| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235019 | A. Building<br>B. Wing | 04/16/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Jackson County Medical Care Facility | 524 Lansing Avenue<br>Jackson, MI 49201 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure proper storage and handling of food and disinfection of thermometers affecting up to 176 residents in the facility. Findings include:<br><br>An observation on 04/14/2026 at 8:53 AM revealed the walk-in refrigerator in the kitchen contained a container of cream of mushroom soup that was labeled as prepped on 4/7/26 and a use by date of 4/13/26 and a container of green beans that was labeled as prepped on 4/8/26 and a use by date of 4/13/26. Dietary Staff (DS) H reported the food items were past their use by date and discarded them.<br><br>On 04/14/2026 at 12:01 PM, DS K was asked to obtain temperatures of each food item being served in the main dining room. DS K removed a digital thermometer from their shirt pocket and placed the thermometer directly into the potato soup without first disinfecting the thermometer. DS K did disinfect the thermometer between each food item.<br><br>On 04/15/2026 at 12:15 PM, the 400 unit refrigerator was observed with numerous (over twenty) individual serving cups of cream cheese and whipped spread that were not labeled with an expiration date.<br><br>On 04/15/2026 at 12:23 PM, DS I was asked about the expiration date for the cream cheese and whipped spread cups. DS I was unable to locate an expiration date on any of the containers. DS I disposed of the items.<br><br>On 04/15/2026 at 11:38 AM, Dietary Supervisor F reported staff were to go through the food storage daily and discard any food past the use by date. Dietary Supervisor F reported thermometers should be disinfected with an alcohol swab prior to each use and bread should not be handled with bare hands.<br><br>During an observation on 04/14/2026 at 11:38 AM, Dietary Staff K was serving potato soup, egg salad sandwiches and tossed salads. Dietary Staff K went from making tossed salad, to scooping out potato soup in bowls, to touching the bread making egg salad sandwich without gloves, or hand hygiene going from one food to the other. Writer observed Dietary Staff K make several egg salad sandwiches using his bare hands, no hand hygiene was performed before or after using his bare hands<br>(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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | touching the bread.<br><br>During an observation on 04/15/2026 at 11:55 AM in the resident's refrigerator in dining room [ROOM NUMBER] hall, 6 individual cream cheese, 20 individual whipped butter spread without an expiration date. Kitchen staff removed these items from the refrigerator and threw them away.<br><br>During the lunch meal on 4/14/2026 at 11:45 AM on the 200 hall, food temperatures were obtained by Dietary Aid S (DA). The temperatures were found as followed: salad 55 degrees Fahrenheit, egg salad 40 degrees Fahrenheit, blended egg salad 40 degrees Fahrenheit, and chopped salad at 50 degrees Fahrenheit. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure three out of three residents (Resident #21, 54 & 151) were treated with respect and dignity.Findings Include Resident #54 (R54)<br><br>Review of the medical records reflected that R54 was admitted to the facility on [DATE]. Diagnoses of Alzheimer's Disease, Dementia and Depression.<br><br>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/11/2026 revealed R54 had a Brief Interview of Mental Status (BIMS) of 11 (Moderate Cognitive Impairment) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R54 receives extensive assistance with bed mobility, total assistance with transfers, and extensive assistance with toileting; she was able to feed herself. R54 is able to make her needs known.<br><br>Resident #151 (R151)<br><br>Review of the medical records reflected that R151 was admitted to the facility on [DATE]. Diagnoses of Motor Neuron Disease, chronic pain, polyosteoarthritis, and difficult in walking.<br><br>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2026 revealed R151 had a Brief Interview of Mental Status (BIMS) of 15 (Cognitively Intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R151 is dependent on bed mobility, toileting needs, feeding, total assistance with transfers using the Hoyer lift.<br><br>During the screening process on 04/14/2026 at 9:22 AM, R54 was applying lipstick and stated she was getting ready for her day. R54 discussed needs, activities she attends, number of showers/baths she gets during the week with clarity and could actively engage in our conversation.<br><br>During the screening process on 04/14/2026 at 9:27 AM, R151 discussed her needs, activities she attends, favorite TV program and number of showers/baths she gets during the week. R151 was able to answer these questions with ease. R151 stated she didn't have a call light due to her motor neuron disease. R151 stated she tried using a Blow In Style call light but didn't like it up by her face all the time, as she had no use of any of her limbs. R151 stated they brought in this baby monitor, hanging off the wall so she yells out for someone to help her, and they will come in. R151 stated she didn't like that one either.