

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Hoyt Nursing & Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 Weiss St Saginaw, MI 48602	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 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 who consume food from the kitchen. Findings include: On 07/07/2026 at 9:15 AM during the initial kitchen tour, a dirty fan with dust on the surface of the fan was observed blowing directly at clean plates stored on a cart and wrapped silverware near the steam table. On 07/07/2026 at 9:23 AM a yellow discoloration on the interior wall of the ice machine was observed. During this observation, Dietary Manager S acknowledged that she saw the yellow discoloration and stated she will have the ice dumped out and have the machine cleaned. In addition, Dietary Manager S stated the ice machine is cleaned monthly. On 07/07/2026 at 9:31 AM a utility sink with an attached hose and a chemical feeder downstream of an atmospheric vacuum breaker was observed in the janitor's closet. On 07/07/2026 at 11:45 AM during lunch observation, a fly was observed flying around the steam table in the main kitchen. On 07/07/2026 at 11:56 AM the wiping cloth sanitizer bucket stored in a cart near the stove was tested with quaternary ammonium test strips, and the result was at 100 parts per million (ppm). During this observation, Corporate Dietician T was interviewed on the sanitizer range requirement, and she stated 150-200 and that the bucket is changed out every two hours, and it's due to be changed in a few minutes. On 07/07/2026 at 12:03 PM milk was temped using a thermometer probe and the temperature was recorded at 55 F. During this observation, Dietary Manager S was interviewed on the temperature requirement for cold holding, and she stated no higher than 41 F, and proceeded to have the milk tossed out. On 07/07/2026 at 12:10PM a fly was observed flying around the serving area in the east kitchen. According to the 2022 FDA Food Code, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, Except as specified in (D) of this section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: In a clean, dry location. Where they are not exposed to splash, dust, or other contamination; and. At least 15 cm (6 inches) above the floor. 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. 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 (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	pressure. According to the FDA 2022 Food Code, 6-501.111 Controlling Pests, The premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises by .Routinely inspecting incoming shipments of food and supplies .Routinely inspecting the premises for evidence of pests .Using methods, if pests are found, such as trapping devices or other means of pest control . Eliminating harborage conditions. According to the FDA 2022 Food Code, 3-304.14 Wiping Cloths, Use Limitation, Cloths in-use for wiping counters and other equipment surfaces shall be .Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114 and The sanitizing solution must be changed as needed to minimize the accumulation of organic material and sustain proper concentration. Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit. According to the facility's Sanitation of Kitchen policy, Sanitizing of environmental surfaces must be performed with one of the following solutions: .150-200ppm quaternary ammonia compound (QAC) . and Between uses, cloths and towels used to clean and sanitize kitchen surfaces will be soaked in containers filled with approved sanitizing solution. Sanitizing solution will be changed at least two-three times per shift or if solution becomes cloudy or visibly dirty. 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. According to the facility's Food Temperature policy, Cold foods must be maintained at an internal temperature of 41 F or below.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 1) Properly and safely store 1 E-tank (full oxygen canister), and 2) Store respiratory equipment (nasal cannula attached to concentrator and CPAP mask) when not in use for 4 residents (#3, #9, #13 and #75) of 4 residents reviewed for respiratory equipment, safety, and storage, resulting in the protentional for the oxygen tank to fall. Findings Include: Resident #13: On 7/07/2026, at 11:07 AM, Resident #13 was sitting in their recliner in their room. There was a single oxygen tank standing upright in the corner behind the recliner unsecured. On 7/07/2026, at 11:15 AM, an observation along with the Director of Nursing (DON) of Resident #13's room was conducted. The DON was asked if the oxygen tank was full and the DON stated that it's full and I will go get a holder for it. On 7/08/2026 at 9:00 AM, a record review of Resident #13's electronic medical record revealed an admission on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Hypertension and Dependence on supplemental oxygen. Resident #13 required assistance with Activities of Daily Living and had moderately impaired cognition. A review of the facility provided OXYGEN ADMINISTRATION & SAFETY Date 6/7/17 