reported would expect staff to report concerns to management staff including allegations abuse/neglect immediately to NHA A or DON and complete grievance forms for residents if necessary.During a telephone interview on 2/27/26 at 12:48 p.m., facility Scheduler BB reported no longer worked at the facility as of today. Scheduler BB reported to NHA A that was unable to fill schedule at least every other weekend and up to 3 times weekly with at least four to five CNA staff and 2 nurses on days on each floor and was told by NHA A to just add transportation staff CC and Medical Record staff DD to schedules and advise to get with Director of Nursing B who reported to call staff. Scheduler BB reported DON B was informed after all attempts had been made to fill schedule including call staff and no one would come in with no support. Scheduler BB reported often completed concern form related to care concerns not being met and staffing at least two times weekly and provide to NHA A and DON B. Scheduler BB reported also report concern to management who shake heads and advise to speak with another manager. During an interview on 2/27/26 at 2:30 p.m., DON C reported 12 residents require assist of two with care needs.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2743515Based on observations, interviews, and record review the facility failed to protect the resident's(R103) right to be free from sexual abuse by another resident (R104).Findings include:Review of the Face Sheet and Minimum Data Set (MDS) with Assessment Reference Date, dated 2/12/26, reflected R103 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included cerebral infarct(stroke), anxiety, depression, altered mental status, substance use disorder, aphasia (impaired ability to speak, understand, read, or write), and required assistance with person care. The MDS reflected R103 had a BIM (assessment tool) score which indicated her ability to make daily decisions was moderately impaired-decisions poor, and she required one-person physical assist with transfers, dressing, hygiene, bathing and two-person physical assist with toileting.During an interview on 2/19/26 at 8:45 a.m., Nursing Home Administrator (NHA) A reported had been employed at the facility for about five months. NHA A reported recent allegation of resident-to-resident sexual abuse for R103 and R104 with five day investigation due that week. NHA A reported R104 was the perpetrator and had prior history of holding hands with R103 and reported R103 was not own responsible party. NHA A verified R103 was not able to consent and R103 responsible party had indicated did not want R104 to have contact with R103. NHA A reported on 2/12/26 R104 was observed by staff kissing R103 neck while in R104 room. NHA A reported to the State of Michigan, police called and arrested R104 related to prior warrant and R103 responsible party and physician were notified. NHA A reported R104 no longer lives at the facility. NHA A reported facility substantiated abuse allegation.Review of complaint received by the State Agency alleged the facility failed to protect the R103's right to be free from sexual abuse by R104.Review of the Facility Reported Incident Investigation, dated 2/12/26 at 7:53 p.m., reflected, On 2/12/26, a CNA observed [named R104] in his room kissing [named R103] on the neck. [named R103] lacks the cognitive ability to consent to physical contact.Prior to this incident, [named R103] mother reported observing [named R103 and R104] holding hands during visit and expressed discomfort. At the time, [named R104] was counseled that [named R103] is unable to consent to physical touching. [named R104] verbalized understanding.He was again reminded that [named R103] lacks capacity to consent and that her mother did not want physical contact between them.Investigation substantiates that non-consensual physical contact occurred. [named R103] lacks capacity to consent. [named R104] had been previously educated that [named R103] could not consent to physical contact and verbalized understanding at that time. Despite prior counseling, [named R104] engaged in physical contact by kissing [named R103] on the neck. This constitutes abuse due to non-consensual physical contact with a resident lacking capacity. Continued review of the facility investigation reflected witness statement, dated 2/12/26, completed and signed by Certified Nurse Aide (CNA) S. The Witness statement reflected, I was walking past [named R104] room, and observed [named R104] kissing the neck of [named R103] and his hand was outside of her pants and touching her inner thigh by her vaginal area. I went in and immediately separated them and told him they cannot be doing this. [named R104] laughed at me and told me as I was removing [named R103] from the room I can't do this. I responded, stating: Yes, I sure can and removed [named R103] from the room. [named R104] began yelling and me. I told the nurse and called the Administrator.During an observation on 2/20/26 at 12:37 p.m., R103 was observed self-propelling in wheelchair near her room doorway. R103 appeared calm, alert and non-verbal. Review of R103 Nurse Progress Note, dated 2/12/2026 at 8:42 p.m., reflected, One-on-one resident interaction, [named R104] was observed by CNA [certified nurse aid] kissing on [named R103] neck, CNA separated the residents, and the management was called. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator and DON [director of nursing] informed. Guardian was calledReview of R103 Provider Note, dated 2/13/2026, reflected, Wellness check History Of Present Illness: This [AGE] year-old female is seen today for a wellness check. Reported that patient did have physical contact with another resident, nursing staff did not intervene. Today patient is seen resting in bed, she is nonverbal at baseline she does continue to appear to be at her baseline.Neuro: alert yelled at me Diagnosis, Assessment and Plan Assessment.Cerebrovascular disease Patient does remain nonverbal, continue to monitor frequently Continue to monitor routine vital signs.Reactive depression Continue to monitor closely for signs of increased depression Wellness visit performed today, overall does appear to be stable no signs of increased agitation or anxiety Will follow closely Resident #104 (R104)Review of the Face Sheet and Minimum Data Set (MDS) with Assessment Reference Date, dated 1/23/26, reflected R104 was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included mood disorder, anxiety, and depression. The MDS reflected R104 had a BIM (assessment tool) score of 14 which indicated his ability to make daily decisions was cognitively intact, and he was independent with care needs.Review of R104 Nurse Progress Note, dated 10/15/2025 at 11:03 a.m., reflected, late entry from 10/12, after further conversation with activity staff member, activity staff stated that resident touched another resident on dorsal left hand. encouraged him to keep hands to self, stated understandingReview of R104 Behavior Progress Note, dated 2/7/2026 at 1:59 p.m., reflected, Resident was observed touching another resident's arm. Resident was instructed not to touch other residents and required multiple redirections to disengage and leave the resident alone.Review of R104 Psychotherapy Consult Note, dated 2/10/26, reflected, Psychotherapy is indicated to support emotional adjustment, anxiety management regarding discharge planning, and ongoing behavioral monitoring given his recent history of inappropriate behavior toward another resident. [named R104] was seen today for Session 4 of 26 in his structured psychotherapy treatment episode. Resident reported improved mood, with no current depressive or anxious symptoms outside of situational stress. He noted increased stress when discussing discharge and housing arrangements, as well as concerns about potential triggers for substance use, particularly financial management.During a telephone interview on 2/26/26 at 12:50 p.m., R103's Durable Power of Attorney (DPOA) R reported was R103 mother. DPOA R reported was notified by nurse and NHA A on 2/12/26 of incident that R103 was in R104 room and staff observed R104 sucking on R103 neck that left a red mark. R103's DPOA R reported had observed R103 in R104 room about one week prior holding hands with R104 and reported had conversation with NHA A. DPOA R reported told NHA A she did not want R104 touching R103 for any reason and was told NHA A spoke with R104 and informed there would be consequences if it happened again and not to touch R103. DPOA R reported then incident on 2/12/26 occurred and was notified and immediately came to facility to see R103. DPOA R reported police arrived and arrested R104. During a telephone interview on 2/26/26 at 1:55 p.m., Certified Nurse Aid (CNA) S reported was working at the time of R103 and R104 Facility Reported Incident on 2/12/26. CNA S reported was rounding around 8:00 p.m. and observed R103 in R104 room and observed R104 standing over R103 kissing her on the neck with his hand on R103 inner thigh by vaginal area over pants, groping R103. CNA S reported entered room and told R104, no, you can't do that, you have been warned and removed R103 from room who was in wheelchair. CNA S reported R104 became very agree and raised voice and started slamming items in room. CNA S reported Licensed Practical Nurse (LPN) T arrived immediately and asked what had happened. CNA S reported had heard R104 had history of inappropriately touching R103 in past and reported NHA A was notified because allegation of sexual abuse. CNA S verified signed witness statement for 2/12/26. CNA S reported incident was reported to NHA A and LPN T and CNA S were only staff working on the floor at the time of the incident.Review of the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided facility working schedule for 2/12/26 reflected two scheduled CNA staff scheduled for 7:00 p.m. shift on second floor. Further review the facility working schedule did not include CNA S. During an interview on 2/26/26 at 2:12 p.m. int NHA A reported provided schedules for 2/12/26 were accurate working schedules. Request was made for accurate working schedules because CNA S (witness to sexual abuse) was not on provided schedule. During a telephone interview on 2/26/26 at 4:30 p.m. LPN U reported was present at facility on 2/12/26 at time of R103 and R104 incident from the day shift. LPN U reported had just returned from break and CNA S reported that R104 was found kissing on R103 neck. LPN U reported R103 was not able to consent and had DPOA. LPN U reported assisted staff and notified physician and R103 DPOA. LPN U reported had planned to move R104's room to another floor but police arrived and arrested R104 and removed from the facility. LPN U reported prior DON B and NHA A were also notified. LPN U reported R104 left red mark on R103 neck and police officer had take photos. LPN U reported two staff were present on 2nd floor at the time of the incident, CNA S and LPN T. LPN U reported R103's Mother R arrived to facility shortly after being notified of incident and was very upset and wanted to confront R104 and verified staff did not allow.