<br><br>During an interview on 04/14/2026 at 4:25 PM, Certified Nursing Assistant (CNA) P stated the monitor in R151's room was like a baby monitor, on all the time. CNA P stated there is a monitor on the medication cart and one in the medication room. CNA P stated R151 had tried a couple of different types, but didn't like any of them, but seems to like this one.<br><br>During an observation and interview on 04/16/2026 at 7:47 AM, Licensed Practical Nurse (LPN) Q was asked to see the monitor used for R151. LPN Q pulled it from the side of the medication cart; you could hear R151's TV plainly, as it was on in her room. When asked LPN Q if he can hear the roommate at any time, LPN Q stated he hadn't that he remembered, he can only hear resident when she yells out for care.<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 04/16/2026 at 8:07 AM, LPN/Unit Manager M stated R151 had the type of call light that you blow in to it, she didn't like it, was unhappy about it so they had this baby monitor already, so they put it in her room on 11/13/2025. When asked LPN/Unit Manager M stated no, R151 did not like the baby monitor at all. When asked why they left it in her room if she was not happy about it. LPN/Unit Manager M stated they had to have something in her room to call out for help. When asked if they tried any other styles of monitors and LPN/Unit Manager M stated no.<br><br>During an observation on 04/16/2026 at 8:15 AM, CNA R was feeding R151 pancakes and sausage. When asked R151 if she wanted to have a private conversation with someone, had she asked to have it turned off so it can remain private, she stated no, I guess not. R151 and CNA R continued talking about the current news on the TV, writer could hear their conversation after leaving the room and being in the hallway.<br><br>During an observation on 04/16/2026 at 9:49 AM, LPN Q took R151's morning medications into her room with the monitor sitting on the medication cart. You could hear LPN Q tell R151 he had her am medications for her.<br><br>During an observation on 04/16/2026 at 9:56 AM, LPN Q could be heard giving roommate to R151 her am medications, you could hear LPN Q ask the roommate her date of birth , and tell her what her medications were for. This private conversation could be heard by anyone walking in the hall.<br><br>During an interview on 04/16/2026 at 11:27 AM LPN/Unit Manager M and Social Worker (SW) N related to the baby monitor. LPN/Unit Manager M stated that SW N wasn't involved with the implementation of the baby monitor, she was the one who initiated it. When asked LPN/Unit Manager what other devices they had tried. LPN/Unit Manager M stated they tried the blow into type and R151 did not like that one and they had this baby monitor type, so they used that one. LPN/Unit Manger M was asked if R151 liked this baby monitor type, LPN/Unit Manager stated no, R151 didn't like this one at all, but they had to use something so they could hear her yell out for care.<br><br>When asked LPM/Unit Manager if they had tried other types of call lights or monitors and LPN/Unit manager M stated no. When asked LPN/Unit Manager M what other options were given to R151, since she did not like that baby monitor. LPN/Unit Manager M stated we had to use something, and we had this baby monitor already, so we used this one.<br><br>LPN/Unit Manager M was asked if R151 was her own person, decision maker and LPN/Unit Manager M stated yes. LPN/Unit Manager M was asked were they aware that the baby monitor was used when R151 did not want it, was very unhappy about it and didn't like it. LPN/Unit Manager M stated yes.<br><br>LPN/Unit Manager M was asked if the monitor in place was discussed with the Interdisciplinary Team. LPN/Unit Manager M was observed looking at her computer at R151's progress notes, she stated there was no discussion of this baby monitor during the last two interdisciplinary meets nor was it charted under nursing progress notes that the baby monitor was put in place.<br><br>LPN/Unit Manager M confirmed that the facility had not received permission from R151's roommates family to use this baby monitor in the room [ROOM NUMBER]/7. LPN/Unit Manager M stated the resident roommate (R54) was not fully alert and may not be aware of it being used in the joint room.<br><br>LPN/Unit Manager M was asked if R54/family needed know that all conversations could be heard, including potential Health Insurance Portability and Accountability Act (HIPAA) from being disclosed<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | without consent for R54. LPN/Unit Manager M stated she didn't think about that. LPN/Unit Manager M confirmed that the facility had not posted signage making visitators aware that there was a monitoring device being used in that room. LPN/Unit Manager M and Social Worker (SW) N conveyed if they had any other reasonable person for a roommate, they would need to give permission and acknowledgement of the device being used, prior to being used.