STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235036	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Rochester Hills Rehab and Nursing C	1480 Walton Blvd Rochester Hills, MI 48309

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 0684 Level of Harm - 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** This citation pertains to Complaint #2578523. Based on observation, interview, and record review, the facility failed to assess, monitor, and document a change in condition in a timely manner for two (R27 and R92) of four residents reviewed for change in condition, resulting in a delay in treating a Urinary Tract Infection (UTI) leading to septic shock and admission into the Intensive Care Unit (ICU) at the hospital. Findings include: R27 On 12/2/25 at 9:40 AM, R27 was observed lying in bed, in a low position. R27 was sleeping with the blanket pulled up over her face. On 12/2/25 at 12:45 AM, an interview was conducted with R27's family member who reported R27 fell in the dining room a couple weeks ago and was sent to the hospital. R27's family member reported the resident was very lethargic earlier in the day and was in the dining room unsupervised by staff. R27's family member further explained R27 was diagnosed with septic shock due to a UTI and is now receiving hospice (end of life) services. A review of R27's Physician's Orders revealed the following orders: 10/16/25 (discontinued on 10/19/25) - UA (Urinalysis) one time only for MSC (mental status change) and increased fatigue for 3 days 10/22/25 (discontinued on 10/24/25) - UA C&S (Culture and Sensitivity) to be obtained. every shift for UTI R/O (rule out) for 3 Days .Please contact the daughter and the MD if the UA cannot be obtained. Novolog (short acting insulin) 100 Unit/ML (milliliter) Inject as sliding scale .401-1000 = 6 units call [physician, subcutaneously before meals for hyperglycemia (high blood sugar) A review of R27's progress notes revealed the following: A General Progress Note dated 10/16/25 that noted, .Resident refused to take meds or eat any food .woken up for a brief change but was combative, unable to collect urine specimen due to resident current situation and her combative self. Endorsed to next shift . On 10/22/25 it was documented R27's blood pressure (BP) was 97/5 [sic] and her BP medication was held due to the low BP reading. A General Progress Note dated 10/22/25 noted, Residents brief was soiled with urine. Attempted to still obtain urine specimen. Was able to obtain small amount of urine but not enough to send out for (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	urinalysis .Will attempt to obtain urine specimen later . An eMAR (electronic Medication Administration Record note dated 10/23/25 at 8:30 AM noted, .contact the daughter and the MD if the UA cannot be obtained .Unable to retrieve specimen .Will notify all parties . A General Progress Note dated 10/23/25 (entered as a late entry) noted, Writer spoke with RP (responsible party) regarding inability to obtain urine for UA as per physician's order. Education provided regarding obtaining urine via straight cath (catheter), daughter declined to allow staff to obtain urine via straight cath . It was documented on 10/24/25 that the urine specimen was unable to be obtained and the order was discontinued to obtain the UA. A review of R27's Medication Administration Record (MAR) for October 2025 revealed R27's blood sugar was 481 on 10/28/25 at 5:00 PM which required six units of Novolog (short acting insulin), 434 on 10/31/25 at 7:00 AM and was administered 6 units of insulin (the progress note documented R27 was given 8 units of Novolog per physician's orders), and 466 on 10/31/25 at 11:00 AM and was administered 6 units of insulin (the progress note for this date/time noted 12 units of Novolog were given per the physician's orders). On 11/6/25 at 3:37 PM, it was documented in a General Progress Note that Staff alerted Nurse pt (patient) observed on the floor in the dining room at (2:20 PM). Pt VS (vital signs) 80/56 (low blood pressure) .BS (blood sugar) 516 (abnormal high). Staff assisted pt to w/c (wheelchair) and back to bed. Writer administered 6 units per sliding scale (according to the physician's orders, R27 received her 5 units of sliding scale Novolog at 11:00 AM and would not have been due for another dose until 5:00 PM) .MD notified send pt out to hospital for observation . A review of R27's vital sign summary revealed R27's vital signs were not consistently documented throughout the period of her change in condition (once a UTI was suspected and a UA was ordered). There was no documentation of any additional monitoring for signs and symptoms of a UTI when R27 was not cooperative with providing a urine sample. There was no evidence that R27 was evaluated by a medical provider to address the change in condition between 10/16/25 when the UA was initially ordered and 11/6/25 when R27 was sent to the hospital after a fall and having abnormal vitals and blood sugar. On 12/4/25 at 1:08 PM, an interview was conducted with the Director of Nursing (DON). When queried about R27 and how she was monitored for signs and symptoms of a UTI and/or any other change in condition when she refused to provide a urine sample, the DON reported the resident's vital signs would be monitored every shift as well as monitoring whether there were any other signs and symptoms of a UTI. The DON further reported any contact made to the physician should be documented in the medical record along with any new recommendations. When queried about where the vital signs were documented, R27 said they would be in the vitals summary in the electronic medical record. When queried about whether R27 should have been evaluated by a physician since she refused to give a urine sample and a UTI could not be confirmed that way, the DON reported R27's family member wanted her to have a UA but would look into whether she was seen by a physician. On 12/4/25 at approximately 2:00 PM, the DON followed up and reported R27 was seen by a psychologist on 10/16/25, a Rehabilitation Physician on 10/29/25 (for therapy needs), and (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Psychiatrist on 10/29/25. However, R27's change in condition and possible UTI were not addressed with those medical providers. A review of R27's hospital records revealed the following: A Discharge summary dated [DATE] documented, .admission Information .presenting to the emergency department (ED) via EMS (emergency medical services) from her nursing home after an unwitnessed fall .According to the patient's daughter .the patient has been noted to be lethargic since this morning .At the nursing home, initial vital signs revealed hypotension (low BP) with systolic blood pressure in the 80s and a markedly elevated blood glucose level on the glucometer .WBC (White Blood Count) 15.8 (abnormal high) .UA was positive for protein, leukocyte esterase, red cells, white blood cells, WBC clumps, bacteria (indicative of an infection) .In the ED patient was given 3 L (liters) LR (lactated ringer's) bolus (electrolytes), Rocephin (antibiotic) 2 g (gram) IV (intravenous), started on insulin drip .admitted to ICU for closer monitoring and further management .Hospital Course .Significant Findings: Septic shock likely due to acute complicated UTI .High anion gap metabolic acidosis due to critical lactic acidosis and DKA (diabetic ketoacidosis) .likely due to UTI . Further review of R27's clinical record revealed R27 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Alzheimer's Disease, Type 2 diabetes mellitus. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R27 had severely impaired cognition. A complaint was submitted to the State Agency on 8/1/25 with the allegations of facility did not give the first day of antibiotics as ordered and R92 was not assessed for a change in condition timely. On 12/3/25 an onsite investigation was completed for the allegations. A review of the medical record revealed that R92 was admitted to the facility on [DATE] with the admitting diagnosis of Local infection of the skin and acute hematogenous osteomyelitis. A Brief Interview for Mental Status (BIMs) score 00 which indicated sever cognitive impairment. A further review of the record revealed that R92 received a prescription on 7/8/25 for Meropenem 500mg IV every eight hours for eleven days. For a total of thirty-three doses. On 7/16/25 starting at 4 PM according to the medication administration record (MAR) it showed that a dependent resident self-administered an IV antibiotic. From 7/16/25-7/22/25 the MAR revealed eighteen self-administered IV meropenem medications. On 12/3/25 at 12:07 PM, Nurse U was interviewed via phone. Nurse U reported that R92 was a resident on the first floor, she was receiving IV antibiotics, missed several doses and became unresponsive. R92 had a pulse and vitals so we sent them to the hospital. Nurse U further reported, they went to the administrator about the change in condition and started an investigation, that is when it was discovered that R92 missed 18 doses of meropenem IV antibiotics. The doctor was called to let them know that R92 had missed several doses of antibiotic therapy and the doctor ordered them to receive a new IV line, obtain x-rays of the affected area and start the antibiotics for three additional days. The daughter was called as well to inform them that R92 needed a new IV line and that medications had been missed. The day R92 was sent out to the hospital, Nurse U reported that they went to the administrator to let them know the findings. Nurse U , reported that the administrator told them to tell the family that R92 was dehydrated. Nurse U reported the facility started doing a soft file on the incident, educating the staff on change in conditions for missed medications, transcribing (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	medication orders correctly, and documentation located in a brown folder in their (administrator) office but they were terminated so they were unsure if the file was still available. A review of the record revealed that R92 was sent out to the hospital on 7/28/25 at 11:50 AM, with a progress note that reads, EMS notified -- Rochester Hills Fire Department accompanied resident via stretcher. A further review of the recorded revealed there was not any vital signs, assessments, notification to family or physician about the transfer. On 12/3/35 at 12:00 PM, a call was made, voice mail left and text message sent to Nurse 'V the nurse who put in the progress note the day of transfer, with no reply or call back. No additional information was submitted at the exit of survey.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a homelike environment during dining for four (R7, R47, R64, and R72) of nine residents reviewed for dining. Findings include: On 12/2/25 at 12:28 PM, an observation was made of the lunch meal in the second floor dining room. On 12/2/25 at 12:39 PM, R47's meal was served on a tray, instead of placing the plate on the table. A television remote control was observed on the tray. On 12/2/25 at approximately 12:40 PM, R64's meal was served on a tray. R7 was not served at the same time and was observed grabbing R64's meal tray and pulling it toward herself. Then R72, who was also seated at the same table and not yet served a tray, pulled R64's tray toward himself. On 12/2/25 at approximately 12:45 PM, R7 was moved to another table and was served her meal on a tray. On 12/2/25 at approximately 12:50 PM, R72 was served his meal on a tray. On 12/3/25 at 2:33PM, an interview was conducted with Regional Registered Dietician (RD) 'O'. When queried about whether residents' meals should be taken off trays when served, RN 'O' reported the meal trays should be removed from the table to provide a homelike dining experience. A review of R7's clinical record revealed R7 was admitted into the facility on 1/10/19. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R7 had severely impaired cognition. A review of R47's clinical record revealed R47 was admitted into the facility on [DATE]. A review of a MDS assessment dated [DATE] revealed R47 had severely impaired cognition. A review of R64's clinical record revealed R64 was admitted into the facility on 1/2/24. A review of a MDS assessment dated [DATE] revealed R64 had severely impaired cognition. A review of R72's clinical record revealed R72 was admitted into the facility on 7/23/25. A review of a MDS assessment dated [DATE] revealed R72 had severely impaired cognition.