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	235016	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Jackson	434 W North Street Jackson, MI 49202

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act.Findings include:Resident #107 (R107)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/10/26, reflected R107 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included severe morbid obesity, cervical disc degeneration, muscle wasting and atrophy, major depression and anxiety. The MDS reflected that R107 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for transfers, showering and toileting.During an interview on 2/19/26 at 8:45 a.m., Nursing Home Administrator (NHA) A reported had been employed at the facility for about five months. This surveyor requested all allegations of abuse for review for past 30 days. NHA A reported R107 recently alleged no care for 14 hours and was not reported because determined did not happen prior to two hours.During an interview and record review on 2/19/26 at 11:34 a.m., Director of Nursing (DON) C reported had additional staff interview statements for R107 allegation of abuse provided and had additional to provide. Provided with 3 staff interviews.Review of R107 concern form, 2/16/26, for care concern from 2/14/26. The form indicated concerns were reported during a care conference that included, R107 was left 14 hours with no staff checking on resident (allegation of neglect), not enough staff, told resident had to go to bed. Continued review of form reflected facility response included, reviewed by management staff in facility at the time who had spoken with staff who reported had gotten R107 up multiple times and changed when needed. The form reflected action taken was investigation complete and educated staff (no evidence provided including no evidence allegation of neglect was reported to State of Michigan). Form signed by NHA A 2/23/26. Provided witness statements received 2/26/26, did not include evidence of dates of times.Review of R107 Electronic Medical Record, dated 2/14/26, reflected no evidence to support R107s allegation of neglect did not occur. During an observation and interview on 2/20/26 at 12:15pm, R107 was sitting in room in recliner and appeared calm, pleasant and able to answer questions without difficulty. R107 reported staff often want to transfer R107 into bed early and R107 reported does not want to around 730 pm and stated that was too early. R107 reported facility had staffing issues with not enough staff to meet resident needs timely including on nights that is why staff try to put residents to bed before leaving day shift around 7:00 p.m. R107 reported staff had assisted her transfer to bed around 11-1130 pm one night and staff were unable to get R107 up until after 3:00 p.m. next day because it takes two staff to use mechanical lift. R107 reported when that incident occurred reported to staff that she was unhappy with long length of time soiled brief and reported recent skin breakdown with no follow up. Resident #111(R111)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 1/20/26, reflected R111 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included multiple sclerosis, functional quadriplegia, and anxiety. The MDS reflected that R110 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was intact, and she required maximum to moderate staff assist for toileting, bathing and dependent on staff for transfers. Resident #112(R112)Review of the Face Sheet reflected R112 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included dementia and repeat falls.Review of R112 Care plans, dated 4/4/25, reflected R112 required two person assist with transfers, toileting and one person assist with showering and personal hygiene. Resident #113(R113)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/9/26, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected R113 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included chronic spinal pain, Alzheimer's disease, anxiety and depression. The MDS reflected that R113 had a BIM (assessment tool) score of 13 which indicated her ability to make daily decisions was intact, and she was dependent on staff for transfers, toileting and showers.During a telephone interview on 2/26/26 at 4:49 p.m. Certified Nurse Aid (CNA) W reported worked the past weekend and reported there were no CNA staff on Saturday night into Sunday night shift on second floor. CNA W reported R211 was not laid down entire night shift and grievance form was completed for resident and given to the NHA A. CNA W reported R113 was also left up in chair all night and remained in the chair the following morning when day shift arrived. CNA W reported R112 was heavily soiled with urine and stool and required shower after being left up in chair entire 12 hour night shift. CNA W' reported no CNA staff arrived during the night shift or were present on Sunday morning when she arrived. CNA W reported two nurses were present on Saturday night shift. CNA W reported when one CNA is scheduled cannot perform every 2 hour check and changes timely for all residents, not enough staff. CNA W reported potential allegations of abuse related to care concerns were reported to nursing staff on 2/22/26 around 7:00 a.m.During an interview on 2/27/26 at 10:10 a.m., Licensed Practical Nurse (LPN) X verified no CNA staff worked Saturday 2/21/26 into 2/22/26 night shift on second floor. LPN X reported called on call manager, Prior Director of Nursing (PDON) B to inform and told to call Nurse Y to cover. LPN X reported Prior DON C never comes in to work if she is on call. LPN X reported CNA Z stayed over late 2/21/25 to get most residents to bed and left three residents up in chairs. LPN X reported same three residents remained up in chairs and with same clothing on upon return in morning for 7am day shift. LPN X reported management staff informed because potential allegation of neglect and resident care needs were not met. LPN X reported two nurses worked 2/21/26 into 2/22/26 night shift 7pm to 7am and second nurse was called in to work as CNA staff but was older and not physically able and was passing medications working as nurse.During an interview on 2/27/26 at 10:58 am NHA reported did not have any concern forms for R105 and verified no care concern forms for R110, R111, R112, or R113 in past 30 days and no additional allegations of abuse over the weekend.During an interview on 2/27/26 at 11:10 NHA A reported no knowledge of three resident who remained up all shift on night shift 2/21/26 into 2/22/26. NHA A reported would expect staff to report concerns to management staff including allegations abuse/neglect immediately to NHA A or DON and complete grievance forms for residents if necessary.During a telephone interview on 2/27/26 at 12:48 p.m., facility Scheduler BB reported no longer worked at the facility as of today. Scheduler BB reported to NHA A that was unable to fill schedule at least every other weekend and up to 3 times weekly. Scheduler BB reported attempted to have at least four to five CNA staff and 2 nurses on days on each floor and was told by NHA A to just add transportation staff CC and Medical Record staff DD to schedules and advise to get with Director of Nursing B who reported to call staff. Scheduler BB reported DON B was informed after all attempts had been made to fill schedule including call staff and no one would come in with no support. Scheduler BB reported often completed concern form related to care concerns not being met and staffing at least two times weekly and provide to NHA A and DON B. Scheduler BB reported also report concern to management who shake heads and advise to speak with another manager.