<br><br>Record review revealed that R151 nursing progress notes nor interdisciplinary team had no documentation regarding call light options.<br><br>Further it was reported to LPN/Unit Manager M that during the screening process on 04/14/2026 at 9:27 AM, for this federal survey, state agency was unaware that there was a device hanging over R151's bed was active and anyone could hear the private conversations the residents, R54 and R151, in the shared room.<br><br>Per the facility face sheet Resident #21 (R21) was admitted to the facility on [DATE].<br><br>Review of R21's care plans revealed R21 received Hospice services for a diagnosis of end of life.<br><br>During an observation in the dining room on 4/14/2026 at 12:10 PM, Registered Nurse (RN) U, who was the visiting Hospice Nurse, was observed to enter the dining room, move a chair next to R21, who was sitting at a table eating her lunch, and sit down next to R21. RN U was observed to document on a tablet, then proceeded to place a pulse oximetry (device that goes on the finger to read oxygen level in the blood) on R21's finger, take R21's temperature, and blood pressure. R21 was observed to stop eating her lunch during the time RN U performed R21's vital sign checks. RN U had to take R21's blood pressure twice. RN U was then observed to take a tape measure and wrap it around the upper part of R21's left arm for a measurement. At 12:16 PM, R21 was observed to not be eating her lunch meal. RN U remained sitting next to R21 performing documentation on a tablet. Thirteen other residents were in the dining room, with five residents sitting at the same table as R21 who had the ability to overhear and observe R21 having her Hospice nurse visitation. At 12:20 PM RN U remained sitting next to R21.<br><br>In an interview on 4/14/2026 at 12:23 PM, RN U stated that she would try not to interrupt R21's lunch by taking her back to her room to do her assessment privately then having to bring her back out again. RN U said R21 was confused and was a safety risk, stating that R21 could not be left in her room alone. During interview after this observation R21 said staff had never spoken to her about performing her assessments in the privacy of R21's resident's room outside of the common areas where other residents and staff frequent.<br><br>In an interview on 4/14/2026 at 12:33 PM, Certified Nurse Aid (CNA) V stated that RN U, the Hospice nurse, would always visit and perform R21's vital sign assessment with R21 in the common areas. CNA V said wherever R21 was when RN U arrived at the facility is where RN U performed R21's assessment, and said it was always in the common area, CNA V stated that she was surprised RN U did R21's assessment while R21 was eating, and said she worked for Hospice once and you don't do that. CNA V also stated that none of the other Hospice nurses performed their visits with R21 in the common areas and said they all take R21 to her room to do her assessment.<br><br>In an interview on 4/15/2026 at 12:17 PM, Director of Nursing (DON) B stated that her expectation was that the Hospice nurse take R21 back to her room to perform vital sign assessment in private as assessment in an open common area was a dignity issue. |

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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Based on Observation, Interview and Record Review the facility failed to ensure that survey results were readily accessible to the residents of the facility with a current census of 176 residents. During a Resident Council Meeting held on 04/15/2026 at 1:00 PM with a group of 10 residents the survey process was discussed. It was conveyed that all survey results are to be available for easy access for residents and families to read. Nine out of the 10 residents stated that did not know the results of any surveys. They did not know where a binder with this information was located. They added that they wondered about the outcome of the surveys, because they never heard anything more about it once surveyors left the building. Sharing that they were now going to ask about it. During an observation on 04/15/2026 at 4:59 PM, No Survey Binder could be located upon entrance or around the main or common areas for access to residents and families.During an observation on 04/16/2026 at 3:06 PM, A State Binder was seen at the front reception desk, after reviewing the contents in the binder, the most current survey results were not provided in this binder for residents or families to review.During an interview on 04/16/2026 at 3:30 PM, LNA's assistant T randomly stuck her head in the conference room door and stated, The last, most current survey was added to the Survey Binder.Per the State Operation Manual (SOM). The resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; Receive information from agencies acting as client advocates and be afforded the opportunity to contact these agencies.The facility must--Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.The SOM further directs that the facility have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. The facility shall not make available identifying information about complainants or residents. |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to maintain personal privacy and confidentiality of medical information in two residents (R54 and R151) of two reviewed for personal privacy.Findings IncludeResident #54 (R54)Review of the medical records reflected that R54 was admitted to the facility on [DATE]. Diagnoses of Alzheimer's Disease, Dementia and Depression.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/11/2026 revealed R54 had a Brief Interview of Mental Status (BIMS) of 11 (Moderate Cognitive Impairment) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R54 receives extensive assistance with bed mobility, total assistance with transfers, and extensive assistance with toileting; she was able to feed herself. R54 is able to make her needs known. Resident #151 (R151)Review of the medical records reflected that R151 was admitted to the facility on [DATE]. Diagnoses of Motor Neuron Disease, chronic pain, polyosteoarthritis, and difficult in walking.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2026 revealed R151 had a Brief Interview of Mental Status (BIMS) of 15 (Cognitively Intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R151 is dependent on bed mobility, toileting needs, feeding, total assistance with transfers using the Hoyer lift. During the screening process on 04/14/2026 at 9:22 AM, R54 was applying lipstick and stated she was getting ready for her day. R54 discussed needs, activities she attends, number of showers/baths she gets during the week with clarity and could actively engage in our conversation.During the screening process on 04/14/2026 at 9:27 AM, R151 discussed her needs, activities she attends, favorite TV program and number of showers/baths she gets during the week. R151 was able to answer these questions with ease. R151 stated she didn't have a call light due to her motor neuron disease. R151 stated she tried using a Blow In Style call light but didn't like it up by her face all the time, as she had no use of any of her limbs. R151 stated they brought in this baby monitor, hanging off the wall so she yells out for someone to help her, and they will come in. R151 stated she didn't like that one either.During an interview on 04/14/2026 at 4:25 PM, Certified Nursing Assistant (CNA) P stated the monitor in R151's room was like a baby monitor, on all the time. CNA P stated there is a monitor on the medication cart and one in the medication room. CNA P stated R151 had tried a couple of different types, but didn't like any of them, but seems to like this one. During an observation and interview on 04/16/2026 at 7:47 AM, Licensed Practical Nurse (LPN) Q was asked to see the monitor used for R151. LPN Q pulled it from the side of the medication cart; you could hear R151's TV plainly, as it was on in her room. When asked LPN Q if he can hear the roommate at any time, LPN Q stated he hadn't that he remembered, he can only hear resident when she yells out for care. During an interview on 04/16/2026 at 8:07 AM, LPN/Unit Manager M stated R151 had the type of call light that you blow in to it, she didn't like it, was unhappy about it so they had this baby monitor already, so they put it in her room on 11/13/2025. When asked LPN/Unit Manager M stated no, R151 did not like the baby monitor at all. When asked why they left it in her room if she was not happy about it. LPN/Unit Manager M stated they had to have something in her room to call out for help. When asked if they tried any other styles of monitors and LPN/Unit Manager M stated no. During an observation on 04/16/2026 at 8:15 AM, CNA R was feeding R151 pancakes and sausage. When asked R151 if she wanted to have a private conversation with someone, had she asked to have it turned off so it can remain private, she stated no, I guess not. R151 and CNA R continued talking about the current news on the TV, writer could hear their conversation after leaving the room and being in the hallway. During an observation on 04/16/2026 at 9:49 AM, LPN Q took R151's morning medications into her room with the monitor sitting on the medication cart. You could hear LPN Q tell R151 he had her am medications for her.During an observation on 04/16/2026 at 9:56 AM, LPN Q could be heard giving roommate to R151 her am medications, you could hear LPN Q ask the roommate her date of birth , and tell her what her<br>(continued on next page) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medications were for. This private conversation could be heard by anyone walking in the hall. During an interview on 04/16/2026 at 11:27 AM LPN/Unit Manager M