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to complaint 2578523.Based on interview and record review the facility failed to ensure one (92) of one resident was free from significant medication error when 18 doses of Intravenous (IV) antibiotics were ,missed and not given as the prescriber's ordered. Findings include:A complaint was submitted to the State Agency on 8/1/25 with the allegations of facility did not give the first day of antibiotics as ordered and R92 was not assessed for a change in condition timely.On 12/3/25 an onsite investigation was completed for the allegations.A review of the medical record revealed that R92 was admitted to the facility on [DATE] with the admitting diagnosis of Local infection of the skin and acute hematogenous osteomyelitis. AR92 had a Brief Interview for Mental Status (BIMs) score 00, indicating severe cognitive impairment.A further review of the record revealed that R92 received a prescription on 7/8/25 for Meropenem 500mg IV every eight hours for eleven days. For a total of thirty-three doses. On 7/16/25 starting at 4 PM according to the medication administration record (MAR) it showed that a dependent resident self-administered an IV antibiotic. From 7/16/25-7/22/25 the MAR revealed eighteen self-administered IV meropenem medications.On 12/3/25 at 12:07 PM, Nurse U was interviewed via phone. Nurse U reported that R6 was a resident on the first floor, she was receiving IV antibiotics, missed several doses and became unresponsive. R92 had a pulse and vitals so was sent them to the hospital. Nurse U further reported, they went to the administrator about the change in condition and started an investigation, that is when it was discovered that R92 missed 18 doses of meropenem IV antibiotics. The doctor was called to let them know that R6 had missed several doses of antibiotic therapy and the doctor ordered them to receive a new IV line, obtain x-rays of the affected area and start the antibiotics for 3 additional days. The daughter was called as well to inform them that R92 needed a new IV line and that medications had been missed. The day R92 was sent out to the hospital, Nurse U reported that they went to the Administrator to let them know the findings. Nurse U , reported that the administrator told them to tell the family that R92 was dehydrated. Nurse U reported the facility started doing a soft file on the incident, educating the staff on change in conditions for missed medications, transcribing medication orders correctly, and documentation which was in a brown folder in the Administrator's office.On 12/3/25 at 12:40 PM, a phone interview was conducted with the Administrator in relation to the allegations for R92 that was submitted to the state agency. The Administrator reported that they did not know about the incident and was not informed about anything. On 12/3/25 at 1PM, the Director of Nursing(DON) was interviewed about the incident where they informed surveyor that they were not a part of the facility at that time and presented the soft file on the incident.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included staff education and audits. The facility was able to demonstrate monitoring of the corrective action and maintained compliance. There was no addition information provided at the exit of the survey.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain sufficient dietary support personnel to meet the needs of the residents in the second floor dining room for five (R7, R23, R26, R64, and R72) of 10 residents reviewed for the dining task. Findings include:On 12/2/25 at 12:28 PM, an observation of the lunch meal was conducted in the second-floor dining room. The following was observed: At 12:39 PM, the cart containing the resident's meals arrived and staff began serving the food. At approximately 12:40 PM, R64's meal was served on a tray. R7 sat to the left of R64 and R72 sat across from R64. R7 and R72 were not served their food at that time. R7 was observed grabbing the tray from R64 and attempted to pull it toward herself. R64 pulled the tray back and began putting food into a cup of juice and stirring it with a knife. There were no staff members seated at the table with the residents. At approximately 12:45 PM, R7 pulled R64's tray in front of herself. At that time, R72 pulled the tray in front of himself and drank the juice with the mixed-up food in it. R7 pulled the tray back in front of herself. At that time, Certified Nursing Assistant (CNA) 'K' walked over to R7 and tried to give the tray back to R64 (it should be noted that no staff observed all of the residents touching R64's food and R72 drinking the juice mixed with food). R7 would not let go of the tray and became agitated when CNA 'K' tried to remove it from her, then eventually moved R7 to another table. At that time, R64's tray was removed after the Director of Nursing (DON) was alerted that other residents had made contact with his food. At approximately 12:49 PM, R72 was served his meal on a tray. A cup of juice was observed with plastic wrap on top of it and a nutritional shake was unopened on the tray. R72 asked the surveyor to help open the shake. At that time, Licensed Practical Nurse (LPN) 'E' sat down and began assisting R72. At 12:51 PM, R64 was served another meal which included a whole pork chop. No set up assistance was provided at that time. LPN 'E' was assisting R72 at 12:53 PM, then washed his hands and began assisting R64 at 12:54pm. However, when LPN 'E switched to assist R64, R72 spilled the nutritional shake and ate his food with a knife instead of the fork. Between 12:42 PM and 1:20 PM, R26 was observed with a plate of food placed in front of her. R26 was observed to pick at the grains of rice with her hands, but never successfully getting anything into her mouth. No staff stopped to encourage or assist R26 during that time frame and no food was consumed. Between 12:51 PM and 1:13 PM, R23 was observed with a plate of food placed in front of her. R23 remained asleep throughout that time. No staff were observed to attempt to wake R23 to encourage her to eat, until 1:13 PM, when CNA 'P' asked to take her tray away. CNA 'P' then fed R23 a few bites of food and then walked away. On 12/4/25 at 9:59 AM, an interview was conducted with Unit Manager, LPN 'B'. When queried about how staffing was determined to ensure residents received the appropriate assistance to meet their needs during meals, LPN 'B' reported she was unsure about the staffing decisions for the dining room on the second floor and would look into it. On 12/4/25 at 10:12 AM, an interview was conducted with the Director of Nursing (DON). When queried about how staffing was determined to ensure residents received the appropriate assistance to meet their needs during meals, the DON said it was based on the facility's policy, but she was not sure how it was determined and would look into it. The DON confirmed the second floor was mostly resident with cognitive impairment or who needed more assistance. A review of R7's clinical record revealed R7 was admitted into the facility on 1/10/19 and readmitted on [DATE] with diagnoses that included: dementia. A review of R7's care plans revealed R7 could be aggressive with other staff and residents and required set up assistance for meals. A review of R23's clinical record revealed R23 was admitted into the facility on 5/14/20 and readmitted on [DATE] with diagnoses that included: dementia. A review of R23's care plans revealed R23 required set up and supervision assistance by one staff member for eating. A review of R26's clinical record revealed R26 was admitted into the facility on 5/16/24 with diagnoses that included: Alzheimer's Disease. A review of R26's care plans revealed (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R26 required partial/moderate assistance from one staff member for eating.A review of R64's clinical record revealed R64 was admitted into the facility on 1/2/24 with diagnoses that included: dementia. A review of R64's care plans revealed R64 requires supervision/touching assistance from one staff member for eating. A review of R72's clinical record revealed R72 was admitted into the facility on 7/23/25 with diagnoses that included: dementia. A review of R72's care plans revealed R72 required set up or clean up assistance by one staff member for eating.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2662526.Based on observation, interview and record review, the facility failed to provide an environment that promoted and enhanced residents' dignity for three (R12, R49 and R23) of three residents reviewed for dignity. Findings include: On 12/2/25 at 10:55 AM, R12 was observed sleeping in a geriatric (geri) chair holding a baby doll. On 12/2/25 at 12:56 AM, Unit Manager [UM] C was observed to enter R12's room, go behind the geri chair R12 was reclining in and turn the chair around and pull R12 in the chair backwards out of the room. UM C then proceeded to pull R12 backwards down the hall to the dining room and continue to pull R12 backwards to a table on the far side of the room to a table. On 12/2/25 at 1:00 PM, UM C was interviewed and asked if she usually pulled residents backwards in geri chairs. UM C explained she always pulled the chairs as it was easier to pull the chair than to push. Review of the clinical record revealed R12 was admitted into the facility on 3/3/25 and readmitted on [DATE] with diagnoses that included: Alzheimer's disease, anxiety disorder and peripheral vascular disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R12 had severely impaired cognition. On 12/3/25 at 3:50 PM, the Director of Nursing (DON) was asked if it was appropriate to pull residents backwards in a geri chair. The DON explained residents should always be pushed in the chair facing forwards, not backwards. On 12/2/25 starting at approximately 12:35 p.m., the following observations were made during the lunch meal in the second-floor dining room: At approximately 1:08 p.m., Unit Manager B (UM B) was observed standing over R49 for an extended period of time while they were seated at the table attempting to help feed them. AT approximately 1:14 p.m., Certified Nursing Assistant P (CNA P) was observed entering the dining room. CNA P was then observed to stand over R23 and start to provide feeding assistance to them. On 12/3/25 at approximately 2:33 p.m., during a conversation with Registered Dietician O (RD O), RD O was queried regarding the provision of providing a dignified dining experience and the multiple observations of staff members standing over seated residents in the dining room providing feeding assistance to them. RD O indicated that staff who are providing feeding assistance should be seated next to them and engaging the residents in order to provide an optimal dining experience and treat them in a dignified manner. On 12/5/25 a facility document titled Feeding the Dependent Resident was reviewed and revealed the following: POLICY: It is the policy of this facility to ensure adequate nutrition for residents who are unable to feed themselves Sit at eye level of the resident. This allows social interaction and better observation if any swallowing difficulty arises . On 12/5/25 a second facility document titled Resident Rights was reviewed and revealed the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following: POLICY: It is the policy of this facility that all resident rights be followed per state and federal guidelines as well as other regulative agencies. 1. The Resident has the right: To be treated with consideration, respect, and full recognition of his or her dignity and individuality .