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to thoroughly investigate allegations of abuse for four residents (R107, R111, R112, R113) of seven reviewed.Findings include:Resident #107 (R107)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/10/26, reflected R107 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included severe morbid obesity, cervical disc degeneration, muscle wasting and atrophy, major depression and anxiety. The MDS reflected that R107 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for transfers, showering and toileting.During an interview on 2/19/26 at 8:45 a.m., Nursing Home Administrator (NHA) A reported had been employed at the facility for about five months. This surveyor requested all allegations of abuse for review for past 30 days. NHA A reported R107 recently alleged no care for 14 hours and was not reported because determined did not happen prior to two hours.During an interview and record review on 2/19/26 at 11:34 a.m., Director of Nursing (DON) C reported had additional staff interview statements for R107 allegation of abuse provided and had additional to provide. Provided with 3 staff interviews.Review of R107 concern form, 2/16/26, for care concern from 2/14/26. The form indicated concerns were reported during a care conference that included, R107 was left 14 hours with no staff checking on resident (allegation of neglect), not enough staff, told resident had to go to bed. Continued review of form reflected facility response included, reviewed by management staff in facility at the time who had spoken with staff who reported had gotten R107 up multiple times and changed when needed. The form reflected action taken was investigation complete and educated staff (no evidence provided including no evidence allegation of neglect was reported to State of Michigan). Form signed by NHA A 2/23/26. Provided witness statements received 2/26/26, did not include evidence of dates or times.Review of R107 Electronic Medical Record, dated 2/14/26, reflected no evidence to support R107s allegation of neglect did not occur. During an observation and interview on 2/20/26 at 12:15pm, R107 was sitting in room in recliner and appeared calm, pleasant and able to answer questions without difficulty. R107 reported staff often want to transfer R107 into bed early and R107 reported does not want to around 730 pm and stated that was too early. R107 reported facility had staffing issues with not enough staff to meet resident needs timely including on nights that is why staff try to put residents to bed before leaving day shift around 7:00 p.m. R107 reported staff had assisted her transfer to bed around 11-1130 pm one night and staff were unable to get R107 up until after 3:00 p.m. next day because it takes two staff to use mechanical lift. R107 reported when that incident occurred reported to staff that she was unhappy with long length of time soiled brief and reported recent skin breakdown with no follow up. Resident #111(R111)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 1/20/26, reflected R111 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included multiple sclerosis, functional quadriplegia, and anxiety. The MDS reflected that R110 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was intact, and she required maximum to moderate staff assist for toileting, bathing and dependent on staff for transfers. Resident #112(R112)Review of the Face Sheet reflected R112 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included dementia and repeat falls.Review of R112 Care plans, dated 4/4/25, reflected R112 required two person assist with transfers, toileting and one person assist with showering and personal hygiene. Resident #113(R113)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/9/26, reflected R113 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chronic spinal pain, Alzheimer's disease, anxiety and depression. The MDS reflected that R113 had a BIM (assessment tool) score of 13 which indicated her ability to make daily decisions was intact, and she was dependent on staff for transfers, toileting and showers.During a telephone interview on 2/26/26 at 4:49 p.m. Certified Nurse Aid (CNA) W reported worked the past weekend and reported there were no CNA staff on Saturday night into Sunday night shift on second floor. CNA W reported R211 was not laid down entire night shift and grievance form was completed for resident and given to the NHA A. CNA W reported R113 was also left up in chair all night and remained in the chair the following morning when day shift arrived. CNA W reported R112 was heavily soiled with urine and stool and required shower after being left up in chair entire 12 hour night shift. CNA W' reported no CNA staff arrived during the night shift or were present on Sunday morning when she arrived. CNA W reported two nurses were present on Saturday night shift. CNA W reported when one CNA is scheduled cannot perform every 2-hour check and changes timely for all residents, not enough staff. CNA W reported potential allegations of abuse related to care concerns were reported to nursing staff on 2/22/26 around 7:00 a.m.During an interview on 2/27/26 at 10:10 a.m., Licensed Practical Nurse (LPN) X verified no CNA staff worked Saturday 2/21/26 into 2/22/26 night shift on second floor. LPN X reported called on call manager, Prior Director of Nursing (PDON) B to inform and told to call Nurse Y to cover. LPN X reported Prior DON C never comes in to work if she is on call. LPN X reported CNA Z stayed over late 2/21/25 to get most residents to bed and left three residents up in chairs. LPN X reported same three residents remained up in chairs and with same clothing on upon return in morning for 7am day shift. LPN X reported management staff informed because potential allegation of neglect and resident care needs were not met. LPN X reported two nurses worked 2/21/26 into 2/22/26 night shift 7pm to 7am and second nurse was called in to work as CNA staff but was older and not physically able and was passing medications working as nurse.During an interview on 2/27/26 at 10:58 am NHA reported did not have any concern forms for R105 and verified no care concern forms for R110, R111, R112, or R113 in past 30 days and no additional allegations of abuse over the weekend.During an interview on 2/27/26 at 11:10 NHA A reported no knowledge of three resident who remained up all shift on night shift 2/21/26 into 2/22/26. NHA A reported would expect staff to report concerns to management staff including allegations abuse/neglect immediately to NHA A or DON and complete grievance forms for residents if necessary.During a telephone interview on 2/27/26 at 12:48 p.m., facility Scheduler BB reported no longer worked at the facility as of today. Scheduler BB reported to NHA A that was unable to fill schedule at least every other weekend and up to 3 times weekly. Scheduler BB reported attempted to have at least four to five CNA staff and 2 nurses on days on each floor and was told by NHA A to just add transportation staff CC and Medical Record staff DD to schedules and advise to get with Director of Nursing B who reported to call staff. Scheduler BB reported DON B was informed after all attempts had been made to fill schedule including call staff and no one would come in with no support. Scheduler BB reported often completed concern form related to care concerns not being met and staffing at least two times weekly and provide to NHA A and DON B. Scheduler BB reported also report concern to management who shake heads and advise to speak with another manager. Review of the facility, Abuse Prohibition Policy, dated 9/9/22, reflected, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the guests/residents. Allegations of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative.Staff members, volunteers, family members, and others shall immediately report incidents of abuse and suspected abuse, and should be assured that they will be protected against repercussions. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a guest/resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware, or should have been aware of, goods or services that a guest/resident(s) requires but the facility fails to provide them to the guest(s)/resident(s), resulting in physical harm, pain, mental anguish or emotional distress.