and Social Worker (SW) N related to the baby monitor. LPN/Unit Manager M stated that SW N wasn't involved with the implementation of the baby monitor, she was the one who initiated it. When asked LPN/Unit Manager what other devices they had tried. LPN/Unit Manager M stated they tried the blow into type and R151 did not like that one and they had this baby monitor type, so they used that one. LPN/Unit Manger M was asked if R151 liked this baby monitor type, LPN/Unit Manager stated no, R151 didn't like this one at all, but they had to use something so they could hear her yell out for care. When asked LPM/Unit Manager if they had tried other types of call lights or monitors and LPN/Unit manager M stated no. When asked LPN/Unit Manager M what other options were given to R151, since she did not like that baby monitor. LPN/Unit Manager M stated we had to use something, and we had this baby monitor already, so we used this one. LPN/Unit Manager M was asked if R151 was her own person, decision maker and LPN/Unit Manager M stated yes. LPN/Unit Manager M was asked were they aware that the baby monitor was used when R151 did not want it, was very unhappy about it and didn't like it. LPN/Unit Manager M stated yes. LPN/Unit Manager M was asked if the monitor in place was discussed with the Interdisciplinary Team. LPN/Unit Manager M was observed looking at her computer at R151's progress notes, she stated there was no discussion of this baby monitor during the last two interdisciplinary meets nor was it charted under nursing progress notes that the baby monitor was put in place.LPN/Unit Manager M confirmed that the facility had not received permission from R151's roommates family to use this baby monitor in the room [ROOM NUMBER]/7. LPN/Unit Manager M stated the resident roommate (R54) was not fully alert and may not be aware of it being used in the joint room. LPN/Unit Manager M was asked if R54/family needed know that all conversations could be heard, including potential Health Insurance Portability and Accountability Act (HIPAA) from being disclosed without consent for R54. LPN/Unit Manager M stated she didn't think about that. LPN/Unit Manager M confirmed that the facility had not posted signage making visitators aware that there was a monitoring device being used in that room. LPN/Unit Manager M and Social Worker (SW) N conveyed if they had any other reasonable person for a roommate, they would need to give permission and acknowledgement of the device being used, prior to being used.Record review revealed that R151 nursing progress notes nor interdisciplinary team had no documentation regarding call light options.Further it was reported to LPN/Unit Manager M that during the screening process on 04/14/2026 at 9:27 AM, for this federal survey, state agency was unaware that there was a device hanging over R151's bed was active and anyone could hear the private conversations the residents, R54 and R151, in the shared room. Per the State Operation Manual (SOM).The facility must respect the residents' right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, Confidentiality is defined as safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the individual's surrogate or representative. Right to personal privacy includes the resident's right to meet or communicate with whomever they want without being watched or overheard. |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>Based on observation, interview and record review the facility failed to implement a process for resident grievances to be resolved by the facility in a current facility census of 176 residents. During a Resident Council Meeting held on 04/15/2026 at 1:00 PM with a group of 10 residents' grievances were discussed. The residents shared that in order to fill out a grievance form they had to go to the Social Workers office on their unit, and the Social Workers would fill them out. Residents stated they did not know the turnaround time in getting them resolved.When asked if they had these forms at eye level and displaced throughout the facility other than the Social Workers office, the residents stated they did not have those forms available at eye level in any of the common areas. Residents in the confidential group meeting stated they did not know they could fill them out themselves or ask someone to help them. Residents stated they didn't know that. Residents shared that they were familiar with the Property Incident Report. Again, stating they did not have easy access to a Resident Concern/Grievance Forms. Residents voiced concern regarding long call light wait times, adding they had reported this concern however this was still a problem and the concerns had not been resolved. Residents in the group shared that residents from all units voiced concerns regarding staff turning off call lights without providing care, saying they will be back, and do not return. Residents asked if the call light can be turned off without providing care. When asked if this had been reported more than once, they