revealed . Safe Administration of oxygen therapy to the resident . when using oxygen cylinder, secure oxygen cylinder in appropriate holder . Resident #3: Review of the Face Sheet, Physician orders, Physician and Nursing progress notes dated 7/26, and care plans dated 6/26, revealed Resident #3 was [AGE] years old, alert and able to be interviewed, admitted to the facility on [DATE], after a fall with a fracture. The resident's diagnoses included, anxiety, multiple sclerosis, chronic lung disease, diabetes, respiratory failure, fall with fracture, obesity, atrial fibrillation, urinary tract infection with the presence of an automatic cardiac defibrillator. Review of Resident #3's physician orders upon admission [DATE]), revealed an order for oxygen at 3L/3 liters per nasal cannula. Review of the residents Alteration in oxygen exchange care plan dated 6/17/26, revealed oxygen/O2 3L, and stated change tubing and clean filters/devices per protocol. Review of the facility Oxygen Administration policy, dated 6/7/17, stated Oxygen administration will be provided per physician's order observing appropriate safety measures (including preventing cross (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contamination and illness). Resident #9: Review of the Face Sheet, Physician orders dated 6/10/26, and care plans dated 6/11/26, revealed Resident #9 was [AGE] years old, alert and his own person, admitted to the facility on [DATE] and re-admitted on [DATE]. The residents diagnosis included, obstructive sleep apnea (with use of CPAP), diabetes, attention-deficit, depression and Dementia. The resident had an order dated 6/12/26, for CPAP use at HS (at night) and remove in am. Review of the resident's facility Alteration in oxygen exchange care plan, dated 3/13/26, revealed that the resident use supplemental oxygen and used a CPAP machine and mask at night. Observations were done on 7/7/26 at 9:41 a.m. and on 7/8/26 at 10:21 a.m., of the resident in bed with his CPAP mask and tubing completely dry sitting on top of his bedside dresser; there was no clear plastic bag on his beside table. Review of the facility BI-PAP/CPAP policy, dated 6/7/17, stated BI-PAP/CPAP therapy will be administered by a Respiratory Therapist or Nurse upon order of a physician. The headgear can be hand washed in a mild soap and water solution if soiled, rinse well and air dry. During an interview done on 7/9/26 at 10:40 a.m., the Director of Nursing/DON stated, The masks and tubing (for O2 and CPAP) should be in a clear plastic bag (when not in use). Resident #75: On 7/7/26 at 9:53 AM, Resident #75 was observed in their room. The Resident was in bed with their eyes closed and they did not respond when spoke to. A nebulizer machine was in place on the dresser next to the Resident's bed. The nebulizer was turned on and running with the nebulizer administration mask above the Resident's head, between the headboard and the mattress. An oxygen concentrator was also present next to the Resident's bed. The concentrator was on and delivering supplemental oxygen at 3 liters (L)/minute via nasal cannula (NC). Resident #75 was not receiving the supplemental oxygen. The NC was observed above the Resident's head, between the headboard and mattress, near the nebulizer administrator mask. 6/13 was written on the oxygen tubing in sharpie marker. On 7/7/26 at 1:33 PM, Resident #75 was observed in their room in bed with their eyes closed. An uneaten food tray was observed on the overbed table. The nebulizer machine was turned off, and the administration mask remained in the same place above the Resident's head between the headboard (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and mattress of the bed. The oxygen concentrator remained on and set at 3L/minute. Resident #75 was not receiving the supplemental oxygen as the NC tubing remained in the same place as prior observation between the headboard and mattress. Record review revealed Resident #75 was admitted to the facility on [DATE] with diagnoses which included bone and prostate cancer, Chronic Obstructive Pulmonary Disease (COPD), schizophrenia, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required moderate to substantial assistance to complete Activities of Daily Living (ADLs) with the exception of supervision and set up for oral care and eating. Review of Resident #75's Electronic Medical Record (EMR) revealed a care plan entitled Potential for alteration in oxygen exchange r/t (related to) COPD (Initiated and Revised: 4/9/26). The care plan included the interventions: - Change tubing and clean filters/devices per protocol (Initiated: 4/13/26; Revised: 4/17/26) - O2 (oxygen) @ 2L/NC (Initiated: 4/9/26; Revised: 4/20/26) An interview was completed with the Director of Nursing (DON) on 7/8/26 at 4:18 PM. When queried regarding the frequency in which oxygen tubing is changed at the facility, the DON responded, Weekly. When queried regarding facility policy/procedure related to administration of nebulizer treatments, the DON indicated nursing staff should stay with the resident while the treatment is administered. When asked what the facility policy/procedure is related to nebulizer administration set after a treatment is complete, the DON stated, Take apart, rinse, dry on a towel, and then put in a clear bag after dry. When queried regarding observations of Resident #75's nebulizer, oxygen rate/administration, and oxygen tubing, the DON verbalized that was inappropriate and indicated they would educate staff. Review of facility policy/procedure entitled, Oxygen Administration and Safety (Effective: 6/17/17) revealed, Oxygen administration will be provided per physician's order observing appropriate safety measures. Procedure: 1. Check physician's order for liter flow and method of administration. 