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate advance directive information was in place for one (R33) of four residents reviewed for advance directives. Findings include: Review of the clinical record revealed R33 was admitted into the facility on [DATE] with diagnoses that included: major depressive disorder, vision loss and chronic kidney disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R33 scored had severely impaired cognition. Review of the facility's electronic medical record [emar] revealed at the top of the screen next to Advance Directive R33 was listed as Full Code.Review of a document titled, Advance Directive for R33 revealed an ?X' was marked in the box labeled Do Not Resuscitate (DNR) MUST HAVE ORDER ON FILE OR INITIATE DNR PAPERWORK, it was signed by R33, dated 12/27/24, signed by two witnesses on 12/27/24, and signed by a physician on 12/27/25. Then next page of the document was titled, DO-NOT-RESUSCITATE ORDER signed by the physician on 12/27/25 and signed by two witnesses on 12/27/25.Review of R33's comprehensive care plan revealed a Focus initiated 12/27/24 that read, Resident has established Advance Directive of DNR. I have a POA [Power of Attorney] that assists in making decisions.Review of R33's physician orders revealed an order for Full Code created by Unit Manager [UM] B on 4/25/25.Review of a document to determine competency for R33 revealed an ?X' was marked in the box labeled Incompetent. The form was signed by a second physician on 6/2/25.On 12/3/25 at 1:46 PM, Social Worker [SW] H was interviewed and asked about R33's emar listing R33 as full code when there was DNR paperwork signed by R33. SW H explained she had been hired recently and was currently doing an audit on Advance Directives on all the residents.On 12/3/25 at 1:54 PM, Licensed Practical Nurse [LPN] F, who was R33's assigned nurse, was asked what R33's code status was. LPN F explained it was full code. LPN F was asked how she knew what the code status was. LPN F explained it was at the top of the emar, and also on the Face Sheet.On 12/4/25 at 9:51 AM, UM B was interviewed and asked why R33's code status had been changed on 4/25/25 to full code when there was a signed DNR order. UM B explained she had been instructed by the former Director of Nursing (DON) to make R33 a full code by default while competency was being determined. UM B was asked why there was no advance directive signed by the POA after 6/2/25 when R33 was deemed incompetent. UM B had no explanation.On 12/4/25 at 11:35 AM, the DON was interviewed and asked what was the procedure for determining resident code status. The DON explained they had separate forms if the resident could sign themself, if there was a POA, or if there was a guardian. all the forms had to be signed by the doctor and witnesses. Review of a facility policy titled, Advance Directives updated 3/22/21 read in part, .Review of Advance Directives: 1. Advance Directive information should be reviewed during quarterly care planning sessions. 2. The staff shall review treatment options wit the resident or legal representative to determine if the wishes remain the same or if changes are desired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235036	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Rochester Hills Rehab and Nursing C	1480 Walton Blvd Rochester Hills, MI 48309

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 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 Incident #2569672 and Complaint #2677444.Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect for one (R5) of six residents reviewed for abuse and neglect, resulting in the resident being confined to bed and their room, not receiving any oral hygiene, and not being changed out of a hospital gown. Findings include:On 12/2/25 at 9:44 AM, R5 was observed asleep in bed. Signage was hung throughout the room and noted the following, Bra on always, Hospital gown on always, No wheelchair or gerichair, No oral care. The signage was signed by R5's responsible party. R5 was observed lying on her back in bed, wearing a hospital gown.On 12/2/25 at 2:35 PM, R5 was observed lying on her back in bed. R5 was awake and did not respond via eye contact or verbally when addressed. R5 was observed in a hospital gown.On 12/3/25 at 8:45 AM, R5 was observed lying on her back in bed wearing a hospital gown.On 12/3/25 at 10:44 AM, R5 was weighed using a mechanical lift by Certified Nursing Assistant (CNA) ?K' and CNA ?M'. Second floor Unit Manager, Licensed Practical Nurse (LPN) ?B' informed R5 that she was going to be weighed. R5 was more alert than the previous observations and stated, I hope so. During the observation, the mechanical lift sling was too big for the resident and she began to slip out and required a smaller size.On 12/3/25 at 10:55 AM, an interview was conducted with LPN ?B' regarding the size of the mechanical lift sling. LPN ?B' reported the mechanical lift was used only to weigh R5 because they do not get her out of bed per family's request. LPN ?B' further reported in the past when they got R5 out of bed and put her in the dining room, she enjoyed it and appeared comfortable.On 12/3/25 at 11:09 AM, an interview was conducted with CNA ?K'. CNA ?K' reported she began working in the facility approximately three weeks ago and has not gotten R5 out of bed.On 12/3/25 at 4:15 PM, an observation of R5's left hand was conducted with LPN ?B' and the Director of Nursing (DON). LPN ?A' reported after the earlier observation at 11:09 AM, R5 tried to swing her legs to the side of the bed and said she wanted to get out of bed to watch television. LPN ?B' reported they did not get her out of bed because the resident representative (family member) did not want her out of bed. At that time, LPN ?B' and the DON were interviewed about what had been done to ensure R5 received care to meet her physical and emotional needs, such as getting out of bed, getting dressed, and receiving oral hygiene. The DON reported they educated the family member. On 12/4/25 at 10:43 AM, an observation of R5's skin was conducted with the DON and LPN ?F'. R5's bra was not clean in appearance and was greenish in color underneath the armpit area.A review of R5's clinical record revealed R5 was admitted into the facility on 3/18/16 with diagnoses that included: [NAME]-Pick Disease Type C (a rare genetic disorder that causes abnormal accumulation of lipids within cells, leading to progressive organ damage and neurological impairment), dysphagia (difficulty swallowing), dementia, and aphasia (difficulty speaking). R5 received all nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) tube (feeding tube inserted in the stomach to deliver nutrition) and did not consume any food or fluids by mouth. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R5 had severely impaired cognition and was dependent on staff for bed mobility, transfers, and all activities of daily living (ADLs) including oral hygiene and upper and lower body dressing.Further review of R5's progress notes revealed R5 had a fall from bed on 6/9/25 and the Interdisciplinary Team (IDT) met and implemented the following intervention Resident to be offered to get up in geri chair daily.A review of a General Progress Note dated 6/9/25 revealed, Writer made contact with (DPOA). Writer attempted to inform RP (responsible party) about intervention that was placed for resident regarding recent fall. RP began to yell at writer stating we are to remove the airloss mattress (a mattress that redistributes air to relieve pressure and to assist in prevention of skin breakdown and pressure ulcers) from resident's bed and we are not to get resident up to any sort of chair. Writer again attempted to educate RP the rationale for intervention RP continued to yell at (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	writer and talk about when her son was at the facility.A review of a General Progress Note dated 6/9/25 revealed, Writer into see resident. As writer entered room, lab was in drawing ordered labs. Resident was awake and responsive to conversation. Writer asked resident if she would like to get up to geri chair. Resident responded with ?yes'. After lab draw was completed CNA completed care and resident was transferred into geri chair and take into dining room. Writer into speak with resident. Resident was asked if she was comfortable, she responded with a smile and stated ?yes'. Resident was then asked did she like that she was up to a chair, again responded with a smile and a ?yes'.A review of a General Progress Note dated 6/9/25 revealed, Resident's [sic] switched out from airloss to regular mattress per RP request.A review of a General Progress Note dated 7/22/25 revealed, This author spoke with the guardian in regards to resident being up in geri-chair. Guardian is requesting resident not to be up in chair. Guardian was educated that resident has the right to get up in chair everyday to prevent wounds.A review of a General Progress Note written by the DON on 10/10/25 revealed, DPOA (Durable Power of Attorney - A document that designates a person to make decisions for the resident when they were no longer able to) does not want oral care performed on this resident, DPOA states that she is afraid she is going to aspirate on water from the sponges. Education provided on oral care and the process of use of the sponges. DPOA does not want the oral care provided at all. Resident DPOA does not want the resident dressed in clothing, DPOA only wants the resident in a gown and a bra. Resident DPOA does not want the partials removed from the mouth of the resident and care perform on the partial dentures. Writer acknowledged understanding and did educate the DPOA on oral care risk vs (versus) benefit. DPOA stated she does not care she does not want it done along with the partials dentures, she does not want them removed either.A review of a General Progress Note dated 10/20/25 revealed, .resident's DPOA does not want the resident up in Geri chair, does not want the resident dressed for the day.A review of R5's care plans revealed the following:A care plan initiated on 10/10/25 that noted, Residents (DPOA) does not [sic] the resident dressed, she only wants the resident in gown. DPOA does want bra on 24 hours a day.DO NOT DRESS THIS RESIDENT IN CLOTHING GOWN ONLY and BRA ONLY, DO NOT REMOVE BRA AT NIGHT. REMOVE AND REPLACE WHEN GOWN IS CHANGED - per DPOA. An intervention initiated on 1/1/24 noted, TRANSFERS: Dependent x 2 person assist.(family requests resident to stay in bed). An intervention revised on 10/2/25 noted, Resident uses a manual wheelchair for locomotion (mother requests resident not get up in w/c - wheelchair).A care plan initiated on 1/23/25 and revised on 10/10/25 revealed, Resident requires tube feeding.Resident DPOA does not want any oral care performed.also does not want care performed on partial dentures. An intervention initiated on 10/10/25 noted, DO NOT PERFORM ORAL CARE ON THIS RESIDENT - per DPOA.DO not remove and perform care on the residents partial dentures. PER DPOA.A care plan that noted R5 was at risk for falls was initiated on 9/27/23 and revised on 10/2/25 and included an intervention to get R5 up to geri chair daily (initiated on 6/9/25).On 12/4/25 at 8:45 AM, an interview was conducted with the DON. When queried about what could happen if partial dentures were not ever removed from someone's mouth and their oral hygiene was not tended to, the DON reported it could result in an infection. When queried about what the facility had done to address the basic care needs R5's DPOA has asked the facility not to provide, the DON reported she talked to the DPOA and the Administrator about it and they educated the DPOA about the risks. The DON reported R5's DPOA gets mad and yells if they did oral care or removed the partial dentures. The DON reported it was the same reaction if the facility got R5 out of bed. When queried about what the facility's protocol was if a resident's representative (decision maker) was not making decisions in the best interest of the resident, the DON asked if it would be the same if a resident wanted to leave the building, but the DPOA said they could not. When queried about the difference between basic care that was necessary for the resident to meet their highest practicable physical and mental well-being and a choice (such as leaving the building unsupervised) that could be unsafe for a resident, the DON did not offer a response. When queried about whether any investigation was done into the neglectful practices requested by the DPOA, the DON reported she spoke with the (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator. On 12/4/25 at 9:10 AM, an interview was conducted with the Administrator/Abuse Coordinator via the telephone. When queried about the facility's process when a resident's legal representative did not make decisions in the best interest of the resident that could potentially cause harm, the Administrator reported it would depend on the situation, but an investigation would be conducted to determine how that allegation was formed.When queried about R5's basic care needs being neglected per the DPOA's request (oral care, getting out of bed, leaving the room, getting dressed), the Administrator reported he was not aware of an issue, but stated, We would have to put a stop to that because we have to base the care on doctor's orders and a team approach. The Administrator reported the facility was responsible for keeping residents at their highest practical level of functioning. The Administrator further reported required care in the facility was not directed based on the desires of the DPOA. When queried about whether he was aware that R5 had a care plans implemented since 1/1/24 to not get R5 out of bed, since 10/2/25 to not get R5 up in a wheelchair, since 10/10/25 to not perform oral care , to not remove partial dentures, and to not dress R5 in clothing other than a gown and to keep a bra on 24 hours a day, the Administrator reported he was not aware but confirmed he was familiar with the resident.A review of a facility policy titled, Abuse and Neglect, revised on 6/17/19, revealed, in part, the following, It is the policy of this facility to provide professional care and services in an environment that is free from any type of.neglect.Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being.Neglect is the failure to provide necessary and adequate (medical, personal or psychological) care. Neglect is the failure to care for a person in a manner which would avoid harm and pain, or the failure to react to a situation which may be harmful. Neglect may or may not be intentional.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Incident #2569672 and Complaint #2677444. Based on observation, interview, and record review, the facility failed to report incidents of neglect to the Abuse Coordinator and the State Agency for one (R5) of six resident reviewed for abuse and neglect. Findings include:On 12/2/25 at 9:44 AM, R5 was observed asleep in bed. Signage was hung throughout the room and noted the following, Bra on always, Hospital gown on always, No wheelchair or gerichair, No oral care. The signage was signed by R5's responsible party. R5 was observed lying on her back in bed, wearing a hospital gown.On 12/2/25 at 2:35 PM, R5 was observed lying on her back in bed. R5 was awake and did not respond via eye contact or verbally when addressed. R5 was observed in a hospital gown.On 12/3/25 at 8:45 AM, R5 was observed lying on her back in bed wearing a hospital gown.On 12/3/25 at 10:44 AM, R5 was weighed using a mechanical lift by Certified Nursing Assistant (CNA) ?K' and CNA ?M'. Second floor Unit Manager, Licensed Practical Nurse (LPN) ?B' informed R5 that she was going to be weighed. R5 was more alert than the previous observations and stated, I hope so. During the observation, the mechanical lift sling was too big for the resident and she began to slip out and required a smaller size.On 12/3/25 at 10:55 AM, an interview was conducted with LPN ?A' regarding the size of the mechanical lift sling. LPN ?B' reported the mechanical lift was used only to weigh R5 because they do not get her out of bed per family's request. LPN ?B' further reported in the past when they got R5 out of bed and put her in the dining room, she enjoyed it and appeared comfortable.On 12/3/25 at 4:15 PM, an observation of R5's left hand was conducted with LPN ?B' and the Director of Nursing (DON). LPN ?A' reported after the earlier observation at 11:09 AM, R5 tried to swing her legs to the side of the bed and said she wanted to get out of bed to watch television. LPN ?B' reported they did not get her out of bed because the resident representative (family member) did not want her out of bed. At that time, LPN ?B' and the DON were interviewed about what had been done to ensure R5 received care to meet her physical and emotional needs, such as getting out of bed, getting dressed, and receiving oral hygiene. The DON reported they educated the family member and updated the care plan to reflect the DPOA's wishes. On 12/4/25 at 10:43 AM, an observation of R5's skin was conducted with the DON and LPN ?F'. R5's bra was not clean in appearance and was greenish in color underneath the armpit area.A review of R5's clinical record revealed R5 was admitted into the facility on 3/18/16 with diagnoses that included: [NAME]-Pick Disease Type C (a rare genetic disorder that causes abnormal accumulation of lipids within cells, leading to progressive organ damage and neurological impairment), dysphagia (difficulty swallowing), dementia, and aphasia (difficulty speaking). R5 received all nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) tube (feeding tube inserted in the stomach to deliver nutrition) and did not consume any food or fluids by mouth. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R5 had severely impaired cognition and was dependent on staff for bed mobility, transfers, and all activities of daily living (ADLs) including oral hygiene and upper and lower body dressing.A review of a General Progress Note dated 6/9/25 revealed, Writer made contact with (DPOA). Writer attempted to inform RP (responsible party) about intervention that was placed for resident regarding recent fall. RP began to yell at writer stating we are to remove the airloss mattress (a mattress that redistributes air to relieve pressure and to assist in prevention of skin breakdown and pressure ulcers) from resident's bed and we are not to get resident up to any sort of chair. Writer again attempted to educate RP the rational for intervention RP continued to yell at writer and talk about when her son was at the facility.A review of a General Progress Note dated 6/9/25 revealed, Writer into see resident. As writer entered room, lab was in drawing ordered labs. Resident was awake and responsive to conversation. Writer asked resident if she would like to get up to geri chair. Resident responded with ?yes'. After lab draw was completed CNA completed care and resident was transferred into geri chair and take into dining room. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Writer into speak with resident. Resident was asked if she was comfortable, she responded with a smile and stated ?yes'. Resident was then asked did she like that she was up to a chair, again responded with a smile and a ?yes'.A review of a General Progress Note dated 6/9/25 revealed, Resident's [sic] switched out from airloss to regular mattress per RP request.A review of a General Progress Note dated 7/22/25 revealed, This author spoke with the guardian in regards to resident being up in geri-chair. Guardian is requesting resident not to be up in chair. Guardian was educated that resident has the right to get up in chair everyday to prevent wounds.A review of a General Progress Note written by the DON on 10/10/25 revealed, DPOA (Durable Power of Attorney - A document that designates a person to make decisions for the resident when they were no longer able to) does not want oral care performed on this resident, DPOA states that she is afraid she is going to aspirate on water from the sponges. Education provided on oral care and the process of use of the sponges. DPOA does not want the oral care provided at all. Resident DPOA does not want the resident dressed in clothing, DPOA only wants the resident in a gown and a bra. Resident DPOA does not want the partials removed from the mouth of the resident and care perform on the partial dentures. Writer acknowledged understanding and did educate the DPOA on oral care risk vs (versus) benefit. DPOA stated she does not care she does not want it done along with the partials dentures, she does not want them removed either.A review of a General Progress Note dated 10/20/25 revealed, .resident's DPOA does not want the resident up in Geri chair, does not want the resident dressed for the day.A review of R5's care plans revealed the facility implemented the requests to withhold oral care, removing the partial denture, getting the resident out of bed and the room, and dressing the resident in clothing per the DPOA's request. On 12/4/25 at 8:45 AM, an interview was conducted with the DON. When queried about what could happen if partial dentures were not ever removed from someone's mouth and their oral hygiene was not tended to, the DON reported it could result in an infection. When queried about what the facility had done to address the basic care needs R5's DPOA has asked the facility not to provide, the DON reported she talked to the DPOA and the Administrator about it and they educated the DPOA about the risks. The DON reported R5's DPOA gets mad and yells if they did oral care or removed the partial dentures. The DON reported it was the same reaction if the facility got R5 out of bed. When queried about what the facility's protocol was if a resident's representative (decision maker) was not making decisions in the best interest of the resident, the DON asked if it would be the same if a resident wanted to leave the building, but the DPOA said they could not. When queried about the difference between basic care that was necessary for the resident to meet their highest practicable physical and mental well-being and a choice (such as leaving the building unsupervised) that could be unsafe for a resident, the DON did not offer a response. When queried about whether any investigation was done into the neglectful practices requested by the DPOA, the DON reported she spoke with the Administrator. On 12/4/25 at 9:10 AM, an interview was conducted with the Administrator/Abuse Coordinator via the telephone. When queried about the facility's process when a resident's legal representative did not make decisions in the best interest of the resident that could potentially cause harm, the Administrator reported it would depend on the situation, but an investigation would be conducted to determine how that allegation was formed. When queried about R5's basic care needs being neglected per the DPOA's request (oral care, getting out of bed, leaving the room, getting dressed), the Administrator reported he was not aware of an issue, but stated, We would have to put a stop to that because we have to base the care on doctor's orders and a team approach. The Administrator reported the facility was responsible for keeping residents at their highest practical level of functioning. The Administrator further reported required care in the facility was not directed based on the desires of the DPOA. When queried about whether he was aware that R5 had a care plans implemented since 1/1/24 to not get R5 out of bed, since 10/2/25 to not get R5 up in a wheelchair, since 10/10/25 to not perform oral care , to not remove partial dentures, and to not dress R5 in clothing other than a gown and to keep a bra on 24 hours a day, the Administrator reported he was not aware but confirmed he was familiar with the resident. The Administrator (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed he did not report the neglect of R5 to the State Agency or conduct an investigation because it was not brought to his attention in that way. A review of a facility policy titled, Abuse and Neglect, revised on 6/17/19, revealed, in part, the following, .Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being.Neglect is the failure to provide necessary and adequate (medical, personal or psychological) care. Neglect is the failure to care for a person in a manner which would avoid harm and pain, or the failure to react to a situation which may be harmful. Neglect may or may not be intentional.All allegations and/or suspicions of abuse must be reported to the Administrator immediately .All allegations of abuse will be reported to the appropriate State Agencies immediately after the initial allegation is received .