stated they had reported these concerns many times. During an interview on 04/15/2026 at 1:37 PM, Licensed Practical Nurse (LPN) L stated she knew grievance forms existed but wasn't sure where they were. Writer observed LPN 'L going through different drawers at the nurse's station in search of the forms. None were found. During an interview on 04/15/2026 at 2:42 PM, Social Worker (SW) and LPN/UM M stated the grievance forms are outside her office door, stating residents were to bring in the completed forms to Social Worker (SW) N. Social Worker (SW) stated regarding the Property Incident Report, she liked to look through the resident's room looking for the missing clothes before sending them out to the unit managers. Writer asked what the turnaround time was, Social Worker (SW) stated she had to check the policy, usually liked to follow up within a week and then go from there. Writer asked if she also filled out Grievance forms for residents as she did for the lost and property incident reports. During an interview on 04/16/2026 at 8:46 AM, when asked Activity Director (AD) O was asked where the grievance forms were kept on the halls/units where residents could reach them from standing or sitting in a wheelchair and fill it out themselves or asking for help. AD O stated they were downstairs by the elevator, and in the social workers offices. When asked if they were anywhere else where residents could reach them, in the hallway, dining room. AD O stated no they were not. Writer explained they needed to be positioned where residents can grab one, fRecord review revealed grievances discussed during the Resident Council Meetings that were not identified as grievances, nor was a grievance form filled out tracking, patterns or resolutions. November 2025 Resident Council Meeting:TV hanging in a resident's room was crooked. Housekeeping throwing away items again from their tray table, denture glue was thrown away. Request to use a larger bathroom on shower days. Nurses are very loud at group times in main dining room and during groups held on their neighborhoods. CarePartners are very disruptive during group times. Baked chicken was over cooked and very tough. Pork Chops were over cooked. Resident reported long periods of time for her call light to be answered. Missing clothing concerns. December 2025 Resident Council Meeting: Waiting a long time for call lights to be answered. Another concern with long wait time for call lights to be answered. Waiting too long for call lights to be answered and often CNAs come in turning off the call lights and not helping or saying they will come back. Not getting cream applied to her feet. Also stating a concern with getting call lights answered by CNAs, naming the individuals that are doing this. Not getting brief changed during 3rd shift until 5:00am. CNAs are not checking her colostomy bag during 3rd shift. Resident reported CNAs were complaining about soaking<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 235019 | A. Building<br>B. Wing | 04/16/2026 |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | through her pad and she is waiting a long time with the call lights. Carrots served were not very tender. Resident requested to have gravy on her meat and that is not always happening and doesn't like mixed veggies. Missing clothing concerns. January 2026 Resident Council Meeting: Long wait time on the call lights on 2nd and 3rd shifts. shifts. Resident had a problem with a CNA on 2nd shift. Never knows who will be their CNA for all shifts. Missing clothes concerns. February 2026 Resident Council Meeting: CNAs are on their cell phones too much. CNAs talking too loud in the hallways on 2nd shift, staff named. Clothes removed from her room for laundry when family was to do her laundry. Had to wait for call light answered r/t her needing 2 CNAs to provide care. Missing clothing concerns. March 2026 Resident Council Meeting: Staff removed personal items from the top of her dresser into a dresser drawer, and she did not like that. CNA on 2nd shift talking to her boyfriend on her phone while providing care, name of CNA given. 2nd complaint of CNA on her phone with her boyfriend while providing care, name given, added resident could hear everything she and her boyfriend were saying. CNAs have cut back on her meal portions due to her weight without her asking them to. CNAs get her up too early to take her shower and she would prefer to have showers after breakfast. Missing clothes. April 2026 Resident Council Meeting: Resident's room needs a paint touch up at the head of her bed. Resident needs her toilet looked at, low water level. level. Residents chair is still being pushed too far back in the corner, doesn't want them moving it. Running out of clothing protectors, towels and washcloths on the neighborhood, CNAs had to go find more. Same concerns by different residents, running out of clothing protectors, towels and washcloths on the neighborhood, CNAs had to go find more. Resident needs her meat chopped up more. Missing clothes concerns.Record review did not reveal any of those concerns or complaints reported during the resident council meetings being identified or documented as concerns or grievances. Per the States Operation Manual (SOM) . all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the residents. The grievance policy must include:Notifying residents individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer one (R9) of one reviewed to the state-designated authority for a change in condition. Findings include:Review of the medical record revealed R9 was admitted to the facility on [DATE] with diagnoses that included hypertension and repeated falls. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/26 revealed R9 scored 5 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Preadmission Screening (PAS)/Annual Resident Review (ARR) Level I Screening revealed the review was completed on 2/09/25. All questions were answered No to include The person has a current diagnosis of mental illness or dementia, The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days, and There is presenting evidence of mental illness or dementia, including significant disturbances in thought conduct, emotions, or judgement. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others. According to R9's diagnosis list, the following diagnoses were added during R9's stay at the facility: visual hallucinations was added on 2/17/25, delusional disorder was added on 3/26/25, Alzheimer's Disease was added on 5/19/25, and auditory hallucinations was added on 8/26/25. Review of the Physician's Orders revealed R9 was first prescribed Seroquel (antipsychotic medication) on 3/28/25 for hallucinations. R9 did not have a Change in Condition Level I Screening or referral to the local Community Mental Health Services Program. In an interview on 04/16/2026 at 8:13 AM, Social Worker (SW) E reported any PASARR renewals were given to Social Services Director (SSD) D to submit. When asked when she gave R9's updated screening to SSD D, SW E reported they did not have that information. In an interview on 04/16/2026 at 9:00 AM, SSD D reported the unit social workers provided him with updated PASARR screens for him to enter into the system. When asked if he had an updated screening/change in condition for R9, SSD D checked the OBRA system and reported R9 was due for an update. SSD D reported R9's last Level I Screening was competed on 2/9/25 at which time all questions received a no response. When asked if R9 has had any changes, SSD D reported R9 was diagnosed with dementia and started an antipsychotic medication in 2025. SSD D reported R9 should have had a Change in Condition Level I Screening completed with the addition of a dementia diagnosis during her stay. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and record review, the facility failed to ensure medications were secure and inaccessible to unauthorized staff and residents. Findings include: An observation on 4/15/26 at 3:41 PM, revealed a grey unsecured tote was sitting on the couch outside the public restroom on the Renewal Center East unit. No authorized staff were supervising the tote. There was a non-nurse staff member sitting in the dining room and a non-nurse staff member who walked by. Inside the tote was a Medication Inventory Record which revealed a list of medications that were being returned to the pharmacy. The list included one Metamucil, two Lovenox 40 milligrams (mg) injections, two Flexeril 10 mg, and 47 Singulair 10 mg. The actual medications inside the tote included two cards of Flexeril 10 mg for a total of 49 tablets, two Lovenox 10 mg injections, and one Singulair 10 mg tablet. A staff member walked by and when asked if they were the nurse for the unit, they reported no. In an interview on 4/15/26 at 3:44 PM, Licensed Practical Nurse (LPN) G walked by. When asked about the tote, LPN G reported they arrived on shift at 2:00 PM and were not the one who placed the medication tote on the couch. LPN G reviewed the paperwork inside the tote and reported the nurse on the prior shift must have set the tote on the couch. LPN G confirmed the tote included one Singulair tablet, two Lovenox injections, and 49 Flexeril tablets. LPN G reported the medications were on the couch because they were being returned to pharmacy and that was the process they always followed. LPN G reported the tote was left on the couch, pharmacy would come in between 5:45 PM and 6:15 PM, pick up the tote and leave a new one. In an interview on 4/15/26 at 3:49 PM, Director of Nursing (DON) B reported the pharmacy delivered and picked up returns twice per day around 11:00 AM and 7:00 PM, Monday through Saturday. DON B reported medications to be returned to the pharmacy should be stored in the medication cart and then handed off to the pharmacy delivery staff when they arrived. DON B was shown the grey tote with medications that was sitting on the couch on Renewal Center East. DON B reported the medications should not be there. |