4. Oxygen tubing will be changed as needed. 5. The tubing will be stored in a plastic bag or similar storage device when not in use. A facility policy/procedure related to nebulizer/respiratory equipment storage was requested from the facility administrator on 7/8/26 at 12:49 PM but not received by the conclusion of the survey.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to 1) Implement and operationalize processes and procedures to ensure the provision of accurate pharmaceutical services, 2) Ensure narcotic medication reconciliation and disposal in two of three medication carts reviewed and 3) Ensure the appropriate disposal of a fentanyl (narcotic medication) patch for one resident (Resident #16), resulting in the potential for controlled substance diversion and medication errors for all 80 facility residents. Findings include: Resident #16: On 7/07/2026, at 10:09 AM, Resident #16 was sitting upright in their bed. There was a fentanyl patch on their over bed table which was next to the bed. Resident #16 denied being in pain. Nurse E entered the room and was asked what was on the overbed table and Nurse E stated, a Fentanyl patch. I will get that. Nurse E was asked to get their manager. On 7/07/2026, at 10:010 AM, Nurse N entered Resident #16's room and was asked why there would be a Fentanyl patch on the over bed table. Nurse N stated, sometimes they just come off. The patch appeared used and had the date 7/3/26 written on it. Nurse N checked Resident #16's skin and there was a new Fentanyl patch on their right chest wall with the date 7/6/26 and secured with a see-through occlusive dressing. Nurse N removed the used fentanyl patch from the over bed table. A Tour of the 200 Hall Medication Cart was completed on 7/9/26 at 8:07 AM with Licensed Practical Nurse (LPN) G. After reviewing the contents of the medication cart, the narcotic medications were counted for reconciliation with LPN G. The form was signed as having been counted by the night shift nurse and LPN G on 7/9/26 at 6:30 AM. The total number of narcotic medication containers in the cart did not match the total number documented on the Narcotic Count Sheet. The Narcotic Count Sheet specified there were seven narcotic medication containers in the medication cart and there were eight present. LPN G confirmed there were eight narcotic medication containers in the medication cart and seven were documented on the Narcotic Count Sheet. When queried regarding the discrepancy, LPN G went through the narcotic medications and indicated a new narcotic medication must have been delivered during the night but not added to the count sheet. LPN G was asked how the discrepancy was not identified when the medications were counted in the morning, LPN G stated, (LPN H) counted it. LPN G was asked if it was their signature on the Narcotic Count Sheet form, LPN G confirmed it was. When asked why they signed the sheet if they did not complete the medication reconciliation count, LPN G stated, Honestly I didn't want you to see that it wasn't signed and it wasn't signed. At 8:20 AM on 7/9/26, an interview was completed with LPN G and LPN H. LPN H was asked if they completed the narcotic medications on the 200 Hall Medication Cart when they started their shift and responded they did. When asked why the total number of narcotic medication packages in the cart did not match the number on the Narcotic Count form if they counted the narcotics with another nurse, LPN H stated, I probably wasn't quite awake and didn't look at the sheet (Narcotic Count Form). LPN H was shown the Narcotic Count Sheet. When asked why they did not sign the form if they completed (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the count, LPN H signed the form next to LPN G's signature but did not provide an explanation. A review and count of the 100 Hall Medication Cart narcotics was completed with LPN H on 7/9/26 at 8:27 AM. The total Narcotic Count Sheet was signed by the outgoing night shift nurse on 7/9/26 at 6:30 AM but not signed by the incoming day shift nurse. When queried if they counted the narcotic medications in the cart with the night shift nurse, LPN H verbalized they did. When asked why they did not sign the form, LPN H did not provide an explanation. An interview was completed with the Director of Nursing (DON) on 7/9/26 at 8:47 AM. When queried regarding the facility policy/procedure related to narcotic medication count and