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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 give the bed hold policy, transfer/discharge paperwork to one of one resident (R106) as he was transferred to the hospital with a change in condition.Findings Include;Resident #106 R106Review of the medical record reflected that R106 was admitted to the facility on [DATE]. Diagnoses of Pneumonitis due to inhalation of food and vomit, severe protein-calorie malnutrition, non-pressure related ulcers in the lower extremities, Dementia and peripheral vascular disease.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/11/2026 revealed R106 had a Brief Interview of Mental Status (BIMS) of 03 (Severe cognitive impact) out of 15.Under section G0100, Activities of Daily Living (ADL) Assistance reveals R106 needed substantial assistance with showering and personal care. R106 was dependent on toileting and perineal hygiene.During an interview on 02/24/2026 at 10:15 AM, R106's family member M stated R106 was only at that facility for three weeks and he didn't have a call light that worked, they said they would work on it, but it still didn't work. R106's family member M stated they gave R106 a bell to ring if he needed help, but nobody could hear this bell, so what's the sense in that. R106's family member M stated she wasn't sure R106 knew how to use it. Record review revealed a nursing progress note regarding the non-working call light. Nursing Progress Note dated 01/11/2026 at 4:34PM .Resident's wife was upset that patient's call light did not work and the bell that he was given to call for assistance with was not loud enough because resident was at the end of the hall. Received permission to move resident into room [ROOM NUMBER]-2, with working call light and closer to the nurse's station. Wife stated, He has received the worst care here She was worried about his safety and stated it was neglectful that no one could hear when he needed help. Spoke with wife and she was upset about someone stating it was fixed on Friday, and it was not. She seemed to calm down after the room change and staff responding to all requests. Notified DON and Unit Manager.During an interview on 02/24/2026 at 10:15 AM, R106's family member M stated she questioned a change in his condition due to him responding a little differently than usual. R106's female nurse LPN E told her R106 wasn't dying. R106's family member M asked LPN E if he/R106 should go to the hospital, LPN E stated they wouldn't do anything for him but send him back to the facility. R106's family member M stated he/R106 was showing signs of decline, told staff they needed to check his vital signs. R106 seemed to have perked back up a little, so R106's family member M ended her visit with R106 and went home for the day.During this same interview on 02/24/2026 at 10:15 AM, R106's family member M stated the hospital called her to let her know that her husband was there and he had been there a couple of hours. R106's family member M stated the facility did not call her with this change in condition, she had checked her cell phone and home landline, no calls from the facility, no message left. R106's family member M stated she was very upset over this especially after her asking LPN E if he should had been sent in earlier that day.During an interview on 02/24/2026 at 11:30 AM, Licensed Practical LPN E stated she had been a rehire employee and had been there approximately 6 weeks. Writer asked LPN E to describe in detail how R106 was while in her care the night he was sent to the emergency room. LPN E stated R106 was good, stated he was alert to person, place and time, he was a nice gentleman, had wounds on his legs. LPN E stated earlier that day R106 was fine, around dinner time he was not fine, she got his vital signs, he was not stable, she hooked R106 up to oxygen and called 911. LPN E stated he was not alert, nor talkative, she went back down to R106's room, but once EMS got there, she left his room. LPN E stated R106's wife had left midafternoon, stated she called his wife. LPN E stated she sent the transfer/discharge paperwork with the resident to the hospital, and documented it in the nursing (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress notes, then stated she don't know if she had done that or not. LPN E then stated maybe they didn't send it, then stated it was kind of crazy at that time and it was the end of her shift. Writer asked if she called the provider about this change in condition, stated she couldn't remember. Writer asked if she had documented all the events that took place during this change in condition for R106, LPN E stated I think so and left at the end of her shift.Record review of the nursing progress notes did not reflect that LPN E had called the primary provider nor the on call provider was notified of this emergency, prior to LPN E leaving at the end of her shift while EMS was still in house. Nor did it reflect that R106 had been given the bed hold policy, transfer/discharge paperwork.During an interview on 02/20/26 at 2:49 PM, Registered Nurse (RN)/Unit Manager F Stated the nurses send the bed hold policy, transfers/discharge paperwork with the resident, then stated they should be documenting it in the nursing progress notes, but obviously they didn't as she looked through the nursing progress notes the date and time he was sent out.During an interview on 02/20/26 at 3:10 PM, Social Worker H stated she thought she did some of those, unsure as she described an unplanned discharge and her role in those. Social Worker H stated she did not see a progress note in his chart, then stated when she did the bed hold/transfer/discharge paperwork, she puts her progress note under regular progress note tab. Writer asked if R106's wife was notified that he was being sent out to the hospital, and she stated it didn't look like it.During an interview 02/24/2026 at 11:54 AM, prior Director of Nursing (DON) B stated R106's wife stopped her and told her she had concerns on his/R106's care, transferring him to the bathroom, was given the call light, dropped the call light, CNA didn't realize he had dropped the call light, went in right away after that. Prior DON B stated by the time the wife brought her the concerns, he was off the toilet and cleaned up. Writer asked prior DON B if she had filled out a grievance form, stated she didn't fill out a grievance or concern form, but informed wife that she could fill one out. Writer aske prior DON B about his call light being put in the dresser drawer out of his reach to use. Prior DON B stated she assumed it was put in the drawer at some point, moved out of the way for care but doesn't really know, but didn't follow up so to speak. Prior DON B stated she would stop in on rounds and didn't see where his call light was not available. Writer asked prior DON B if she was notified of the change in condition on R106 prior to sending him out to the hospital, prior DON B stated she didn't get an update until after they sent him out, after the fact. Prior DON B stated they did talk to the nurse about the course of events that took place and what could they have done differently.

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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 comprehensive care plans were in place for two out nine residents (Residents 104 & 108) related to leave of absence (LOA).Findings Included:Resident #104 (R104):Per the facility face sheet R104 was admitted to the facility on [DATE]. Record review of a Determination to Leave the Facility Against Medical Advice not dated, revealed R104 was not cleared by the Physician to be allowed to leave the facility due to being a high risk for an accident, falls, or other acute illness/condition as a result of being outside of the facility unsupervised, which may result in a serious negative health outcome. R104 signed the document with the understanding of any consequences. The signed document also revealed under number 5) The resident (R104) had participated in care planning related to his/her decision to leave the facility unsupervised and agrees to abide by the plan of care. The resident is aware that the plans of care will be reviewed periodically and may be revised at any time. Lastly the document revealed R104 was his own person and not deemed incompetent. Review of R104's care plans revealed there was no care plan in place for R104's decision to leave the facility against medical advice (AMA) or go on leave of absence (LOA). There was no documentation that R104 had participated in care planning related to his decision to go AMA or on a LOA.Review of the most recent Interdisciplinary Team (IDT) meeting notes dated 10/23/2025 revealed no discussion related to R104's decision to go on LOA against medical advice and/or regarding the form he had signed. There was no documented discussion of care planning. Resident #108 (R108):Per the facility face sheet Resident #108 (R108) was admitted to the facility on [DATE].Record review of a Minimum Data Set (MDS) dated [DATE], revealed R108 had a Brief Interview of Mental Status (BIMS) score of 13 out of 15 which indicated R108 cognition was intact.Review of LOA sign out sheets revealed R108 frequently left the faciity on LOA. Review of IDT notes dated 12/29/2025 revealed no discussion regarding R108 going on LOA and evaluation of safety.Review of R108's care plans revealed no care plan in place that addressed R108's LOA and safety interventions and assessments. In an interview on 2/25/2026 at 2:10 PM, Director of Nursing (DON) C stated she did not find an evaluation for R108's ability to go on LOA and said she did not find any documentation from IDT for R108's LOA ability. DON C stated that her expectation was that an evaluation and care planning be completed for a resident who goes LOA.Review of the facility's policy and procedure dated 11/16/2022; revealed, A corresponding care plan shall also be developed and initiated. The care plan shall address any applicable