STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235044	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay County Medical Care Facility	564 West Hampton Road Essexville, MI 48732

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings include: On 04/27/2026 at 9:27 AM, during the initial kitchen tour with Director of Dining Services L, observed the drain line to the ice machine sitting inside the drain. According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. On 04/27/2026 at 9:54am observed the interior walls of the microwave visibly soiled in the one east kitchenette. During this observation, Director of Dining Services L was interviewed on how often the microwave is cleaned, and he stated it's cleaned after every use. On 04/27/2026 at 10:00am observed the interior wall of oven door visibly soiled with grease in the one west kitchenette. During this observation, Director of Dining Services L was interviewed on how often the oven is cleaned, and he said he wasn't sure, but he thinks it's cleaned monthly. According to the FDA 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.On 04/27/2026 at 12:04pm during lunch observation in two west kitchenette, observed [NAME] M wash hands and then proceeded to touch the trash can lid with their bare hand to throw paper towel away and continued to prepare food without rewashing hands. According to the FDA 2022 Food Code, 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and .After engaging in other activities that contaminate the hands.On 04/27/2026 at 12:25pm temped shredded lettuce at 49 F, sour cream at 45 F, and shredded cheese at 48 F sitting in cold well, using a thermometer probe. During this observation, Director of Dining Services L was interviewed on what temperature food should be cold holding, and he stated 41 F. In addition, Director of Dining Services L was interviewed whether cold foods are temped before lunch service once it arrives at the kitchenette, and he stated he thought cold foods were temped at the kitchenette, but he could not find the cold holding temperatures in the temperature book at the kitchenette. According to the facility's policy on cold holding, Foods should be held cold for service at a temperature of 41 F or less.According to the FDA 2022 Food Code, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, Except during preparation, cooking, or cooling, or when time is used as the public health control, time/temperature control for safety food shall be maintained: .at 5 C (41 F) or less.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP) and, follow enhanced barrier precautions (EBP) for residents identified with qualifying wounds, for one resident #65 (R65) of three residents reviewed for infection prevention. This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among all residents in the facility.Findings include: On 04/27/2026 at 9:27am observed ice machine filter dated 4/30/2020. On 04/27/2026 at 1:28pm observed an unused ozone treatment for the washers located in the laundry chemical room. The ozone tanks are partially capped from the plumbing system leading to the washers, but it remains connected to the water lines leading out towards the hallways. During this observation, Environmental Services Director O was interviewed on how long the ozone tanks haven't been used and she said they haven't been used for at least 10 years. On 04/27/2026 at 1:33pm observed two dead end pipes running from the ceiling located in the laundry personal clothing room. During this observation Environmental Services Director O was interviewed on whether these pipes were used for anything and she stated she's never seen anything hooked to those pipes. On 04/27/2026 at 1:34pm observed what appears to be an unused faucet with the cold and hot water valves removed and the sink was unable to turn on. On 04/27/2026 at 1:37pm observed two uncapped water lines to an old utility sink located in B11 utility closet. On 04/27/2026 at 2:08pm observed inside spigot at the old garage. During this observation, Assistant Director of Plant Operations N was interviewed on whether this spigot is flushed regularly as a legionella control measure, and he stated to his knowledge, it isn't flushed. On 04/27/2026 at 2:16pm observed an inside spigot in the new garage. During this observation, Director of Environmental Services O was interviewed on whether the spigot was flushed, and she stated it's probably not flushed. On 04/27/2026 at 2:18pm observed an outside pavilion with a kitchenette and a bathroom. During this observation, Assistant Director of Plant Operations N stated the water is shut off starting around October and reopens in April, and that the hot water doesn't turn on because the hot water tank doesn't work and the valve is closed off. 04/28/2026 at 9:19am interview with Environmental Services Director O and Assistant Director of Plant Operations N on winterizing and reopening the outside pavilion, and he stated the lines are blown out to close the pavilion and the water is run for a long time when reopening. In addition, Assistant Director of Plant Operations N was interviewed on whether there were a policy and procedure for winterizing and reopening the pavilion, and he stated there wasn't a policy. 04/28/2026 at 9:34am during the interview with Environmental Services Director O she called Senior (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Maintenance P, and he was asked whether the hot water tank to the outside pavilion was drained before it was shut off, and he stated the hot water tank is drained. 