reconciliation, the DON revealed the nurse who is leaving counts the narcotics with the nurse who is starting their shift. When queried if the staff who complete the narcotic medication count are supposed to sign the Narcotic Count Sheet, the DON verbalized they are. When asked how the total number of narcotic medication containers could be wrong if staff are counting the medications, the DON did not provide an explanation. The DON was informed of the 100 Hall Medication Cart count inaccuracies as well as the lack of signing the forms. No further explanation was provided. On 7/9/26 at 9:49 AM, a tour of the 400 Hall Medication Cart was completed with LPN I. Two loose, white colored half tablets were present in the narcotic drawer of the medication cart. The tablets were not the same size, and both had been cut in half. When queried, LPN I stated they did not know what the tablets were nor how long they had been in the drawer. Due to the tablets being cut in half, they were unable to be identified. The DON came to the medication cart. When asked, the DON was unable to say how long they had been in the narcotic medication drawer, what the medications were and/or who they belonged to. Review of facility policy/procedure entitled, Medication Storage in the Facility (Dated: 9/1/23) revealed, Policy. controlled substances are subject to special handling, storage, disposal and record keeping. E. At each shift change or when keys are transferred, a physical inventory of all controlled substances. is conducted. and is documented. F. Any discrepancy in controlled substance counts is reported to the Director of Nursing. G. Current controlled substance accountability reports are kept in the. designated binder.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that safe medication storage and labeling procedures were implemented in two of four medication carts resulting in undated, expired, and unlabeled medications. Findings include: A tour of the 400 hall Medication Cart was completed on [DATE] at 2:03 PM with Licensed Practical Nurse (LPN) J and LPN K. The following items were noted in the medication cart:- Open and undated 30 fluid (fl) ounce (oz) container of ProStat. The bottle specified, Discard 3 months after opening.- Box of Budesonide Inhalation Suspension 0.5 milligrams (mg)/2 milliliter (mL) (nebulizer) solution for Resident #75, Dated as Opened [DATE]. The package specified the package was good for two weeks after opening.- Novolog Flexpen (insulin), Dated as opened [DATE] with no resident name and/or identifier.- Humalog Kwik pen (insulin), Dated as opened [DATE]. The insulin pen had a room number written on it but no resident name.- Open container of Assure Prism control solution for blood glucose monitor dated as opened [DATE]. The package stated, Discard 3 months after opening. When queried regarding the ProStat bottle not being labeled when opened, LPN K revealed they were unaware the medication had to be used within a specific time frame after being opened. LPN K was then shown the date on Budesonide Inhalation Suspension and asked how long the medication is able to be used for after being opened. LPN K revealed they would need to look. LPN K was then asked who the Novolog Flexpen belonged to and responded that they did not know because the pen did not have any resident identification on it. When queried who the Humalog Kwikpen belonged to, LPN K indicated the room number written on the insulin pen and proceeded to look in the Electronic Medical Record (EMR) to locate the resident's name. When queried if residents can change rooms, LPN K replied, Yes. LPN K was then asked if labeling the insulin pen with only a room number was best practice and replied, No. An interview was completed with the Director of Nursing (DON) on [DATE] at 4:29 PM. When queried if insulin pens should be labeled with the resident's name, the DON replied, Yes. The DON was informed about the two open insulin pens in the 400 Hall Medication Cart not being labeled with the Resident name and/or other resident specific identifier, the DON verbalized that was unacceptable. When queried if medications and medical supplies that have shorten expiration dates after being opened should be labeled with the date opened, the DON verbalized they should. After being informed of expired and undated items in the 400 Hall Medication Cart, the DON verbalized understanding but did not provide an explanation. The facility policy/procedure related to medication storage and labeling was requested at this time but not received by the conclusion of the survey. A tour of the 100 Hall Medication Cart was completed with LPN H on [DATE] at 7:26 AM. The following items were present in the cart:- Novolog Flexpen, Dated as opened [DATE] with no resident name and/or identifier.- Lantus Solostar (insulin pen), Dated as opened [DATE] with no resident name and/or identifier.- Open container of Assure Prism control solution for blood glucose monitor dated as opened [DATE]. The package stated, Discard 3 months after opening. - Open and undated 30 fluid (fl) ounce (oz) container of ProStat.		