clinical issues such as the Resident's possible need for medication(s) during leaves, education related to the administration of such medication, and possible dietary issues during leaves. Any other potential concerns or problems should also be addressed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2747784, 2727148, 2724902, 2720062Based on observation, interview, and record review the facility failed to ensure seven out of seven residents (R105, R106, R107, R110, R111, R112, R113) received activities of daily living (ADL) care per the plan of care. Findings Included:Resident #107 (R107) Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/10/26, reflected R107 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included severe morbid obesity, cervical disc degeneration, muscle wasting and atrophy, major depression and anxiety. The MDS reflected that R107 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for transfers, showering and toileting. During an observation and interview on 2/20/26 at 12:15pm, R107 was sitting in room in recliner and appeared calm, pleasant and able to answer questions without difficulty. R107 reported staff often want to transfer R107 into bed early and R107 reported does not want to around 730 pm and stated that was too early. R107 reported facility had staffing issues with not enough staff to meet resident needs timely including on nights that is why staff try to put residents to bed before leaving day shift around 7:00 p.m. R107 reported staff had assisted her transfer to bed around 11-1130 pm one night and staff were unable to get R107 up until after 3:00 p.m. next day because takes two staff to use mechanical lift. R107 reported when that incident occurred reported to staff that she was unhappy with long length of time soiled brief and reported recent skin breakdown with no follow up. Review of R107 concern form, 2/16/26, for care concern from 2/14/26. The form indicated concerns were reported during a care conference that included, R107 was left 14 hours with no staff checking on resident (allegation of neglect), not enough staff, told resident had to go to bed. Continued review of form reflected facility response included, reviewed by management staff in facility at the time who had spoken with staff who reported had gotten R107 up multiple times and changed when needed. The form reflected action taken was investigation complete and educated staff (no evidence provided including no evidence allegation of neglect was reported to State of Michigan). Form signed by NHA A 2/23/26. Provided witness statements received 2/26/26, did not include evidence of dates of times. Review of R107 Electronic Medical Record, dated 2/14/26, reflected no evidence to support R107s allegation of neglect did not occur. Resident #105(R105) Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 1/9/26, reflected R105 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included cerebral vascular event(stroke) effecting right dominate side and depression. The MDS reflected that R105 had a BIM (assessment tool) score of 11 which indicated her ability to make daily decisions was moderately impaired, and she was dependent on staff for transfers, bed mobility, hygiene, dressing, showering and toileting. During an observation and interview on 2/20/26 at 12:37 pm, R105 was observed in bed in room. R105 appeared to have difficulty expressing words and able to clearly answer yes, no questions. R105 verified had care concerns, not enough staffing to meet resident needs, call light response times and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lack of dignity and respect. Review of R105 tasks report, dated 2/1/26 through 2/26/26, reflected multiple holes with no documentation of care provided including hygiene, activities of daily living, toileting and several missed showers. During an observation and interview on 2/27/26 at 10:23 a.m., R105 family could be overheard in room with raised voices that appeared upset. LPN X entered room and R105 family member reported sheets soiled and resident leaning in bed almost falling out. R105 family AA reported was R105 daughter and does not like to visit because causes her to get upset and stated, Every time, every time. R105 family AA reported speaks with staff about R105 care concerns every time she visits and nothing every changes and was not aware of concern form process. Resident #110(R110) Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/3/26, reflected R110 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included respiratory failure, post-traumatic stress disorder, anxiety and depression. The MDS reflected that R110 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was intact, and she required maximum to moderate assist from staff for toileting and bathing. During an interview on 2/20/26 at 1246 pm, observed R110 in bed appeared reported complaint that had not received shower for two weeks, and then several weeks prior to that. R110 reported had reported several complaints to staff and concern form completed without follow-up or improvement. Review of R110 task reports, dated 1/1/26 through 2/26/26, reflected multiple holes with no documentation of care provided including hygiene, activities of daily living, toileting and several missed showers. Further review reflected that R110 had received one shower in past 2 months. Resident #111(R111) Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 1/20/26, reflected R111 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included multiple sclerosis, functional quadriplegia, and anxiety. The MDS reflected that R110 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was intact, and she required maximum to moderate staff assist for toileting, bathing and dependent on staff for transfers. Resident #112(R112) Review of the Face Sheet reflected R112 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included dementia and repeat falls. Review of R112 Care plans, dated 4/4/25, reflected R112 required two person assist with transfers, toileting and one person assist with showering and personal hygiene. Resident #113(R113) Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/9/26, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected R113 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included chronic spinal pain, Alzheimer's disease, anxiety and depression. The MDS reflected that R113 had a BIM (assessment tool) score of 13 which indicated her ability to make daily decisions was intact, and she was dependent on staff for transfers, toileting and showers. During a telephone interview on 2/26/26 at 4:49 p.m. Certified Nurse Aid (CNA) W reported worked the past weekend and reported there were no CNA staff on Saturday night into Sunday night shift on second floor. CNA W reported R111 was not laid down entire night, and grievance form was completed for resident and given to the NHA A. CNA W reported R113 was also left up in chair all night and remained in the chair the following morning when day shift arrived. CNA W reported R112 was heavily soiled with urine and stool and required shower after being left up in chair entire 12 hour night shift. CNA W' reported no CNA staff arrived during the night shift or were present on Sunday morning when she arrived. CNA W reported two nurses were present on Saturday night shift. CNA W reported when one CNA is scheduled cannot perform every 2-hour check and change timely for all residents, not enough staff. CNA W reported potential allegations of neglect related to care concerns and condition of resident were reported to nursing staff on 2/22/26 around 7:00 a.m. During an interview on 2/27/26 at 10:10 a.m., Licensed Practical Nurse (LPN) X verified no CNA staff worked Saturday 2/21/26 into 2/22/26 night shift on second floor. LPN X reported called on call manager, Prior Director of Nursing (PDON) B to inform and told to call Nurse Y to cover. LPN X reported Prior DON C never comes in to work if she is on call. LPN X reported CNA Z stayed over late 2/21/25 to get most residents to bed and left three residents up in chairs. LPN X reported same three residents remained up in chairs and with same clothing on upon return in morning for 7am day shift. LPN X reported management staff informed because potential allegation of neglect and resident care needs were not met. LPN X reported two nurses worked 2/21/26 into 2/22/26 night shift 7pm to 7am and second nurse was called in to work as CNA staff but was older and not physically able and was passing medications working as nurse. During an interview on 2/27/26 at 10:58 am NHA reported did not have any concern forms for R105 and verified no care concern forms for R110, R111, R112, or R113 in past 30 days. During an interview on 2/27/26 at 11:10 NHA A reported no knowledge of three resident who remained up all shift on 2/21/26 evening. NHA A reported would expect staff to report concerns to management staff including allegations abuse/neglect immediately to NHA A or DON and complete grievance forms for residents if necessary. During a telephone interview on 2/27/26 at 12:48 p.m., facility Scheduler BB reported no longer worked at the facility as of today. Scheduler BB reported to NHA A that was unable to fill schedule at least every other weekend and up to 3 times weekly with at least four to five CNA staff and 2 nurses on days on each floor and was told by NHA A to just add transportation staff CC and Medical Record staff DD to schedules and advise to get with Director of Nursing B who reported to call staff. Scheduler BB reported DON B was informed after all attempts had been made to fill schedule including call staff and no one would come in with no support. Scheduler BB reported often completed concern form related to care concerns not being met and staffing at least two times weekly and provide to NHA A and DON B. Scheduler BB reported also report concern to management who shake heads and advise to speak with another manager. During an interview on 2/27/26 at 2:30 p.m., DON C reported 12 residents require assist of two with care needs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #106 R106 Review of the medical record reflected that R106 was admitted to the facility on [DATE]. Diagnoses of Pneumonitis due to inhalation of food and vomit, severe protein-calorie malnutrition, non-pressure related ulcers in the lower extremities, Dementia and peripheral vascular disease. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/11/2026 revealed R106 had a Brief Interview of Mental Status (BIMS) of 03 (Severe cognitive impact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R106 needed substantial assistance with showering and personal care. R106 was dependent on toileting and perineal hygiene. During an interview on 02/20/2026 at 2:40 PM, Certified Nursing Assistance (CNA) G stated they serve water to the residents when they ask or during each shift, there should be dates and times on the foam cups. Writer asked CNA G if they had enough staff to provide the care to those residents. CNA G stated all they can do it go one room at a time, and she had to decide if she was going to pass lunch trays or care for residents. During an interview on 02/24/2026 at 10:15 AM, R106's family member M stated R106 was only at this facility three weeks. R106's family member M stated R106 had not received showers but one time during his stay. He had a pull up on and would pull on the side of it so he could pee in the urinal. He/R106 would ask to go poop, and he couldn't go on a bed pan, she told them he would go on a commode, so they didn't, they brought him the bed pan. R106's family member H added that they finely took him into the bathroom to sit on the toilet, his call light was behind him and he couldn't reach it. He sat on the toilet and yelled for someone to come in help him. Staff told him to use the call light, but he couldn't reach the light, so he had to yell out for help. Finally, someone came in to help him get off the toilet. Record review revealed R106 was scheduled to receive showers every Wednesday and Saturday morning. The completed task sheet revealed R106 did not receive a shower on 01/07/2026 with no reason given for not providing this shower. Record revealed R106 refused a shower on 01/10/2026 but did not provide an explanation or any additional attempts to shower him that day. The completed task sheet revealed R106 did not receive a shower on 01/14/2026, with no reason given for not providing this shower. The completed task sheet revealed R106 received a shower on 01/21/2026. R106 was not offered a shower on 01/17/2026 or on 01/24/2026. R106 received one shower during his three weeks stay at the facility. During an interview on 02/24/2026 at 2:30 PM, Director of Nursing (DON) B stated her expectations would be that the CNAs ask the residents once, if they decline or refuse, have another CNA go in and ask if they could give him a shower, it they still say no, then let the nurse know. Record review did not reveal any documentation as to why the showers were not given, no documentation to support they had asked more than once, nor supporting documentation supporting the CNAs told the nurse they were not able to shower R106 on one of his scheduled days.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure for one out of three residents (R108) an evaluation was completed to determine ability for leave of absence (LOA).Findings Included:Per the facility face sheet Resident #108 (R108) was admitted to the facility on [DATE].Record review of a Minimum Data Set (MDS) dated [DATE], revealed R108 had a Brief Interview of Mental Status (BIMS) score of 13 out of 15 which indicated R108 cognition was intact.During an interview with R108 on 2/25/2026 at 12:02 PM, R108 was observed lying in bed and answered all questions appropriately.Per progress notes dated 2/11/2026, R108 had signed out LOA with another resident, and upon returning to the facility R108 did not use the crossed walk to cross back over the street. Upon crossing the street, R108 was struck by a vehicle that was aggressively driving over the speed limit. R108 was found to have fractured spleen, rib, and laceration of the scalp. Record review of a care plan dated 10/25/2026, revealed a care plan was in place that identified R108's impaired visual function, related to visual changes as result from stroke. The care plan did not have any interventions that addressed R108's LOA for safety with visual impairment.Per the facility policy and procedure dated 11/16/2022 and titled, Resident Leave of Absence Policy, .The nature of the environment and individual associations related to the leave should also be considered. Affected Residents should be evaluated regarding such abilities at admission, quarterly, upon a significant change in condition, and following any new developments that may warrant a change in the findings of the evaluation.In an interview on 2/25/2026 12:20 PM, Social Worker N (SW) stated that she had heard that staff had to know if a resident was safe to go out on LOA as their own responsible person. SW N said she would imagine that there was an assessment form that was used. SW N said she had never seen an assessment form, nor had she ever performed an assessment on a resident. Record review of R108's electronic medical record (EMR) revealed there was one Interdisciplinary Team (IDT) meeting on 11/11/2025, however the meeting notes did not address R108's LOA and did not evaluate R108's ability to go on an LOA safely.In an interview on 2/25/2026 at 2:10 PM, DON B upon review of R108's EMR, stated that she was not able to find an evaluation for LOA ability for R108. DON B stated that it was her expectation that the policy be followed, and an IDT meeting be held where an evaluation for LOA ability was completed.No IDT meeting or evaluation for R108's LOA ability was conducted or found in R108's EMR after the 2/11/2026 accident.

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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** This citation pertains to intake: 2740492, 2724902, 2747784, 2720062Based on observation, interview, and record review, the facility failed to ensure adequate staff to meet the resident needs for 7 residents (R105, R107, R110, R111, R112, R113) reviewed for staffing, resulting in resident care and needs not being consistently met and the potential for negative outcomes for all residents.Findings include:Resident #107 (R107)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/10/26, reflected R107 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included severe morbid obesity, cervical disc degeneration, muscle wasting and atrophy, major depression and anxiety. The MDS reflected that R107 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for transfers, showering and toileting.Review of R107 concern form, 2/16/26, for care concern from 2/14/26. The form indicated concerns were reported during a care conference that included, R107 was left 14 hours with no staff checking on resident (allegation of neglect), not enough staff, told resident had to go to bed. Continued review of form reflected facility response included, reviewed by management staff in facility at the time who had spoken with staff who reported had gotten R107 up multiple times and changed when needed. The form reflected action taken was investigation complete and educated staff (no evidence provided including no evidence allegation of neglect was reported to State of Michigan). Form signed by NHA A 2/23/26. Provided witness statements received 2/26/26, did not include evidence of dates of times.Review of R107 Electronic Medical Record, dated 2/14/26, reflected no evidence to support R107s allegation of neglect did not occur. During an observation and interview on 2/20/26 at 12:15pm, R107 was sitting in room in recliner and appeared calm, pleasant and able to answer questions without difficulty. R107 reported staff often want to transfer R107 into bed early and R107 reported does not want to around 730 pm and stated that was too early. R107 reported facility had staffing issues with not enough staff to meet resident needs timely including on nights that is why staff try to put residents to bed before leaving day shift around 7:00 p.m. R107 reported staff had assisted her transfer to bed around 11-1130 pm one night and staff were unable to get R107 up until after 3:00 p.m. next day because takes two staff to use mechanical lift. R107 reported when that incident occurred reported to staff that she was unhappy with long length of time soiled brief and reported recent skin breakdown with no follow up. Resident #105(R105)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 1/9/26, reflected R105 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included cerebral vascular event(stroke) effecting right dominate side and depression. The MDS reflected that R105 had a BIM (assessment tool) score of 11 which indicated her ability to make daily decisions was moderately impaired, and she was dependent on staff for transfers, bed mobility, hygiene, dressing, showering and toileting.During an observation and interview on 2/20/26 at 12:37 pm, R105 was observed in bed in room. R105 appeared to have difficulty expressing words and able to clearly answer yes, no questions. R105 verified had care concerns, not enough staffing to meet resident needs, call light response times and lack of dignity and respect.Review of R105 tasks report, dated 2/1/26 through 2/26/26, reflected multiple holes with no documentation of care provided including hygiene, activities of daily living, toileting and several missed showers. During an observation and interview on 2/27/26 at 10:23 a.m., R105 family could be overheard in room with raised voices that appeared upset. LPN X entered room and R105 family member reported sheets soiled and resident leaning in bed almost falling out. R105 family AA reported was R105 daughter and does not like to visit because (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	