04/28/2026 at 10:29am interview with Assistant Director of Plant Operations N on whether the ice filter dated 4/30/2020 in the main kitchen has been changed out recently, and he stated he wasn't entirely sure. When asked how often the filter should be changed, Assistant Director of Plant Operations N answered it should be changed every 6 months. 04/28/2026 at 11:19am During the interview with Environmental Services Director O on whether the cold and hot water lines are flushed on the empty unit in 2 East, Environmental Services Director O called a staff member who stated they were only flushing the hot water in 2 East. Record review of the flushing logs in Tels, it states on 4/11/2026 ran hot water in all sinks and showers for 3 min each - flushed all toilets on 2- East -preventing legionella bacteria growth and it was marked completed. On 4/4/2026 it states, flushed all toilets - ran hot water in all sinks - ran hot water in all showers and on 3/28/26 it states, flushed all toilets and ran hot water in sink/showers on 2 East, and it was marked as completed. Record review of the facility's water management plan states under control measures procedures, Dead legs have been identified and removed. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Eliminate dead legs, which are sections of no- or low-water flow. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. A review of Resident 65 (R65) medical record and Minimum Data Set (MDS) assessment revealed R65 was admitted to the facility on [DATE] with diagnoses: displaced bicondylar fracture of left tibia, unsteadiness on feet, abnormality of gait (walk) diabetes mellitus type 2 (DM), left foot drop, depression, hypertension. The MDS assessment dated [DATE] indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15/15 and needed assistance with care. During an observation on 04/27/2026 at 9:45 AM an orange Enhanced Barrier Precautions (EBP) sign and red hand stop sign were observed outside R65's room. When Nurse K was asked about the posted signs she identified R65 was on enhanced barrier precautions for a surgical wound on left leg with dehiscence (opening) and infection. Review of the facility's Enhanced Barrier Precautions policy last revised 1/28/26 revealed, Implementation of Enhanced Barrier Precautions.Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). According to a record review of R65's orders revealed: Revision 04/27/2026 Initiate enhanced barrier precautions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to a record review of R65's care plan revealed: Focus: Enhanced Precautions: I have enhanced precautions in place r/t (related to) dehisced left knee incision with Interventions: All staff to wear appropriate PPE (personal protective equipment) when providing direct care. On 04/27/2026 at 10:21AM, During an interview with R65's roommate it was observed that Certified Nurse Assistant (CNA) F performed a bed bath, brief change and assisted in dressing of R65, CNA F wore PPE of gloves only. Upon completion of the bed bath CNA F carried the basin of used bath water through the room past SA and roommate and emptied the basin in the resident's shared restroom donning PPE of gloves only. CNA F did not clean the shared restroom after use and stored the empty wet basin in the resident's closet. On 04/27/2026 at 10:25AM, Observation or R65 laying on bed she was partially dressed and said she was waiting for CNA to return with socks. R65 confirmed she just completed a bed bath, when asked if staff wore gowns with her care and she said sometimes but not when she gets a bath. According to the training record of CNA F completed EBP in nursing homes training dated 06/04/2025; Infection prevention and control for all staff dated 06/04/2025; Personal protection equipment (PPE) donning and doffing dated 06/04/2025. On 04/28/2026 at 1:30 PM, During an interview Wound Care (WC) Nurse E was inquired about EBP residents. WC Nurse E said that high activity care for residents on EBP required gown and gloves at minimum and could require more PPE depending on the activity. On 04/28/2026 at 2:28PM, During an interview Infection Control and Prevention (ICP) Nurse D she was queried how residents in EBP were identified, she said residents in EBP had an orange Centers for Disease Control and Prevention (CDC) EBP sign on their rooms door that identified precautions and PPE needed for activities, a red hand stop sign that directed visitors to the nurse before entering. ICP Nurse D reviewed types of residents that needed EBP and said that staff followed EBP per policy for residents identified with EBP precautions. On 04/28/2026 at 2:53 PM, During a follow up interview with R65 she said she had been to the orthopedic doctor at 10:00 am and had new wound care orders for three times a day and was confirmed she had an infection in the open area on her leg. R65 was queried what PPE staff wore with her care, she said they always wear gloves. R65 was asked if staff wore gowns, she said no they do not. When asked specifically about wearing PPE with wound care she said honestly, no and further said 'they never wear gowns just gloves'. On 04/28/2026 at 3:30 PM, During an interview Nurse G was asked to review PPE for residents in EBP, Nurse G said that residents in EBP required gloves and gowns to be worn with any care provided. Nurse G said PPE is not required to answer a call light, pass a drink or tray. Nurse G was asked if activities of daily living (ADL's) such as personal care, bathing and toileting/brief changing required PPE, she said yes, it does. Review of the facility's policy, Enhanced Barrier Precautions (EBP) last revised 1/28/26, the policies definition of EBP was refer to an infection control prevention designed to reduce transmission of multi-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .1a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions;1b. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions;2b. An order for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	enhanced barrier precautions will be obtained for all residents with any of the following: i. Wounds (e.g., chronic wounds such as. unhealed surgical wounds.); 3a. note: face protection may also be needed if performing activity with risk of splash or spray. 3b. PPE for enhanced barrier precautions is only necessary when performing high contact care activities.; 4High contact care activities include a. Dressing, b. Bathing, d. Providing hygiene, e. changing linens, f. changing briefs.; 7. Enhanced Berry precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure appropriate backflow prevention was installed at plumbing fixtures, resulting in the potential for contamination to the water supply, affecting all residents. Findings include:On 04/27/2026 at 9:50am observed chemical feeder downstream of an atmospheric vacuum breaker (AVB) at the mop sink in the janitor's closet adjacent to the kitchen. On 04/27/2026 at 10:15am observed hose with attached spray nozzle downstream of a hose bib vacuum breaker (HBVB) in the trash compact area. On 04/27/2026 at 10:16am observed chemical feeder downstream of an AVB in the trash compact area. On 04/27/2026 at 1:54pm observed outside spigot with an attached hose without backflow prevention. During this observation, Assistant Director of Plant Operations N stated the backflow preventer is on work order, but they haven't gotten to installing them yet. On 04/27/2026 at 2:08pm observed an inside spigot with an attached hose without backflow prevention in the old garage. During this observation, Assistant Director of Plant Operations N stated that no one has fulfilled the work order yet.According to the State of Michigan's 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve).According to the State of Michigan's 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure.

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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** Based on observation, interview and record review, the facility failed to ensure that timely care was provided in a dignified manor to 3 of 3 residents reviewed for dignity (Residents R4, R10 and R45).Findings include: A review of R4's medical record revealed an admission into the facility on 2/20/24 and re-admission on [DATE] with diagnoses that included paraplegia, muscle weakness and open wound of scrotum and testes. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 10/15 that indicated moderately impaired cognition and the Resident was dependent on helper for personal hygiene and toileting hygiene and needed substantial/maximal assistance to roll left and right. On 4/29/26 at 9:20 AM, an observation was made of the Resident lying in bed. CNA R had the Resident positioned flat on his back with covers off, gown pulled up, and incontinence brief opened. The CNA was assisting with perineal care. The Resident's bed was elevated to about window height. There was a large window and the Resident's bed was positioned in front of the window with enough space for staff to be on that side of the bed. The CNA was on the other side of the bed while performing peri-care. The Resident's shade was not pulled down to provide privacy. Nurse E came in to perform wound care on the Resident's buttock area and scrotal area. The Resident was turned back and forth in bed to remove the brief and cleanse the resident. The CNA turned the Resident towards her with the Resident's buttock exposed towards the window side and the Nurse performed wound care. During wound care, the Nurse was asked by the surveyor to pull the shade to provide privacy for the Resident. The shade was pulled down over some Resident items on the window area. Outside the window was a paved walk/driveway, grassy area and houses past the grassy area. After wound care and perineal care, the Resident was covered. The CNA was asked about providing privacy during personal care. The CNA reported that usually the Resident's curtain/shade was pulled down because he didn't like the bright light. The CNA reported she did not notice the shade was up and reported it should be down when providing care. A review of the facility policy titled Resident Rights, revealed, . 7. Privacy and confidentiality- You have a right to personal privacy and confidentiality. a. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care. A review of Resident #10's Face sheet and Minimum Data Set (MDS) assessment indicated R10 was admitted to the facility on [DATE] with diagnoses: spastic hemiplegia affecting right dominant side, dementia, muscle weakness, lack of coordination, contracture of the right hand, unsteadiness on feet, diabetes mellitus type 2 (DM) , [NAME]-[NAME] syndrome (abnormal fusion of neck vertebrae), stage 4 chronic kidney disease (CKD), gastro-esophageal reflux disease (GERD), bipolar disorder, depression and anxiety. The MDS assessment dated [DATE] indicated that the resident had severely impaired cognitive abilities and needed assistance with care. On 04/27/2026 at 3:14PM, An observation of R10 resting in bed with eyes closed lying on right side, bed in low position to the floor, touch call light pad was hung over the top of the head of the bed and out of reach of resident and unable to be triggered by movement of the resident. On 04/27/2026 at 3:17PM, During an interview with CNA I she was asked to observe the location of R10's touch call and light location. CNA I verified the touch call light pad was hanging over the top of (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the head of the bed said 'it is usually in the middle of his bed so he can reach it' she confirmed that R10 was unable to reach the touch call light pad and then CNA I placed the touch call light pad on R10's bed. Review of R10's care plan revealed, Focus: ADL's: I need assistance with my care including bathing, shaving, and dressing r/t (related to) having impaired mobility, cognitive & communication deficits, contractures in right hand (thumb, 3rd & 4th fingers), muscle spasticity, balance impairments. with Interventions: BATHING: I am mainly dependent upon staff for bathing needs; DRESSING: Staff chooses my clothing. I need max to total assist with dressing; PERSONAL HYGIENE: I am mainly dependent upon staff for personal hygiene. Focus: FALLS/Safety: I am at risk for falls r/t confusion and impulsiveness. with Intervention: Staff to provide resident with the following safety interventions: Floor bed in lowest position when in bed; safety mat along left side of bed when in bed; touch pad call light; keep right side of bed up against wall.According to a record review of R65's daily care plan (kept in residents' room) revealed: Safety . Touch pad call light. During an observation on 04/28/2026 at 9:30AM, R10 was resting in bed on his right side facing the wall, bed in low position to the floor, touch call light pad is laying at the far left side of bed away from the residents reach, light and controller was hung on the head board of the bed away from resident reach. During an interview with R10, he stated he was cold and wanted a blanket and the light turned on, when he was requested to trigger his touch call light pad he said he was un able to reach it, he was not able to trigger the call light as he rolled over in bed it was out of reach of him. R10 reached up toward the light control on the headboard and was unable to reach the controller to turn on his room light. On 04/28/2026 at 9:39AM, CNA H was asked to observe the location of R10's touch call light pad and light controller. CNA H visualized and confirmed that R10 was unable to trigger the touch call light pad either by movement or purposefully and was unable to reach the light controller that was hung on the top of the headboard to use it. CNA H said 'I think it is in his care plan to lay it behind him so if he rolls it will trigger'. CNA H verified that when R10 rolled to reach for the touch call pad that it was out of reach and R10 did not trigger the touch call light pad when he rolled over because it was out of touch range. CNA H moved the touch call pad within reach of the resident. A review of Resident #45's Face sheet and Minimum Data Set (MDS) assessment indicated R45 was admitted to the facility on [DATE] with diagnoses: atherosclerotic heart disease (ASHD), stage 4 chronic kidney disease (CKD), unsteadiness on feet, muscle weakness, gastro-esophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD) peripheral vascular disease (PVD), orthostatic hypotension (low blood pressure upon standing), anxiety and depression. The MDS assessment dated [DATE] indicated the resident was cognitively intact. On 04/27/2026 at 12:47PM, During an interview with R45 she said she has had to wait up to an hour for a response to her call light. R45 said she needs assistance to get to the restroom and cannot get there on her own. R45 said she had a kidney disease and that she took medications that increased her urine output, she said that she had refused to take the medication (clarified as Lasix with her) a few times because she had to wait too long and that she had an accident and wet herself because of the long wait, she said that is not right and it is embarrassed her. On 04/29/2026 at 10:16Am, during a follow up interview with resident she said she had not taken her diuretic in a couple days so she wouldn't wet her pants waiting for help to the rest room. When asked if she discussed why she said she had before with the doctor. R45 said not that by not taking the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication worked out better and stated well, I don't have wet pants. Review of R45's progress notes revealed, Date: 04/20/2026. Type: PA plan of care.The patient does request to have her Lasix dose changed to once daily dosing rather than twice daily due to frequent nighttime urination. Review of R45's Falls care plans revealed the following: Focus: FALL/SAFETY RISK. I am at risk for falls due to fatigue and activity intolerance. I have an abnormal gait and tend to shuffle feet; no longer ambulatory. I have decreased ROM that may contribute to my unsteadiness.I am receiving medications with potential for s/e (side effects) . with Interventions: Sit at edge of bed before rising and rise slowly; may sit edge of bed unsupervised. Focus: CONTINENCE: I am both continent