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure PASSAR (Preadmission Screening/Annual Resident Review) documentation and OBRA Level II exemption criteria were completed appropriately for two residents (R3 and R20) of three residents reviewed for PASSAR/OBRA (Omnibus Budget Reconciliation Act) assessments. Findings include:R3A review of R3's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Bipolar disease, paranoid schizophrenia, PTSD (post-traumatic stress disorder) and chronic pain. Continued review of R3's clinical record noted a document dated November 6, 2024 that read, .completed an OBRA Level II Evaluation on the above named individual (R3).Determination.Specialized Mental Health Services.Individual's physical, mental and psychosocial needs can be met in a nursing facility.If the above named individual remains in the nursing facility a Level II Evaluation is needed by November 5, 2025. *It should be noted that the Level II Evaluation that needed to be completed by 11/5/25 was not done. R20A review of R20's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: undifferentiated schizophrenia, bipolar disorder and adjustment disorder. Continued review of R20's clinical record noted a document dated September 11, 2024 that read, .completed an OBRA Level II Evaluation on the above named individual (R3).Determination.Specialized Mental Health Services.Individual's physical, mental and psychosocial needs can be met in a nursing facility.If the above named individual remains in the nursing facility a Level II Evaluation is needed by September 10, 2025. *It should be noted that the Level II Evaluation that needed to be completed by 9/10/25 was not done. 12/03/2025 at approximately 1:40 PM, Social Worker (SW) H was interviewed and asked about OBRA Level II evaluations that had not been completed. SW H reported that they were fairly new to the facility and determined that prior to their employment several residents, including R3 and R20 had not received Level II evaluations as needed. SW H reported that they were completing audits on the residents and hoped the Level II's would be addressed.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure professional standards for Nursing were practiced including performing accurate assessments and maintaining an accurate treatment record for two residents (R5 and R64) of two residents reviewed for Professional Standards. Findings include: On 12/2/25 at 9:44 AM, R5 was observed lying in bed sleeping. A tube feeding pole was observed tucked behind the privacy curtain, but no tube feeding formula was hung or infusing. On 12/2/25 at approximately 12:20 PM, an observation of R5 was made. When spoken to R5 did not respond or make eye contact. No tube feeding was hung in the room at that time. A review of R5's Physician's Orders revealed an active order for .Jevity 1.5 via pump per PEG (Percutaneous Endoscopic Gastrostomy - a tube surgically inserted into the stomach to deliver nutrition) at 65 ml/hr (milliliters per hour) x 18 hours (up at 6pm) or until total volume of 1170 mL is reached daily . On 12/3/25 at 8:13 AM, R5 was observed in bed with no tube feeding hung in the room. On 12/3/25 at 8:30 AM, a review of R5's Medication Administration Record (MAR) for December 2025 revealed Licensed Practical Nurse (LPN) 'E' signed off that 325 ml of tube feeding was administered on 12/3/25 day shift. However, it should be noted that there was no tube feeding hung during the observation at 8:13 AM and if the tube feeding was hung according to the physician's orders at 6:00 PM, the tube feeding would not have been taken down until 12:00 PM to equal 18 hours of feeding. On 12/3/25 at 8:45 AM, an interview was conducted with LPN 'E'. When queried about R5's tube feeding and why there was nothing hung and infusing, LPN 'E' said there was nothing hanging when he arrived on the day shift and stated, The night nurse must not have hung the second bottle. When queried about why he signed off that 325 ml was administered if there was nothing hung, LPN 'E' stated, That is the amount she will get today. When queried about whether it was protocol to sign out administration of something that was not yet done, LPN 'E' stated, I don't know. I don't want to say the wrong thing. At that time, LPN 'E' then obtained a bottle of tube feeding formula, hung it up, but did not start it. The bottle of Jevity contained 1000 ml of formula when full. On 12/3/25 at 9:00 AM, an interview was conducted with Unit Manager, LPN 'B'. When queried about when the nurses documented administration of medication or treatments, including tube feeding, LPN 'B' reported they would document on the MAR after it was administered. On 12/3/25 at 10:55 AM, Certified Nursing Assistant (CNA) 'K' and CNA 'M' were observed weighing R5 using a mechanical, battery powered lift that utilized a cloth sling placed underneath the resident, hooked to the lift, which then was operated to lift the resident up into the air. At that time, CNA 'K' and CNA 'M' placed an extra-large (XL) underneath R5, hooked the sling to the mechanical lift, and began lifting R5 off the bed. As they lifted R5, R5's lower body started slipping out of the end of the sling. Unit Manager, Licensed Practical Nurse (LPN) 'B' and LPN 'E' were present in the room during the transfer. LPN 'B' instructed CNA 'K' and CNA 'M' to readjust the position of the sling. When R5 was lifted a second time, the sling began to slip overtop her head. At that time, CNA 'K' and LPN 'B' went to find a different size sling. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/25 at approximately 11:05 AM, an interview was conducted with LPN 'B'. When queried about how the CNAs knew what sling size to use, LPN 'B' reported it was based off of the assessment. LPN 'B' reported R5's responsible party did not want her to get out of bed, so the mechanical lift was only used once a month to weigh the resident. A review of a Resident Lift Assessment for R5 dated 12/3/25 at 9:46 AM (prior to the above observation) completed by the Director of Nursing (DON) revealed the sling size for R5 was XL - Xtra Large. A review of the previous Resident Lift Assessment for R5 dated 11/29/25 revealed the sling size was L - Large. A review of a Resident Lift Assessment for R5 dated 12/3/25 at 11:25 PM completed by LPN 'B' revealed the sling size for R5 was changed to L - Large. On 12/3/25 at 11:37 AM, an interview was conducted with the DON. When queried about how she assessed R5 for the correct sling size on that day, the DON stated, We talked about it. The DON further explained that she did not physically assess R5 and LPN 'B' said R5 was an XL so that was what she documented on the assessment. On 12/3/25 at 12:33 PM, an interview was conducted with LPN 'B'. When queried about the assessment completed on 12/3/25 prior to weighing R5, LPN 'B' reported they did an assessment because we knew you wanted her weight. When queried about how R5 was assessed for the sling size, as the size was incorrect and too big which caused the resident to start to slip out of the sling, LPN 'B' stated, We held the sling over here. LPN 'B further said a large sling was not available, so they just measured it on her by holding it over her. LPN 'B' stated, I'm glad I was in there to stop them (when R5 started falling out of the sling). A review of R5's clinical record revealed R5 was admitted into the facility on 3/18/16 with diagnoses that included: [NAME]-Pick Disease Type C (a rare genetic disorder that causes abnormal accumulation of lipids within cells, leading to progressive organ damage and neurological impairment), dysphagia (difficulty swallowing), dementia, and aphasia (difficulty speaking). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R5 had severely impaired cognition and was dependent on staff for transfers. R64 On 12/2/25 at approximately 10:55 a.m., R64 was observed in the second-floor dining room. R64's left forearm was observed to have a foam dressing that had an application date of 11/30/25 with Nurse T's initials on it, indicating who administered the dressing. On 12/2/25 at approximately 12:34 p.m., R64 was observed in the dining room, sitting at a table and was still observed to have the dressing on their left forearm that was dated 11/30/25. On 12/2/25 the medical record for R64 was reviewed and revealed the following: R64 was initially admitted on [DATE] and had diagnoses including Dementia and Hypokalemia. A review of R64's MDS (minimum data set) with an ARD (assessment reference date) of 10/7/25 revealed R64 needed assistance from facility staff with most of their activities of daily living. R64's BIMS score (brief interview for mental status) was zero indicating severely impaired cognition. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's order dated 11/20/25 revealed the following: Cleanse L (left) elbow skin tear with wound cleanser. Pat dry. Apply thin layer TAO (triple antibiotic ointment) and cover with boarder foam dressing. A review of R64's December 2025 Treatment Administration Record (TAR) revealed documentation by Nurse S that they had changed R64's dressing on 12/1/25. On 12/3/25 at approximately 2:04 p.m., during a conversation with Unit Manger B (UM B), UM B was informed of the multiple observations of R64's forearm dressing on 12/2/25 with the date of 11/30/25 and Nurse T's initials on it. R64's December 2025 TAR was reviewed with UM B and they were shown that Nurse S had documented they had administered the treatment on 12/1/25 when it was dated 11/30/25 by Nurse T. UM B indicated that Nurse S should not have documented the treatment as being completed when it was not and that Nurses should only document in the TAR if they actually performed the treatment. A document from the American Nurses Association titled Principles for Nursing Documentation revealed the following: Overview of Nursing Documentation-Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Nurses practice across settings at position levels from the bedside to the administrative office; .Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review, the facility failed to provide nail care and eating assistance for three dependent residents (R3, R23 and R26) of three residents reviewed for activities of daily living (ADL's). Findings include: On 12/2/25 starting at approximately 12:35 p.m., the following observations were made during the lunch meal in the second-floor dining room: At approximately 12:42 p.m., R26 was observed in dining room attempting to each the lunch meal by themself without any assistance. R26 was observed to be having a hard time getting any food off of their plate. At that time, a review of R26's Meal ticket (an informational paper that states the residents assistive deices, diet order and assistance level) was conducted which indicated R26 required assistance from staff with meals. At approximately 12:51 p.m., R23 was observed in the dining room, attempting to eat the lunch meal. R23 was observed sitting in their chair. R23 was observed to be silently staring, and their food was not touched. No assistance was observed being provided to R23 to help them eat the lunch meal. At approximately 12:56 p.m., R26 was still observed attempting to eat the lunch meal. R26's plate was observed to contain almost all of their food. R23 was observed to not have any staff assisting them. At approximately 1:05 p.m., R23 and R26 were both observed at their tables without having consumed any food. No assistance was observed to have been provided from staff with eating. At approximately 1:13 p.m., Certified Nursing Assistant P (CNA P) was observed to enter the dining room and ask to take R23's and R26's full meals away from them. At approximately 1:14 p.m., CNA P was observed to attempt to assist R23 with feeding by standing up over them and trying to encourage R23 to take a bite of food and then after a few bites, left R23's presence. At that time, CNA P was queried if R23 needed assistance from staff with eating and they indicated that they normally did not. At approximately 1:20 p.m., R26 was still observed attempting to eat the lunch meal. R26's plate was observed to contain almost all of their food and did not appear successful in eating the lunch meal without any assistance. At approximately 1:21 p.m., CNA P was queried if R26 needed assistance from staff with eating and they indicated that they sometimes did require help with eating. On 12/3/25 at approximately 8:19 a.m., R26 was observed lying in bed awake. R26 expressed feeling hungry and said she had not received breakfast yet. R26 was asked if she had any concerns about the care in the facility and R26 stated, They don't pay any attention to us. When queried about the lunch observation on 12/2/25 when R26 was observed having difficulty feeding herself and did not consume her meal or receive assistance from staff, R26 reported she needed help eating at times and stated, They don't pay attention to us. R26 again expressed that she was very hungry and wanted to know when she would receive breakfast. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/25 at approximately 2:33 p.m., during a conversation with Registered Dietician O (RD O), RD O was queried regarding the lack of assistance being provided to both R23 and R26 during the lunch meal observation on 12/2/25 and they reported that staff should being providing assistance to residents who were having difficulty eating the meal on their own. On 12/3/25 a review of R23's comprehensive plan of care was conducted and revealed the following: Focus-I have nutritional problem or potential nutritional problem r/t (related to) h/o (history of) dementia, dysphagia, anxiety DO (disorder), diabetes and major depressive DO provide finger foods-Hospice patient. Date Initiated: 09/18/2024 .Interventions-Offer meal setup and feeding assistance as resident allows. Date Initiated: 09/18/2024 On 12/3/25 a review of R26's comprehensive plan of care was conducted and revealed the following: Focus-I have an ADL self-care performance deficit related to Alzheimer's Disease, Adjustment disorder with mixed Anxiety and depressed mood, Psychotic disorderwith hallucinations, muscle weakness, Difficulty in walking, generalized muscle weakness, and psychoactive drug use Date Initiated: 08/14/2023 .Interventions-EATING: 1 person partial/moderate assist Date Initiated: 05/25/2024 . On 12/4/25 at 9:59 a.m., an interview was conducted with second floor Unit Manager, Licensed Practical Nurse (LPN) 'B'. When queried about what should be done if a resident was having difficulty eating or they had not touched their food, LPN 'B' reported the expectation was that staff would physically assist or attempt to encourage the resident to eat. On 12/4/25 a facility document titled Feeding the Dependent Resident was reviewed and revealed the following: POLICY: It is the policy of this facility to ensure adequate nutrition for residents who are unable to feed themselves Sit at eye level of the resident. This allows social interaction and better observation if any swallowing difficulty arises . On 12/2/25 at approximately 9:30 AM, R3 was observed lying in bed. The resident had disheveled hair and dirty long fingernails on both hands. The resident was alert and able to answer questions asked. R3 was asked about the dirty long nails and stated that they had not been cut in a while and could not remember the last time they had a shower. R3 also alleged their roommate bit them and tried to kiss them. They indicated the bite was on their left arm near their elbow. The allegation was reported to facility staff. A review of R3's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Bipolar disease, paranoid schizophrenia, PTSD (post-traumatic stress disorder) and chronic pain. A review of the Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 11/15 (moderate cognitive impairment). A review of R3's ADL Kardex and Tasks for the past 30 days showed no documentation that pertained to nail care. The last noted shower provided was on 11/27/25. Continued review of R3's record was a General Progress Note dated 12/4/25: . During survey resident reported that he had been bitten by (name redacted) roommate. Area.is on the top of left forearm.the top of the left forearm appears as a skin abnormality.resident has 2 small open areas to the left wrist.The resident.was scratching both areas.Writer asked if the writer could see his nails, nails are over the base of the finger. Redness was noted under the residents' nails as well and dry brown in color was grit under the nails as well .it was reported that resident refused nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was asked to provide documentation pertaining to nail care. The DON reported that it is not in the electronic record but would attempt to locate paper skin observations. The documents were reviewed and noted a section titled: Nails Filed and Needs Clipping. Documents provided for November dated: 11/3/25, 11/10/25, 11/13/25, 11/20/25 and 11/27/25 did not indicate R3's nails were either filed or needed clipping.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure timely identification of pressure ulcers for one (R12) of three residents reviewed for pressure ulcers resulting in R12's right heel pressure ulcer and right gluteal fold pressure ulcer being first identified as an Unstageable (obscured full-thickness skin and tissue loss) pressure ulcer. Findings include:This citation pertains to Intake 2598727On 12/2/25 at 10:55 AM, R12 was observed sleeping in a geriatric (geri) chair holding a baby doll.On 12/2/25 at 11:40 AM, R12's Power of Attorney (POA) was interviewed by phone and asked about the care at the facility. R12's POA explained back in the first part of April 2025, she had noticed R12's socks were dirty and seemed wet on the bottom so she took them off and found an open wound on R12's right heel. then a little while later R12 got a pressure ulcer on the left heel. then in September 2025, R12 got a pressure ulcer on her bottom. was told it was from the brief rubbing on R12's skin. Review of the clinical record revealed R12 was admitted into the facility on 3/3/25 and readmitted on [DATE] with diagnoses that included: Alzheimer's disease, anxiety disorder and peripheral vascular disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R12 had severely impaired cognition.Review of a Wound IDT [Interdisciplinary Team] progress note for R12 dated 5/6/25 at 12:54 PM read in part, Resident was seen today during wound care rounds, due to a new area that was found on resident right heel.Review of a Skin & Wound Evaluation for R12 dated 5/6/25 read in part, .Type: 4. Blister. Location: Right Heel. Acquired: 1. In-House Acquired. Exact Date: 5/6/25. Length: 4.5 cm [centimeters]. Width 3.2 cm. Other: 10. Ruptured blister. Exudate [drainage]: 1. Amount: 3. Moderate. 2. Type: Serosanguineous [containing blood and serous fluid] . 3. Odor noted after cleansing: 2. Faint. Additional Care: 18. Other. 18a. Other, specify: heel protection.Review of progress notes for R12 revealed:A Wound IDT note dated 5/14/25 at 11:07 AM read in part, Wound care rounds completed. on 5/13/25. Right heel unstageable wound measures 6.5 x 6.5 x UTD [undetermined]. Wound bed is noted with 90% eschar [dead or devitalized tissue that is hard or soft in texture] and 10% slough eschar [dead or devitalized tissue that is hard or soft in texture]. There is moderate serosang [sic] malodorous drainage noted to old dressing. The wound is fragile and has noted decline. The left heel has a new stage 2 [partial-thickness skin loss with exposed dermis] clear fluid filled blister. Area measures 5.5 x 4.5 x UTD. The superior aspect of the blistered area has a DTI [Deep Tissue Injury - persistent non-blanchable deep red, maroon or purple discoloration] that measures 0 x 1.5 x UTD. Area is 100% maroon purplish in color.A Wound IDT note dated 5/20/25 at 8:59 PM read in part, Resident was seen today during wound care rounds. Right heel DTI due to trauma. Measurements are 4.0x2.1xUTD, wound bed was 10% slough and 90% eschar. There was a moderate amount of drainage that had an odor to it. Also seen. left heel that has a fluid filled blister with measurements of 5.5x4.5xUTD.A General note dated 8/11/25 at 1:27 PM read in part, Wound care rounds completed on 8/7/25. Right heel stage 4 [full-thickness skin and tissue loss] pressure injury measures 2.2 x 2.5. Wound bed is 90% granulated and 10% eschar. Left heel DTI measures 2.5 x 1.8 it is 100% scabbed.A General note dated 9/9/25 at 11:28 AM read in part, Writer made aware via floor nurse that resident has a new open area to right gluteal fold. Upon assessment by writer area measures 2.3 x 1.2 x 1.3. Wound bed is 60% granulation tissue and 40% slough.Review of consultation reports by Nurse Practitioner (NP) Q, who was the facility's contracted Wound Care NP, revealed:9/11/25, .Wound 1: Right heel stage IV, pressure wound. Measurement: 5.7 x 3.1 x 1.0 cm [centimeters]. Wound 2: Left heel stage III pressure wound. Measurement: 1.1 x 0.5 cm x SF [superficial] . Wound 3: Right gluteal unstageable pressure-induced tissue damage. New wound. Measurement: 1.9 x 1.1 cm x UTD. Tissue Type: 50% granulation, 50% slough.9/18/25, .Wound 1: Right heel, stage IV, pressure wound. Measurement: 1.6 x 3.8 x 0.1 cm. Wound 2: Left heel, stage III pressure wound. Measurement 1.1 x 0.7 cm x SF. Wound 3: Right gluteal unstageable pressure-induced tissue damage is now reclassified as stage IV pressure wound. Measurement: 2.4 x (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.2 x 3.0 cm.On 12/4/25 at 11:28 PM, the Director of Nursing was interviewed and asked about R12's pressure ulcers. The DON explained she had not been the DON when R12's pressure ulcers were first identified; however, Unit Manager [UM] B had been the Wound Care Coordinator at that time.On 12/4/25 at 2:20 PM, UM B was interviewed and asked at what stage should a pressure ulcer be identified. UM B explained ideally, it would be identified at Stage 1 [non-blanchable erythema of intact skin], but Stage 2 is often when they are identified. When asked if pressures ulcers should be discovered when Unstageable or Stage 3, UM Q explained they should not. UM Q was asked about R12's right heel and right gluteal fold not being discovered until they were Unstageable. UM Q had no explanation.Review of a facility policy titled, Skin Monitoring and Management - Pressure Ulcer adopted 7/11/18 read in part, .F. Assessment of wounds identified after admission: A licensed nurse (which may be the facility Wound Nurse) must assess/evaluate a resident's skin at least weekly. All areas of breakdown, excoriation, or discoloration, or other unusual findings much be documented in the resident's clinical record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has two deficient practices. Deficient Practice #1 Based on observation, interview and record review the facility failed to ensure effective interventions were implemented to prevent multiple/re-occurring falls for one resident (R49) of nine residents reviewed for Accidents/Hazards. Findings include: Resident #49 On 12/2/25 at approximately 10:51 a.m., R49 was observed in the second-floor dining room, up in their wheelchair. R49 was observed to have a large green/yellow bruise on their upper left extremity. R49 was queried how they got the bruise and they reported they could not remember. On 12/2/25 the medical record for R49 was reviewed and revealed the following: R49 was originally admitted to the facility on [DATE] and had diagnoses including Parkinsons and Lack of coordination. A review of R49's MDS (minimum data set) with an ARD (assessment reference date) of 11/2/25 revealed R49 needed assistance from staff with their activities of daily living. A review of R49's care plan revealed the following: Focus- [R49] is at risk for falls/injury related to bladder incontinence, hypotension, needs assistance with ADLs (activities of daily living), psychoactive medication use, Muscle weakness, Difficulty in walking, and Abnormal posture, Date Initiated: 08/11/2023 .Interventions-Encourage resident to wear non skid socks when shoes are not being worn. Date Initiated: 05/08/2025 .Assist the resident to wheelchair when awake and move to common area for frequent observations. Date Initiated: 11/24/2025 A review of R49's falls over the last month revealed the following incident and accident reports (I/A's): 11/18/25-Incident Description-Nursing Description: Nurse Manager at nurses station witnessed resident walking with walker from her room towards nurses station when resident stumbled and fell to the floor on her buttocks. Patient Description: Resident stated she was on her way to a bedpan .Immediate Action Taken-Description: .Physician notified, Guardian made aware. Intervention: non skid socks when shoes are not worn .Other Info (information)-Resident had no footwear on just socks at time of occurrence. 11/19/25-Incident Description-Nursing Description: Writer called to room by nurse aide, upon entering resident room, writer observed a half circle skin tear to side of L (left) elbow. Patient Description: Resident reported she attempted to toilet herself in the night, her feet twisted reaching for her walker and fell to the floor, she then transferred herself back into bed. Immediate Action Taken-Description: Writer assessed resident for injuries, .pain level assessed, pain medication administered, nonskid socks applied, wound care given per order, writer educated resident on use of call light, .Neuro checks initiated. 11/20/25-Incident Description-Nursing Description: Writer observed patient crawling out of bed onto the floor on the left side of the bed closest to the roommate. Bed was observed in lowest position. Call light on the floor, call light was not active Patient Description: Writer asked what initiated the incident, patient stated I wanted to get up. Immediate Action Taken-Description: Assessment (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed. Resident has no noted injuries and no c/o pain. Resident assisted up in chair, in hallway by 2 staff and gait belt Physician made aware, new orders obtained to transfer resident out for further evaluation. Guardian notified. Intervention: bolster mattress to bed to help define bed boundaries .Other Info-Resident wearing plain black socks no grippers. 