causes her to get upset and stated, Every time, every time. R105 family AA reported speaks with staff about R105 care concerns every time she visits and nothing every changes and was not aware of concern form process. Resident #110(R110)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/3/26, reflected R110 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included respiratory failure, post-traumatic stress disorder, anxiety and depression. The MDS reflected that R110 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was intact, and she required maximum to moderate assist from staff for toileting and bathing.During an interview on 2/20/26 at 1246 pm, observed R110 in bed appeared reported complaint that had not received shower for two weeks, and then several weeks prior to that. R110 reported had reported several complaints to staff and concern form completed without follow-up or improvement. Review of R110 task reports, dated 1/1/26 through 2/26/26, reflected multiple holes with no documentation of care provided including hygiene, activities of daily living, toileting and several missed showers. Further review reflected that R110 had received one shower in past 2 months. Resident #111(R111)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 1/20/26, reflected R111 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included multiple sclerosis, functional quadriplegia, and anxiety. The MDS reflected that R110 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was intact, and she required maximum to moderate staff assist for toileting, bathing and dependent on staff for transfers. Resident #112(R112)Review of the Face Sheet reflected R112 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included dementia and repeat falls.Review of R112 Care plans, dated 4/4/25, reflected R112 required two person assist with transfers, toileting and one person assist with showering and personal hygiene. Resident #113(R113)Review of the Face Sheet and Minimum Data Set (MDS), with Assessment Reference Date, dated 2/9/26, reflected R113 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included chronic spinal pain, Alzheimer's disease, anxiety and depression. The MDS reflected that R113 had a BIM (assessment tool) score of 13 which indicated her ability to make daily decisions was intact, and she was dependent on staff for transfers, toileting and showers.During a telephone interview on 2/26/26 at 4:49 p.m. Certified Nurse Aid (CNA) W reported worked the past weekend and reported there were no CNA staff on Saturday night into Sunday night shift on second floor. CNA W reported R111 was not laid down entire night, and grievance form was completed for resident and given to the NHA A. CNA W reported R113 was also left up in chair all night and remained in the chair the following morning when day shift arrived. CNA W reported R112 was heavily soiled with urine and stool and required shower after being left up in chair entire 12 hour night shift. CNA W' reported no CNA staff arrived during the night shift or were present on Sunday morning when she arrived. CNA W reported two nurses were present on Saturday night shift. CNA W reported when one CNA is scheduled cannot perform every 2-hour check and change timely for all residents, not enough staff. CNA W reported potential allegations of neglect related to care concerns and condition of resident were reported to nursing staff on 2/22/26 around 7:00 a.m.During an interview on 2/27/26 at 10:10 a.m., Licensed Practical Nurse (LPN) X verified no CNA staff worked Saturday 2/21/26 into 2/22/26 night shift on second floor. LPN X reported called on call manager, Prior Director of Nursing (PDON) B to inform and told to call Nurse Y to cover. LPN X reported Prior DON C never comes in to work if she is on call. LPN X reported CNA Z stayed over late 2/21/25 to get most residents to bed and left three residents up in chairs. LPN X reported same three residents remained up in chairs and with same clothing on upon return in morning for 7am day shift. LPN X reported management staff informed because potential (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	allegation of neglect and resident care needs were not met. LPN X reported two nurses worked 2/21/26 into 2/22/26 night shift 7pm to 7am and second nurse was called in to work as CNA staff but was older and not physically able and was passing medications working as nurse.During an interview on 2/27/26 at 10:58 am NHA reported did not have any concern forms for R105 and verified no care concern forms for R110, R111, R112, or R113 in past 30 days.During an interview on 2/27/26 at 11:10 NHA A reported no knowledge of three resident who remained up all shift on 2/21/26 evening. NHA A reported would expect staff to report concerns to management staff including allegations abuse/neglect immediately to NHA A or DON and complete grievance forms for residents if necessary.During a telephone interview on 2/27/26 at 12:48 p.m., facility Scheduler BB reported no longer worked at the facility as of today. Scheduler BB reported to NHA A that was unable to fill schedule at least every other weekend and up to 3 times weekly with at least four to five CNA staff and 2 nurses on days on each floor and was told by NHA A to just add transportation staff CC and Medical Record staff DD to schedules and advise to get with Director of Nursing B who reported to call staff. Scheduler BB reported DON B was informed after all attempts had been made to fill schedule including call staff and no one would come in with no support. Scheduler BB reported often completed concern form related to care concerns not being met and staffing at least two times weekly and provide to NHA A and DON B. Scheduler BB reported also report concern to management who shake heads and advise to speak with another manager. During an interview on 2/27/26 at 2:30 p.m., DON C reported 12 residents require assist of two with care needs.

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 prepare and serve food in sanitary conditions resulting in an Immediate Jeopardy due to the likelihood of foodborne illnesses to affect 72 resident who ate meals out of the kitchen.Findings Included:During an observation on 2/19/26 at 8:42 a.m., garden hoses were observed coming from an open Dinng Room window to drain located near main entrance of the facility with what appeared to be water coming from the hose. Plumbing contractor van was parked in front of the Dining Room window. After entering the facility very loud sound of what sounded like jack hammering could be heard on the ground floor. During an interview on 2/19/26 at 8:45 a.m., Nursing Home Administrator (NHA) A reported had been employed at the facility for about five months. NHA A reported facility had recent water line break underground in the kitchen and started work this week Monday (2/16/26). NHA A reported the repair estimate was two days and reported need to extend time frame because contractors now need to dig up lines to the laundry as of today. HNA A reported temporary barrier walls were placed in the kitchen to contain area of repair. During an observation and interview on 2/19/26 at 10:35 a.m., upon entering main dining room table and carts were located around perimeter of dining room with no resident dining areas available. Table had kitchen items stacked on them and dry storage food was present on several carts. Garden hoses were observed coming from the kitchen, across the dining room floor and out an open window duct taped to the floor. Certified Dietary Manager (CDM) O reported had worked at the facility for about two weeks. Observed dietary staff holding kitchen door open with garden hoses duct taped to kitchen floor alongside tray line steam table. The garden hoses were observed coming from behind an area in the center of the kitchen that had temporary unsecured plastic walls hanging with loose dirt piles exposed on the floor located directly next to the tray service steam table and stovetop/overhead ventilation system. Dietary staff was observed prepping desserts on small table located in kitchen near dining room door. The kitchen floors appeared heavily soiled with boot prints through kitchen. CDM O reported contractors plan to expand hole in kitchen floor today so all refrigerator/freezer/dry storage items had to be removed because area of floor digging would block those areas. Continued tour of kitchen revealed several large open areas in temporary plastic walls with large holes in kitchen floor (about 4 feet deep and about 20 feet long), exposed plumbing, large piles of dirt, broken tile/concrete, and rocks. Observed a heavily soiled wheelbarrow and contractor equipment located near the three-compartment sink, reach in coolers, food warmer and several carts of dishes. CDM O reported had been serving resident meals on disposable dishes since Monday from kitchen and planned to wash all the uncovered dishes in kitchen prior to use after kitchen construction. Contractor was observed standing in about 4-foot-deep hole in ground actively digging dirt in office, located inside kitchen, with door open to kitchen with several large piles of dirt about 2-3 feet high. CDM O reported was currently working on moving items out of dry storage and door was open, located about 6-10 feet from contractor digging in floor with no barriers in place. Continued tour revealed several prepped and wrapped silverware located on steam table, directly next to plastic barrier on tray line (within 2 feet of large hole in kitchen floor and exposed piles of dirt on the floor). Several cardboard boxes of disposable meal service items directly on kitchen floor near tray line area. During an observation on 2/19/26 at 11:37 a.m., Observed dietary staff serving food from steam table located in kitchen, directly next to unsecured temporary plastic barrier with large hole in kitchen floor and exposed dirt piles, concrete debris, rocks and wastewater. Observed contractor staff walk past tray line steam