and incontinent of bladder and bowel. I have a dx of obstructive uropathy with Interventions: I am able to use my call light for assist to the bathroom; I transfer to commode with SBA (stand by assist) to moderate assist of 1 at grab bar with staff swapping chairs. May have privacy in bathroom with frequent checks; I wear a pull-up at all times for incontinence protection & prefer to wear a pad in my pull-up; I'm requiring max assistance for completion of my toileting hygiene; Offer to take me to toilet every 2 hours, PRN and per request. Review of the facility's Call light system policy revealed that the facility must ensure adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. and the Procedures: 1) 1. All staff will be educated on the proper use of the resident call light system, including how the system works and ensuring residents have access to the call light; 3) Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed for the resident to utilize the call system; 6) All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. Review of the facility's Resident Rights policy revealed Procedures: 11. The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. With residents rights listed as 2. Planning and implementing care: iv. The right to receive the services and/or items included in the plan of care; 4. Respect and dignity- You have a right to be treated with respect and dignity, including: c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences.

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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 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 advance directives were in place and completed appropriately for one resident (Resident #99) of one resident reviewed for advanced directives.Findings include:Review of the medical record revealed Resident #99's (R99) most recently admitted to the facility on [DATE] with diagnoses that included cerebral infarction, heart disease, heart failure, atrial fibrillation and dysphagia.Further review of the medical record revealed R99 was able to make his own informed medical decisions. Review of the Minimum Data Set assessment dated [DATE] revealed R99 was cognitively intact and was able to make his own medical decisions.Review of R99's Resident Code Status and Specific Treatments form dated 4/16/26 revealed that Do not resuscitate (DNR) was selected, however R99 did not sign the form, rather R99's wife had signed the form.Further review of R99's medical record failed to reveal any type of Durable Power of Attorney (DPOA) for Health Care (HC) documentation.On 4/29/26 at 11:49 AM, an interview was conducted with Social Service Assistant (SS) S regarding Resident 99's advance directive/code status. The SS reviewed Resident 99's medical record and reported he was capable and stated, He is his own decision maker. The Resident's code status documents were reviewed and the SS indicated that the DNR was signed by the Resident's spouse. When asked about DPOA-HC documentation, SS S reported they were waiting for the paperwork from the spouse and indicated a care conference today. The SS stated, We don't have healthcare POA yet. SS S stated that the document signed on 4/17/26 was the new status code upon return when the Resident came back to the facility. When asked if the Resident was his own responsible party, why did the spouse sign the new DNR code status form. SS S stated, He should have signed it, I agree with you. She was not the POA. We don't have the paperwork on that, and he is his own person. The SS was asked if the Resident was involved with the DNR status change. The SS reviewed the medical record and reported there was not documentation from the Nurses who signed as witnesses, and the new code status was completed when the Resident had an episode, and he had returned to the facility on 4/16/26. The SS reported that Nurses were to do the code status on admission as part of the admission packet. The SS reported the Nurse should have the Resident sign or make a note if the Resident wanted the wife to sign instead and document in the medical record. The SS was asked if the Resident was aware of the DNR status. The SS reported visiting with the Resident that Monday morning and reported discussing code status at that time and he was a DNR. On 4/29/26 at 1:10 PM, an interview was conducted with Nurse T and Nurse U who had signed as witnesses for the DNR with the spouse on 4/17/26. Nurse T reported that the Resident was fully aware and that the Resident was competent but was non-verbal. The Nurse reported the spouse, and the Resident agreed of the DNR code status. The Nurse reported that the spouse had signed for the Resident. When asked if the Nurse was given the POA documentation at that time, the Nurse reported she was not given the POA paperwork. The Nurse reported she should have had the Resident sign and it was discussed that if the Resident wanted the spouse to sign, documentation should be made on the documents or in the progress notes. A review of the facility policy titled, Advance Directives, revealed Policy: It is the intent of (Facility name) to support and facilitate a resident's right to request, decline and/or discontinue medical or surgical treatment and to formulate an Advance Directive. Procedures: .3. Upon admission, should the resident have an Advance Directive, the documents will be saved in the resident's chart. 4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities.