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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 interview and record review, the facility 1. Failed to ensure dignity for 6 residents (#3, #8, #18, #20, #89 and #90) of 18 residents reviewed for dignity regarding timely call light response from staff, and 2. Failed to provide snacks at night per confidential residents' group meeting, and resident verbalizations during the initial tour, resulting in anger, frustration, incontinent episodes, embarrassment, protentional isolation and hunger at night. Findings Include: Resident #3: Review of the Face Sheet, Physician orders, Physician and Nursing progress notes, dated 7/26, and care plans, dated 6/26, revealed Resident #3 was [AGE] years old, alert and able to be interviewed, admitted to the facility on [DATE], after a fall with a fracture. The residents diagnosis included, anxiety, multiple sclerosis, chronic lung disease, diabetes, respiratory failure, fall with fracture, obesity, atrial fibrillation, urinary tract infection with the presence of an automatic cardiac defibrillator. Review of the Nutrition care plan dated 6/16/26, revealed the resident was to have snacks/supplement offered daily. During an interview done on 7/7/26 at 10:54 a.m., Resident #3 stated It takes them (staff) over an hour to answer my light (call light); I have peed, I got mad, embarrassed; it's all the time. Resident #8: Review of the Face Sheet, Physician and Nursing progress notes dated 7/26, and care plans dated 12/29/25, revealed Resident #8 was [AGE] years old, alert and able to be interviewed, initially admitted to the facility on [DATE], The resident's diagnoses included, diabetes, end stage renal disease, gastroenteritis and colitis, anemia (low iron), high blood pressure, stroke with left sided weakness, muscle weakness and depression. Review of the Safety care plan dated 12/29/25, revealed the residents call light placement/accessibility. During an interview done on 7/7/26 at 10:29 a.m., Resident #8 stated On the weekends it takes longer (for staff to answer her call light), about an hour; they are working with less people (on the weekends). Resident #18: Review of the Face Sheet, Physician and Nursing progress notes dated 7/26, and care plans dated 3/26, revealed Resident #18 was [AGE] years old, confused and not able to be interviewed, admitted to the facility on [DATE]. The resident's diagnoses included, Dementia, anxiety, depression, history of seizures, heart disease, stroke and diabetes. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the residents Nutrition and Falls care plans, dated 3/19/26, revealed he was to be offered snacks, and his call light was to be accessible at all times when in bed. Observation of the resident done on 7/7/26 at 11:10 a.m., revealed him in bed with his call light clipped to the upper left side of his pillow. When asked if he could find his call light, he was unable to locate it and when told it was on his upper part of his pillow, he was not able to reach it. Resident #20: Review of the Face Sheet, Physician and Nursing progress notes dated 7/26, and care plans dated 9/25/25, revealed Resident #20 was [AGE] years old, alert and able to be interviewed, admitted to the facility on [DATE]. The resident's diagnoses included stroke with left sided weakness, seizures, metabolic disease, and adult failure to thrive. Review of the residents Nutrition and Safety care plans dated 9/25, revealed he was to be offered snacks, and his call light was to be accessible at all times when in bed. During an interview done on 7/7/26 at 9:54 a.m., Resident #20 stated Sometimes it takes an hour (to answer his call light), sometimes more than that and sometimes they (staff) don't even come. The resident was upset that staff never came at all at times when he put his call light on. Resident #89: Review of the Face Sheet, Physician and Nursing progress notes dated 7/26, and care plans dated 6/25/26, revealed Resident #89 was [AGE] years old, alert and able to be interviewed, admitted to the facility on [DATE], after cancer treatment and a brain bleed. The resident's diagnoses included cancer with chemotherapy treatments, high blood pressure, vascular disease, brain bleed, anxiety, and depression with history of a fall. Review of the residents Nutrition and Safety care plans dated 6/25/26, revealed she was to be offered snacks, and his call light was to be accessible at all times when in bed. During an interview done on 7/7/26 at 10:19 a.m., Resident #89 expressed it takes staff too long to answer her call light. Resident #90: Review of the Face Sheet, Physician and Nursing progress notes dated 7/26, and care plans dated 7/2/26, revealed Resident #90 was [AGE] years old, alert and able to be interviewed, admitted to the facility on [DATE]. The resident's diagnoses included Atrial Fibrillation, urinary tract infection, chronic kidney disease, diabetes, Parkinson's Disease, anxiety and depression. Review of the residents Nutrition and Safety care plans dated 7/2/26, revealed he was to be offered snacks, and his call light was to be accessible at all times when in bed. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview done on 7/7/26 at 10:49 a.m., Resident #90 stated It takes them (staff) an hour sometimes to answer the light (call light); I have wet myself and it's embarrassing. During an interview done on 7/7/26 at 10:51 a.m., Nurse Manager, RN A stated I got here about March and it was worse with the lights (took even longer to answer residents' call lights); we need to get better, yes it takes a while for the lights to get answered. During an interview done on 7/8/26 at 2:20 p.m., the Administrator stated, 10 minutes to 15 minutes is an appropriate time to answer call lights. Review of the facility Call Report Summary, dated 7/4/26 and 7/5/26, revealed a total of 26 times in two day's that resident call lights were not answered timely (greater than 15-minute response time). Review of the facility Call Light Policy dated 5/1/17, stated Call lights will receive consistent and adequate response in order to best meet the individual needs of each resident. On 7/08/2026, at 1:41 PM, During resident council task, there were multiple complaints regarding call lights and timely staff responses; listed below: My bathroom light was on for 30 minutes before they came in They cancel call lights all the time and don't come back Sometimes they don't clip my call light on my bed at night and I can't reach it Ok, I will get you some Tylenol and then never come back They need to staff more aides at night I was on the floor and had to yell for help They never check on me at night They need to make sure our call lights are in reach The aides don't cross over (they stay on their own hall and don't help the other hall) They come in and shut the light off and go away They don't even go to the other halls to help They will cancel the light and say your aide is giving a shower and not help me (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	They will say she's finishing up with someone else and still cancel the light I will let your aide know but still cancel the light The first thing they do is shut the light off, leave and don't come back They will cancel the light and say I'm doing something else The nighttime nurses can be rude The changing of shifts you can hear them at the nurses' station. We hit the call bell, and you can hear them up there and nobody comes to answer the light A lot of time you can hear them visiting and they don't come answer the light On 7/08/2026, at 1:41 PM, during resident council task, the following complaints were voiced regarding bedtime snacks: You have to ask for snacks at night and then they don't bring you one The last two nights I didn't get it They say there's nothing in the fridge They don't stock the fridge The aides try to blame the kitchen for not stocking the fridge Why can't the aides go to the kitchen and get them (snacks) They keep the door locked (snack room) On 7/09/2026, at 8:57 AM, the Administrator was interviewed regarding call light complaints from the Resident Council and the Administrator stated, I will continue to work on call lights with them and plan to meet with the Resident Council weekly to work on their complaints. The Administrator was alerted regarding bedtime snacks and that the residents don't always get them and the administrator responded, I was told there are several snacks available. A review of the facility provided Resident Council Minutes revealed the following ongoing concerns: Date 7-3-26 . Old Business . Concerns . Call Lights, snacks yes/no . will continue to review weekly . Date 6-24-26 . New Business . Discussion with Admin regarding call lights snacks being offered, customer service . The snack issue has been addressed by ADM (dietary manager), It is a hit or miss, plans to resolve this issues will be discussed + implemented by dietary manager, + staff. Follow up .		