11/23/25-Incident Description-Nursing Description: Writer was informed by cna (Certified Nursing Assistant) that resident was on the floor. [R49] was observed lying on her right side on the side of her bed. Patient Description: Resident stated, I was trying to get up and get into my chair. Immediate Action Taken Description: Writer advised cna to get patient dressed and up into her chair. She was moved to sit at the nurse station for further observation. Resident was taken then taken by an activity aide for activities in the dining room. 11/25/25-Incident Description Nursing Description: Writer observed resident roll out of bed onto floor. Resident was lying on her right side on the side of her bed. Patient Description: Patient stated, I wanted to get on the floor or in my chair. 11/29/25-Incident Description Nursing Description: Writer was informed by CNA that resident was observed laying on her right side on the floor in the dining room. Patient Description: Writer asked the patient what led to the incident, patient stated, I was trying to get out Immediate Action Taken-Description: Staff assisted resident into geri (geriatric) chair. CNA provided care and placed resident in her room in her bolstered mattress. Bed placed in lowest position. A progress note dated 12/3/2025 at 07:59 revealed the following: Nurse made writer aware resident was in her room sitting on her buttocks in front of her wheelchair. Upon assessment resident is noted to be diaphoretic, with elevated BP (blood pressure). Physician contacted and made aware orders obtained to transfer resident to hospital for further evaluation. EMS (emergency medical system) contacted for transport. Bed hold policy sent with EMT's and hospital paperwork. On 12/4/25 at approximately 12:30 p.m., during a conversation with Unit Manger B (UM B), UM B was queried regarding R49's multiple reoccurring falls. UM B indicated that they had put interventions in place like non-skid/grippy socks. UM B informed of the multiple falls after the sock intervention was initiated on 5/8/25 that documented R49 did not have any grippy socks applied and they acknowledged the concern and reported that they believed R49 was experiencing a change due to some elevated blood sugars and had tried to add some medication to their regimen. UM B was quired regarding any increased monitoring if they identified a change and increase in fall and they indicated that they were trying to ensure R49 was in the common room during the day. UM B was informed of the multiple falls in R49's room that occurred in the day like the one on 11/25/25 at 15:06 and they indicated the staff were trying to monitor them. On 12/5/25 a facility document titled Fall Prevention was reviewed and revealed the following: POLICY: It is the policy of this facility that the Fall Prevention Program is designed to ensure a safe environment for all residents. Each resident will be evaluated upon admission, quarterly and as needed by an RN/LPN to assess his/her individual level of risk. The Interdisciplinary Team will review the Fall Risk Assessment completed by the nursing department and if appropriate, a fall prevention protocol will be initiated. PURPOSE: 1. To identify residents at risk in a timely manner. 2. To gather accurate, objective and consistent data for the purpose of implementing an individualized Plan of Care designated to meet the resident's needs. 3. To ensure consistency in the implementation of preventive measures to assist with the reduction of falls. 4. To evaluate outcomes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Deficient Practice #2 Based on observation, interview, and record review, the facility failed to properly assess a resident for the correct mechanical lift sling size for one (R5) of nine residents reviewed for accidents. Findings include: On 12/3/25 at 10:55 AM, Certified Nursing Assistant (CNA) 'K' and CNA 'M' were observed weighing R5 using a mechanical, battery powered lift that utilized a cloth sling placed underneath the resident, hooked to the lift, which then was operated to lift the resident up into the air. At that time, CNA 'K' and CNA 'M' placed an extra-large (XL) underneath R5, hooked the sling to the mechanical lift, and began lifting R5 off the bed. As they lifted R5, R5's lower body started slipping out of the end of the sling. Unit Manager, Licensed Practical Nurse (LPN) 'B' and LPN 'E' were present in the room during the transfer. LPN 'B' instructed CNA 'K' and CNA 'M' to readjust the position of the sling. When R5 was lifted a second time, the sling began to slip overtop her head. At that time, CNA 'K' and LPN 'B' went to find a different size sling. On 12/3/25 at approximately 11:05 AM, an interview was conducted with LPN 'B'. When queried about how the CNAs knew what sling size to use, LPN 'B' reported it was based off of the assessment. LPN 'B' reported R5's responsible party did not want her to get out of bed, so the mechanical lift was only used once a month to weigh the resident. On 12/3/25 at 11:09 AM, an interview was conducted with CNA 'K'. CNA 'K' reported she began working in the facility a few weeks ago and had not yet utilized the mechanical lift for R5, as she was weighed monthly and did not get out of bed per family's request. When queried about how she knew what size sling to use, CNA 'K' reported she used the size documented in the Kardex (care guide for CNAs). A review of a Resident Lift Assessment for R5 dated 12/3/25 at 9:46 AM (prior to the above observation) completed by the Director of Nursing (DON) revealed the sling size for R5 was XL - Xtra Large. A review of the previous Resident Lift Assessment for R5 dated 11/29/25 revealed the sling size was L - Large. A review of a Resident Lift Assessment for R5 dated 12/3/25 at 11:25 PM completed by LPN 'B' revealed the sling size for R5 was changed to L - Large. On 12/3/25 at approximately 10:30 AM, a review of R5's care plans and Kardex revealed as of 12/3/25, it was documented R5 required an XL sling for transfers with a mechanical lift with assistance of two staff members. On 12/3/25 at 11:37 AM, an interview was conducted with the DON. When queried about how she assessed R5 for the correct sling size on that day, the DON stated, We talked about it. The DON further explained that she did not physically assess R5 and LPN 'B' said R5 was an XL so that was what she documented on the assessment. On 12/3/25 at 12:33 PM, an interview was conducted with LPN 'B'. When queried about the assessment completed on 12/3/25 prior to weighing R5, LPN 'B' reported they did an assessment because we knew you wanted her weight. When queried about how R5 was assessed for the sling (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	size, as the size was incorrect and too big which caused the resident to start to slip out of the sling, LPN 'B' stated, We held the sling over here. LPN 'B further said a large sling was not available, so they just measured it on her by holding it over her. LPN 'B' stated, I'm glad I was in there to stop them (when R5 started falling out of the sling). A review of R5's clinical record revealed R5 was admitted into the facility on 3/18/16 with diagnoses that included: [NAME]-Pick Disease Type C (a rare genetic disorder that causes abnormal accumulation of lipids within cells, leading to progressive organ damage and neurological impairment), dysphagia (difficulty swallowing), dementia, and aphasia (difficulty speaking). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R5 had severely impaired cognition and was dependent on staff for transfers. A review of a facility policy titled, Mechanical Lifts, dated 7/11/18, revealed, in part, the following, .Use sling compatible with mechanical lift and appropriate size .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2597945Based on interview and record review the facility failed to ensure timely catheter care was provided and guardian recommendations were timely addressed for one R (48) of one resident reviewed for catheter care/urinary tract infection (UTI). Findings include:A complaint was filed with the State Agency (SA) that alleged they had made several attempts to contact the facility to request that R48 be sent to the hospital as they were showing signs of a UTI. A phone interview was conducted with the complainant/guardian on 12/4/25 at approximately 10:52 AM. The complainant reported that on numerous occasions they tried to contact the facility to let them know that R48 was showing signs of a UTI. They reported that the facility would not answer the call timely and when they finally did answer they received information that the resident did not need to be sent out. Finally, their request was addressed and when they got to the hospital, R48 was diagnosed with a UTI, dehydration and low blood pressure and spent five days at the hospital. A review of R48's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: paraplegia, urinary tract infection and bipolar disorder. A review of the resident's Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (intact cognition). Continued review of R48's clinical record revealed, in part, the following:8/9/25: Order: Change 16 fr(French) with 10cc (cubic centimeter) balloon on the 9th of each month.8/9/25: Default for eMAR (electronic Medication Administration Record): Change 16 fr catheter with 10 cc balloon on the 9th.NA (not applicable). *A review of R48's Treatment Administration Record (TAR) for 8/9/25 that noted Change 16fr catheter with 10 cc balloon on the 9th of each month was left blank. 8/13/25: General Progress Note: Writer spoke with legal guardian.requesting resident be sent out to hospital for f/u (follow-up) regarding recent UTI. Writer educated (legal guardian) regarding no s/sx (signs) of UTI resident is not presenting with fever, confusion, frequency or urgency. (Guardian) still requesting resident go out to hospital as she stated that resident had been more fatigued and sleeping more and showed confusion when resident contacted her last evening. Physician contacted order obtained to transfer out to hospital. (authored by Nurse B). *It should be noted that review of R48's vitals showed that no vitals (temperature, 02 States (oxygen), pulse ox) had been obtained between 8/7/25 and 8/13/25.8/14/25: Hospital Records/Internal Medicine: .IMPRESSION AND PLAN.UTI complicated, related to catheter.8/14/25: Hospital Record/Final Report: .Pt.(R48).who was admitted on [DATE] for hypotension (low blood pressure) and urinary tract infection. Patient has a chronic Foley catheter which has been in place for years.cannot recall the last time the catheter was changed. 8/18/25: General Progress Note: .arrived at facility via ambulance. Recently admitted to hospital due to UTI.On 12/4/25 at approximately 2:19 PM, an interview and record review were conducted with Nurse B. Nurse B was queried about R48 and the note that was written on 8/13/25 regarding educating the Guardian. Nurse B reported they were familiar with the resident and their Guardian. They stated that R48 used to reside on the 2nd floor where they were the unit manager. However, at the time the note was written they were no longer assigned to the resident. Nurse B stated that the Guardian had tried contacting the facility prior and at some point, was able to get to them. They further noted that the nurse manager on the first floor is no longer employed with the facility. When asked if R48's catheter should have been changed per the order, they replied it should have. When asked about daily vitals, Nurse B reported those should have been done as well. On 12/4/25 at approximately 2:29 PM, an interview was conducted with the Director of Nurse (DON). The DON reported that they were not employed by the facility in August 2025 and could not directly speak about the resident. However, when asked should R48's catheter been changed as ordered and should the resident's vitals been taken, they reported they should have.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Physician ordered weight monitoring was obtained and completed for two residents (R64 and R70) of two residents reviewed for weight loss. Findings include: Resident #70 On 12/2/25 at approximately 10:38 a.m., R70 was Observed in their room, laying in their bed. R70's Breakfast tray was observed to be untouched. R70 was queried if they had lost any weight or had any issues with the facility food and they reported they did not know. On 12/2/25 the medical record was reviewed and revealed the following: R70 was initially admitted to the facility on [DATE] and had diagnoses including Dysphagia and Muscle weakness. A review of R70's MDS (minimum data set) with an ARD (assessment reference date) of 11/11/25 revealed R70 needed assistance from facility staff with most of their activities of daily living. R70's BIMS score (brief interview for mental status) was nine indicating moderately impaired cognition. A review of R70's care plan revealed the following: Focus- Resident has nutritional problem or potential nutritional problem r/t (related to) COVID (COVID-19), RSV bronchitis (Respiratory syncytial virus), AMS (altered mental status), depressive DO (disorder), syncope, debility, DVT (Deep-vein thrombosis), stenosis and GERD (gastroesophageal reflux disease). Is at risk for malnutrition, variable appetite aeb weight loss, supplementation, enhanced nutrition program Date Initiated: 05/07/2025 .A review of R70's Dietary notes revealed the following: 7/11/2025-Noted with a significant weight loss of 9% x 1 month. Per the food acceptance records shows resident has a variable appetite, likely contributing weight loss. Discussed with nurse manager, recommend Ensure QD (once a day) to help provide additional nutrition to help maintain weight. 