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	235044	A. Building B. Wing	04/29/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide clinical rationale for administration of duplicate/triplicate antidepressant therapy of two (#6 & #55) residents of six reviewed for unnecessary medications.Findings Include:Resident #6On 4/28/2026 at approximately 1:00 PM, a review was completed of Resident #6's medical records and it revealed she admitted to the facility on [DATE] with diagnoses that included, Alzheimer's Disease, Major Depressive Disorder, Insomnia and Generalized Anxiety Disorder. Further review of Resident #6's chart yielded the following:Physician Orders:Escitalopram (Lexapro) Oxalate Oral Tablet 20 MG (milligrams) for Major Depressive Disorder.Trazadone HCl (hydrochloride) Oral Tablet 50 MG for Major Depressive DisorderLexapro and Trazadone are both antidepressants.Care Plan: .admitted with diagnoses of Deprssion, Anxiety, Panic Disorder and insomnia in addition to Dementia. administer medications as prescribed.psychotropic medication management provided by (psychiatric group) . Review was conducted of Resident #6's nursing, physician and psychiatric progress notes were conducted and there was no documentation located regarding Resident #6 usage of dual antidepressant therapy. Resident #55On 4/28/2026 at approximately 1:30 PM, a review was conducted of Resident #55's record and it revealed she admitted to the facility on [DATE] with diagnoses that included, Major Depressive Disorder, Mood Disorder and Anxiety. Further review yielded the following: Physician Orders:Escitalopram (Lexapro) Tab (tablet) 10 mg for Major Depressive DisorderTrazadone Tab 50 MG for Major Depressive DisorderDoxepin HCL Cap (capsule) 10 MG for Major Depressive DisorderLexapro, Doxepin and Trazadone are all antidepressant medications. Care Plan: .I have a dx (diagnosis) of.mood disturbance, insomnia and anxiety. I also have a dx of depression, anxiety, and visual hallucinations.psychotropic medication management provided by (psychiatric group) and the Behavior Wellness Committee to ensure appropriate dosage is given. Review was conducted of Resident #55's nursing, physician and psychiatric progress notes were conducted and there was no documentation located regarding Resident #55's usage of three antidepressants. On 4/28/2026 at 2:00 PM, an interview was conducted with Social Work Director Q who shared Resident #6 is prescribed two antidepressants and Resident #55 is prescribed three antidepressants due to their diagnosis of Major Depressive Disorder. Both residents are currently stable on their current medication regime, and their psychiatric provider is aware of their antidepressant medication orders. Social Worker Q was asked to provide the documentation (regarding the clinical rationale) and upon returning she explained that per their psychiatric practitioner their old charting system would denote the rationale but in the new system it did not. There was no clinical rationale for Resident #6's duplicate medication therapy and Resident #55's triplicate medication therapy. Review was conducted of the facility policy entitled, Psychotropic Medication Use, Revised 4/24/24. The policy did not address duplicate therapy.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure peripherally inserted central catheter (PICC) dressing changes were completed timely for one resident (R23) of one reviewed for PICC lines. Findings include:R23 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include infection of a superficial incisional surgical site, acute respiratory failure and atherosclerotic heart disease. On 04/27/2026 at 11:08AM, a peripherally inserted central catheter (PICC) line was observed in the right upper arm of R23. The dressing was dated 4/15/26. On 04/27/2026 at 11:11AM, record review revealed a physician's order dated 03/26/2026 that reads: PICC line dressing change one time a day every Wednesday related to infection following a procedure, superficial incisional surgical site subsequent encounter. On 04/27/2026 at 11:13AM, record review of the April 2026 treatment administration record (TAR) revealed that on 04/22/2026 the dressing change was signed out as not completed by Registered Nurse (RN) C and has a corresponding nurses note. The nurses note from RN C, dated 04/22/2026 at 10:45AM revealed that the dressing change was not completed due to the item (dressing change kit) not being available in the backup system. On 04/27/2026 at 11:16AM, an interview was completed with RN B. RN B confirmed the date on the dressing is 4/15/26. RN B was asked how often PICC line dressings should be changed. RN B stated that the dressings should be changed weekly or as needed if they come off or are soiled. RN B stated, I am not sure how they missed it, it should be done weekly. I will check and see who should've taken care of that. RN B stated that the PICC line is