table during tray line prep. Verified menu served on disposable dishware was (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	glazed ham, potatoes, veggie collards, dinner roll, pudding with topping. Observed soiled blender in dining room, located on dining room table directly next to personal drinks and soiled towel. In an interview on 2/19/2026 at 2:09 PM, Certified Dietary Manager (CDM) O stated on 2/16/2026 at about 8:00 AM, after the breakfast meal was served, the first hole was dug in the floor around where the steamer (cooking appliance) sat. CDM O said all further meals after breakfast continued to be prepped and served in the kitchen next to where the hole in the floor was being dug. During the interview it was observed that the tray line (where the food was placed to keep it warm and be served onto plates) was next to a plastic barrier wall which was not sealed tight to the wall, having several openings. Mounds of dirt were observed to be piled up alongside the open hole, with some dirt seeping outside of the plastic barrier wall into the area where the food was being prepared. CDM O stated that with the digging and the dirt, the floor in the food prep area was hard to keep clean. The refrigerators were observed to be in the back of the kitchen which was beyond the barrier and passed by the large hole, and per CDM O food had been taken back and forth from the two refrigerators from the time the hole was dug at approximately 8:00 AM on Monday 2/16/2026, risking the chance and having the likelihood of pathogen contamination. In an interview on 2/19/2026 at 2:00 PM, Dietary Aid (DA) P stated that the kitchen floors were mopped between meals but were hard to keep clean because the plumbers walked through the food prep area all the time which tracked dirt in the food prep area. In an interview on 2/19/2026 at 2:43 PM Director of Nursing (DON) C stated that she agreed that if the wall barrier in the kitchen around the hole was broke open there was the risk of pathogens contaminating the food, and when the residents eat the food, they could become ill with most likely gastrointestinal (GI) illnesses. DON C stated that her expectations were that there be a sealed barrier and then food could have been prepared in the kitchen, but because the barrier was not sealed the food should not have been prepared in the kitchen but should have been taken out of the kitchen area. The Administrator was notified on 2/19/2026 at 12:06 PM of the Immediate Jeopardy that began on 2/16/2026 as a result of the facility's failure to prepare and serve food in sanitary conditions resulting in the likelihood of food borne illness for 74 residents who are food out of the facility's kitchen. In an interview on 2/20/2026 at 7:58 AM, Maintenance Director (MD) Q stated that the water had backed up in the laundry room and backed up under the three-compartment sink in the kitchen. MD Q said the drain had to be snaked out, and then when the laundry room drain was snaked out a broken pipe was found. MD Q said the pipes were rotted out, and the blockage was in the kitchen at the steamer and the tray line area. MD Q said the hole was dug starting on Monday 2/16/2026, and the plumbers put up the plastic prior to the digging which was next to the area of the food prep. MD Q stated that he did not verify that the plastic barrier wall was secured to prevent any containments over into the food prep area, nor did he check the barrier frequently to ensure the barrier was secure at all times. MD Q said the plumbers sealed the plastic. MD Q said the plumbers used a wet saw to break through the floor tiles but stated that does still cause dust. In an interview on 2/20/2026 at 11:32 AM the previous DON, DON B stated she was aware that the plumbers were digging a hole in the kitchen but did not know when it was going to start. DON B said she was fully aware that they were digging on 2/17/26 but did not go into the kitchen as she was under the impression that there was a barrier up. DON B said she had first entered the kitchen on 2/19/2026 (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	and was monitoring the barrier wall by verbalizing in the morning meetings that the barrier needed to stay secure, but stated she never checked the barrier wall and said no one else did either. DON B said she did not know that food was still being prepped in the kitchen next to the hole that was being dug and stated that she thought the food preparation had been moved out of the kitchen but stated that she did not check. DON B said she would expect that no food was to be prepared in the kitchen during the time of the pipe repair. DON B said she should have asked more questions. DON B said the pathogens that would be of concern were things like e-coli and that would affect the residents with GI problems, vomiting, and diarrhea. In another interview on 2/20/2026 at 12:05 PM, CDM O stated she looked at the barrier wall all the time but did not document that it was secure. CDM O said she was never asked about the barrier wall in morning meeting and said no one monitored that the barrier was always secure. From 2/16/2026, beginning with the lunch meal until 2/19/2026 ending with the lunch meal, 10 meals were served out of the kitchen during the time the barrier was up, and the hole was being dug in the kitchen. In an interview on 2/20/2026 at 12:17 PM, Administrator A stated she went into the kitchen after the barrier was put up and said she did see that the barrier was secure and closed, however never ordered that the food preparation be removed from the kitchen to a clean area. Administrator A said the barrier wall was discussed at all morning meetings and said she did not assign a staff member to check the barrier to assure that it was secured. The Administrator submitted a Plan of Correction to remove the Immediate Jeopardy on 2/19/2026. On 2/24/2026 the surveyor verified that the facility implemented the following to remove the Immediate Jeopardy: 2/13/26 Facility plans to use prepared food from US Food Vendor for upcoming meals; ordered and received from US food delivery today. This started on 2/13/2026 as a back-up plan. 2/13/26 Facility is using disposable paper products immediately. This was received in the facility on 2/12/2026 for back-up plan. 2/19/26 Facility discarded all lunch that was ordered for residents and lunch trays that were enroute to the units were stopped. Lunch was catered in for the residents. 2/19/26 Dietician and Medical Director were notified of the Immediate Jeopardy. 2/19/26 The kitchen immediately closed fir services. 2/19/26 The dining room next to the kitchen is being set up to be used as the temporary kitchen until the pipe work and construction are completed. The juice machine, coffee maker, steamer, steam table, tray line, prep area, and 3 compartment area, handwashing station are items being utilized in the temporary kitchen. 2/19/26 74/74 resident who eat meals were immediately assessed for food borne illness. 2/19/26 74/74 residents at risk for food borne illness. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2/19/26 Temporary refrigeration truck is at the building now and provides both freezer and refrigeration. 2/19/26 Electrician notified to inspect for correct plug for steamer to be used in temporary kitchen. They rewired to accommodate the steamer in the temporary kitchen and passed to use now in the temporary kitchen. 2/19/26 Steam table disinfected once it was removed from construction zone. 2/19/26 Hand washing station was delivered and is set up in the temporary kitchen While the Immediate Jeopardy was removed on 2/19/2026, the facility remained out of compliance at a scope of no actual harm with a potential for more than minimal harm that is not Immediate Jeopardy at scope and severity of widespread, due to the fact that sustained compliance has not been verified by the state agency.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number 2720063.Based on interview and record review the facility failed to ensure immunizations were administered for one out of three residents (Resident #108) who consented to receiving the Pneumococcal (PCV) and the Respiratory Syncytial Virus (RSV) vaccinations.Findings Included:Per the facility face sheet Resident #108 was admitted originally admitted to the facility on [DATE]; with a most recent admission date of 2/14/2026.Review of a consent form revealed R108 had signed the consent on 10/28/2025 to receive the vaccination.Review of a consent form revealed R108 had signed a consent on 10/28/2026 to receive the vaccination.Review of R108's electronic medical record (EMR) revealed under immunizations that the RSV and PCV20 immunizations were pending immunization with a confirmation date of 10/28/2025.Record review of R108's Physician orders for the month of October 2025 through 2/26/2026 revealed no Physician's order was ever written for either of the vaccinations to be administered.Review of Medication Administration Records (MARS) for the months of October through December 2025, and January and February 2026 revealed neither the PCV nor RSV vaccinations were documented on the MARS as administered to R108.In an interview on 2/26/2026 at 2:25 PM, Director of Nursing (DON) B stated that R108 did sign the consent forms for the RSV and PSV20 vaccinations, but after reviewing the October ad November 2025 MARS DON B said R108 never received the two vaccinations. DON B also reviewed R108's progress notes for the months of October and November 2025 and stated that there was no documentation of R108 receiving the two vaccinations, nor a note of the reason why R108 did not receive the two vaccinations.On 2/26/2026 at 3:23 PM, DON B stated that she was able to look into R108's 10/28/2025 consent for the PSV20 and RSV vaccination, and found the consents were signed by R108 on 10/28/2026, but the vaccinations were never administered. DON B said the vaccinations should have been administered to R108 because R108 requested them and signed consent.