8-5-2025- .Regular diet order. Appetite and intakes have been fair with variability noted. Her current weight is 108lbs (pounds)~ stable this past month however has a h/o (history of) weight loss. Ensure supplementation ordered in July and is accepting per the MAR (medication administration record) Weekly weights are monitored. 9/26/2025-WEIGHT WARNING: Value: 107.2lbs BMI (body mass index) (20.9 Weight loss of 9% weight loss over a span of 3 months, however, has been stable within past 2 months at 107-108lbs. Per SLP (Speech and Language Pathologist), downgraded diet texture to pureed due to mandible fracture. Resident has made statements that she does not like pureed textures. Continues on an enhanced diet which provides fortified foods. Ensure in place QD and is accepted per the MAR. Appetite is good and is consuming 75% or more during mealtimes, see the food acceptance records for confirmation. Recommend to increased Ensure to BID per previous weight loss and meet needs per recent conditional changes. Will also order weekly weights for additional weight monitoring . A review of R70's Physician orders for weight monitoring revealed the following: 1. Weekly Weight every day shift every 7 day(s) for resident monitoring for 4 Weeks. Start date-5/8/25 .End date-6/5/25. 2. weekly weight one time a day every 7 day(s) for 4 Weeks. Start date 7/30/25 .End date 8/27/25. 3. weekly weight one time a day every 7 day(s) for 4 Weeks. Start date-9/26/25 .End date-10/24/25. A review of R70's documented weights for the Physician ordered monitoring time periods revealed the following: 10/7/2025 -103.0 Lbs (pounds), 9/8/2025 -107.2 Lbs, 8/4/2025 -108.0 Lbs, 7/9/2025 -107.2 Lbs, 6/10/2025-117.9 Lbs, 5/22/2025-118.2 Lbs .Further review of the documented weights did not reveal any further weights for the Physician ordered weekly weight monitoring. R64 On 12/2/25 the medical record for R64 was reviewed and revealed the following: R64 was initially admitted on [DATE] and had diagnoses including Dementia and Deficiency of Vitamins. A review of R64's MDS (minimum data set) with an ARD (assessment reference date) of 10/725 revealed R64 needed assistance from facility staff with most of their activities of daily living. R64's BIMS score (brief interview for mental status) was zero indicating severely impaired cognition. A review of R64's progress notes revealed the following: 8/6/25-WEIGHT WARNING: Current weight is 110.6lbs which triggers for a significant weight loss of 9.1% x 3 months, however, is up slightly from July. BMI remains underweight at 15.4. Ensure was increased to TID (three times a day) last month to help meet (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needs and prevent further weight loss. LPS (liquid protein supplement) BID (twice daily) ordered for additional kcal/protein support. Supplements are mostly accepted by resident per the MAR. Continued on an enhanced regular diet, appetite has been fair to good with intakes at 50-75% per the food acceptance records. Ordered weekly weights x 4 weeks for additional monitoring . 10/8/25-WEIGHT WARNING: Value: 98.1lbs BMI 13.7 Triggers for a significant weight loss of 11.4% x 1 month (12.7lbs). Ensure in place 3x/day and LPS BID ordered for additional kcal/protein support. Supplements are mostly accepted by resident per the MAR. Continued on an enhanced regular diet, appetite has been fair to good with intakes at 50-75% per the food acceptance records. 9/17 labs reviewed, notable for low protein 5.9, BG 79, calcium 8.6, cre (creatinine) .63. Discussed with IDT (interdisciplinary team), weekly weights ordered for additional monitoring . A review of R64's Physician orders for weight monitoring revealed the following: 1. weight one time a day every 7 day(s) for 4 Weeks. Start Date-8/6/25. End Date-9/3/25. 2. WEEKLY WEIGHT one time a day every 7 day(s). Start Date-10/9/25. A review of R64's documented weights for the Physician ordered monitoring time periods revealed the following: 8/5/25-110.6 lbs, 9/3/25-110.8 lbs, 10/2/2025-98.1 lbs, 11/5/2025-97.8 lbs. Further review of the documented weights did not reveal any further weights for the Physician ordered weekly weight monitoring. On 12/3/25 at approximately 2:33 p.m., Registered Dietician O (RD O), was queried regarding the lack of documented weights and weekly weight monitoring for R64 and R70. RD O reported that getting weekly weights completed was an ongoing concern at the facility and the facility had developed an action plan to try to correct it but it was still an ongoing issue that the facility was trying to correct. RD O was queried how the facility can accurately track resident nutritional progress if weights were not being completed per the Physicians order and they acknowledged it was a concern.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer tube feeding according to the resident's assessed needs and physician's orders for one (R5) of one resident reviewed for tube feeding. Findings include: On 12/2/25 at 9:44 AM, R5 was observed lying in bed sleeping. A tube feeding pole was observed tucked behind the privacy curtain, but no tube feeding formula was hung or infusing. On 12/2/25 at approximately 12:20 PM, an observation of R5 was made. When spoken to R5 did not respond or make eye contact. No tube feeding was hung in the room at that time. A review of R5's Physician's Orders revealed an active order for .Jevity 1.5 via pump per PEG (Percutaneous Endoscopic Gastrostomy - a tube surgically inserted into the stomach to deliver nutrition) at 65 ml/hr (milliliters per hour) x 18 hours (up at 6pm) or until total volume of 1170 mL is reached daily . On 12/3/25 at 8:13 AM, R5 was observed in bed with no tube feeding hung in the room. On 12/3/25 at 8:30 AM, a review of R5's Medication Administration Record (MAR) for December 2025 revealed Licensed Practical Nurse (LPN) 'E' signed off that 325 ml of tube feeding was administered on 12/3/25 day shift. However, it should be noted that there was no tube feeding hung during the observation at 8:13 AM and if the tube feeding was hung according to the physician's orders at 6:00 PM, the tube feeding would not have been taken down until 12:00 PM to equal 18 hours of feeding. On 12/3/25 at 8:45 AM, an interview was conducted with LPN 'E'. When queried about R5's tube feeding and why there was nothing hung and infusing, LPN 'E' said there was nothing hanging when he arrived on the day shift and stated, The night nurse must not have hung the second bottle. When queried about why he signed off that 325 ml was administered if there was nothing hung, LPN 'E' stated, That is the amount she will get today. When queried about whether it was protocol to sign out administration of something that was not yet done, LPN 'E' stated, I don't know. I don't want to say the wrong thing. At that time, LPN 'E' then obtained a bottle of tube feeding formula, hung it up, but did not start it. The bottle of Jevity contained 1000 ml of formula when full. On 12/3/25 at 9:00 AM, an interview was conducted with Unit Manager, LPN 'B'. When queried about when the nurses documented administration of medication or treatments, including tube feeding, LPN 'B' reported they would document on the MAR after it was administered. On 12/3/25 at 11:30 AM, an interview was conducted with Registered Dietician (RD) 'O'. When queried about how he monitored whether or not residents were receiving the correct amount of tube feeding, RD 'O' reported he would review weights, review the documentation from the nurses that would show the resident was receiving the tube feeding, through observation of the resident, and communication with the staff. A review of R5's MAR for December 2025 revealed the following: On 11/26/25, 11/27/25, 11/28/25, 11/29/25, 11/30/25, 12/1/25, and 12/2/25, it was signed off on all three shifts that R5 received 325 ml of tube feeding formula which would equal 975 ml (the order is for a total of 1170 ml). On 12/3/25 at 2:40 PM, a second interview was conducted with RD 'O'. When queried about the documented amounts of administered tube feeding not meeting the ordered amount, RD 'O' confirmed based on what was documented R5 did not receive their required amount of tube feeding and said he would have to look into it. A review of R5's clinical record revealed R5 was admitted into the facility on 3/18/16 with diagnoses that included: [NAME]-Pick Disease Type C (a rare genetic disorder that causes abnormal accumulation of lipids within cells, leading to progressive organ damage and neurological impairment), dysphagia (difficulty swallowing), dementia, and aphasia (difficulty speaking). R5 received all nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) tube (feeding tube inserted in the stomach to deliver nutrition) and did not consume any food or fluids by mouth. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R5 had severely impaired cognition and was dependent on staff for bed mobility, transfers, and all activities of daily living (ADLs).

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to provide ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for one (R6) of one resident reviewed dialysis communication. Findings include:A record review of R6 medical record was conducted, it revealed that R6 was admitted to the facility on [DATE] with the medical diagnosis of End Stage Renal Disease and dependent on dialysis.A review of R6's Order summery revealed that there was a physician's order to receive Hemodialysis on Tuesdays, Thursdays, and Saturdays. The medical record also showed that the facility had initiated a care plan for R6.On 12/4/25 at 11:24 AM, the Director of Nursing(DON) was asked to provide dialysis communication forms for four months between the facility and the dialysis center.On 12/4/25 at 1:23 PM, a review of the communication forms submitted revealed that the facility did not have communication between the facility and the dialysis center for the month of October. The medical record revealed R6 was a resident without any leave of absences or hospital visits for the month of October. The DON was interviewed and asked if they had any communication forms for the month of October. The DON reported that what was uploaded was what they had.No additional information was provided at the end of the survey.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a medication error rate less than five percent when two medication errors out of 26 opportunities were observed for two (R78 and R35) of six residents reviewed during the medication administration observation, resulting in a 7.69% error rate. Findings include: On 12/3/25 at 8:37 AM, Licensed Practical Nurse [LPN] E was observed as part of the medication pass task. LPN E prepared five medications for R78, including one Oyster [NAME] Calcium 500 milligrams [mg] tablet. LPN E was then observed enter R78's room and administer all five medications to R78.On 12/3/25 at 8:43 AM, LPN D was observed preparing four medications for R35, including one Docusate Sodium 100 mg tablet. LPN D crushed all four medications, including the Docusate Sodium tablet. LPN D entered R35's room and administered all four medications to R35.On 12/3/25 at 11:10 AM, R35's physician orders were compared to the medications observed to have been given. The reconciliation revealed R35 had an order for Senna Plus 8.6-50 mg. It should be noted that Docusate Sodium tablets should not be crushed.On 12/3/24 at 11:13 AM, R78's physician orders were compared to the medications observed to have been given. The reconciliation revealed R78 had an order for Oyster Shell Calcium/Vitamin D 500-200 mg/Unit.On 12/3/24 at 11:54 AM, LPN E was interviewed and asked if Oyster Shell Calcium/Vitamin D 500-200 mg/Unit stock bottle was in the medication cart that had been used to prepare R78 medications. LPN E looked in the medication cart and no bottle of the combination medication was in the cart.On 12/3/25 at 1:14 PM, LPN D was interviewed and asked if Senna Plus 8.6-50 mg stock bottle was in the medication cart that had been used to prepare R35's medications. LPN D looked in the medication cart and a bottle of Senna Plus 8.6-50 mg was in the cart.On 12/3/25 at 1:18 PM, the Director of Nursing [DON] was interviewed and asked if the facility had stock bottles of Oyster Shell Calcium/Vitamin D 500-200 mg/Unit. The DON explained she did not know, but would check to see, and if the did not currently have it they could get it from the pharmacy. No information was provided if the facility had any Oyster Shell Calcium/Vitamin D stock bottle prior to the end of the survey.Review of a facility policy titled, Administration of Drugs updated 12/19/19 read in part, .Medications must be administered in accordance with the written orders of the ordering/prescribing physician. Prior to administering the resident's medication, the nurse should compare the drug and dosage schedule on the resident's MAR [Medication Administration Record] with the drug label.