due to be removed this week. On 4/28/2026 at 1:23PM, an interview was conducted with the Director of Nursing (DON). The DON was asked who supplies the dressing change kits for PICC lines. The DON stated that Remedi Pharmacy supplies the PICC line dressing change kits and we also have some in our backup system in the building. The DON stated, we don't have a lot in backup, so if multiple residents need a dressing change on that day, we could've run out. On 04/28/2026 at 1:25PM, an interview was conducted with RN C. RN C was asked why the dressing change was not completed on 04/22/2026. RN C stated, I didn't have the supplies available to do it. RN C was asked if they attempted to access the backup system to get a dressing change kit. RN C stated, yes, I tried, but it was out supplies. The pharmacy did not send the supplies either. Review of the facility policy titled, Catheter Insertion and Care, revealed: General Guidelines:4b. Change the TSM dressing on CVAD's and midlines every 5-7 days, when site is rotated, if the integrity of the dressing is compromised (e.g., damp, loosened or visibly soiled) and/or upon suspected contamination.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure oxygen tubing was changed out weekly and nebulizers were stored properly for two residents (R2 and R75) of five residents reviewed for respiratory care. Findings include: Review of the medical record revealed that Resident #2 (R2) was [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease (COPD), chronic respiratory failure, heart failure and tachycardia. During an observation on 04/27/2026 at 12:39PM, R2's oxygen tubing was dated 4/20/26 and there was a nebulizer in a bag, hanging on the wall next to the bed. The nebulizer equipment was stored together, and moisture was noted in the medication reservoir. During an observation on 04/28/2026 at 1:10PM, R2's nebulizer was found hanging on the wall in a bag, was dated 4/20/26 and the oxygen tubing was dated 4/20/26. During an interview on 04/28/2026 at 1:18PM, Assistant Director of Nursing (ADON) was asked how often the oxygen tubing is changed out. The ADON stated that the oxygen tubing is changed every 7 days. The ADON was asked what the process is for storing and cleaning nebulizers after a treatment. The ADON stated, after each use the nurses take it apart, rinse it and then either goes on a paper towel to dry or they dry it and place it on the wall in a bag. The ADON was made aware of the findings related to dating oxygen tubing and the storage of a nebulizer for R2. Review of the policy titled, Oxygen Administration, revealed: Care and Maintenance: -All tubing will be changed on a weekly basis labeled with the date, time and nurses initials. Review of the policy titled, Nebulizer/Aerosol Treatments, revealed: Procedure: 15. Disassemble equipment: -Discard left over medication. -Rinse cup with sterile saline. -Place equipment in wiki bag. -Wipe Pulmo-Aide machine with a cleaning disinfectant when visibly soiled, upon completion of treatment, and at the end of each shift. A review of R75's medical record revealed an admission into the facility on 4/23/25 and readmission on [DATE] with diagnoses that included heart failure, acute respiratory failure with hypoxia, chronic respiratory failure with hypercapnia and chronic obstructive pulmonary disease. During an interview and observation on 4/27/26 at 11:52 AM, R75 answered questions and engaged in (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conversation. An observation was made of a nebulizer with a mask on the bedside table. The Resident reported getting breathing treatments a couple times a day and indicated he had one earlier in the morning. The nebulizer was stored on the bedside table, assembled and moisture was observed in the medication chamber. On 4/28/26 at 2:56 PM, an observation was made in R75's room of the nebulizer equipment assembled and laying on the bedside table. An observation was made of moisture in the medication chamber. On 4/28/26 at 3:12 PM, an interview was conducted with the Director of Nursing (DON) regarding storage of nebulizer equipment. An observation was made with the DON of R75's nebulizer assembled and positioned on the bedside table. When asked about facility policy of storage of nebulizers after use, the DON reported the nebulizer equipment should be disassembled, rinse out the cup (medication chamber), let dry or place in a special bag that lets it air dry. A review of R75's medication administration record revealed the Resident was ordered Ipratropium-Albuterol inhalation, 1 dose inhale via nebulizer three times a day related to chronic respiratory failure with hypercapnia, scheduled at 9:00 AM, 2:00 PM, and 8:00 PM. The MAR was documented as received in the morning on 4/27, not administered at 2:00 PM, received the evening dose on 4/27, received the morning dose on 4/28 but not the afternoon dose or evening dose.