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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 advance directives (AD) were executed, and code status was obtained per professional standards for one resident (Resident #48) of one resident reviewed. Findings include: Resident #48:Record review revealed Resident #48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia without behavioral disturbance, subdural hemorrhage (collection of blood between the brain and outermost protective membrane layer), subarachnoid hemorrhage (stroke caused by bleeding into the layers surrounding the brain), and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to moderate assistance to complete all Activities of Daily Living (ADLs) with the exception of eating. Review of Resident #48's code status documentation in the Electronic Medical Record (EMR) revealed a signed, Code Status Form dated 3/24/26. The option selected on the form was Do Not Resuscitate (DNR) and was signed by Resident #48's Family Member Witness V. Further review of Resident #48's EMR revealed the Resident had Durable Power of Attorney (DPOA) AD documentation which designated Witness V as their DPOA if they were unable to make medical decisions for themselves. A determination of incompetency was not present in Resident #48's EMR. An interview was completed with Social [NAME] Designee (SSD) W on 7/8/26 at 1:09 PM. When queried regarding Resident #48's AD and code status, SSD W stated, I know (Resident #48) has a DPOA. When asked if the Resident has been deemed incompetent, SSD W indicated they thought the Resident had. A review of Resident #48's EMR was completed with SSD W at this time. SSD W confirmed Resident #48 did not have incompetency documentation in the EMR and not been deemed incompetent. Resident #48's Code Status Form dated 3/24/26 was reviewed with SSD W. SSD W confirmed Witness V signed the form. When queried why Witness V signed the form when Resident #48 had not been deemed incompetent, SSD W stated, Shouldn't have. No further explanation was provided. An interview was completed with the Director of Nursing (DON) on 7/8/26 at 4:04 PM. The DON was asked when a DPOA takes effect and responded when a resident is unable to make their own decisions. When queried if a resident has to be deemed incompetent in order for a DPOA to be activated, the DON confirmed they did. When asked why Witness V signed Resident #48's DNR code status form when the Resident has not been deemed incompetent and responded that they should not have signed the form. The DON verbalized Resident #48 should complete and sign the form. The facility policy/procedure related to Advance Directives was requested at this time but not received by the conclusion of the survey.		

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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 ensure that psychotropic medications were used with adequate indications for use and for treatment of a diagnosed condition for one resident (Resident #48) of five residents reviewed. Findings include: Findings include: Resident #48: Record review revealed Resident #48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Unspecified Dementia, Unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, subdural hemorrhage (collection of blood between the brain and outermost protective membrane layer), subarachnoid hemorrhage (stroke caused by bleeding into the layers surrounding the brain), and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to moderate assistance to complete all Activities of Daily Living (ADLs) with the exception of eating. The MDS further specified that the Resident had no signs/symptoms of depression, no indicators of psychosis, and did not display any behaviors. Resident #48 did not have a mental health and/or psychiatric diagnosis present in the facility Electronic Medical Record (EMR). Review of Resident #48's Medication Administration Record (MAR) for July 2026 revealed Resident #48 was receiving Seroquel (antipsychotic medication used to treat schizophrenia and bipolar disorder with a Black Box Warning that it is not approved to treat elderly patients with dementia-related psychosis due to an increased risk of death) 25 milligrams (mg) at bedtime related to Unspecified Dementia, Unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (Start Date: 3/26/26). Review of Resident #48's Electronic Medical Record (EMR) revealed a care plan entitled, Behavior- Trauma Assessment is negative (Initiated and Revised: 3/16/26). The care plan included the intervention, Resident assessed on admission for Trauma Care needs and does not have any concerns (Initiated: 3/16/26). A second care plan entitled, I have an alteration in my mood state r/t (related to) insomnia, acute metabolic encephalopathy (sudden onset dysfunction of the brain with a reversible cause) (Initiated: 2/26/26; Revised: 3/25/26) was present in Resident #48's EMR. This care plan included the intervention, Monitor for potential side effects of psychotropic meds. (Initiated: 2/26/26). No further care plans and/or documentation of daily monitoring for signs/symptoms of side effects of psychotropic medications was noted in Resident #48's EMR. An interview was completed with Social Services Designee (SSD) W on 7/8/26 at 1:19 PM. When queried if unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety was an appropriate diagnosis and reason to take Seroquel, SSD W replied, It shouldn't be unspecified. It should be Alzheimer's/dementia. When asked if Alzheimer's/dementia was a reason to take Seroquel, SSD W replied, No. When queried, SSD W reviewed Resident #48's EMR and verbalized the Resident did not have a diagnosis and/or indication for use of Seroquel. An interview was completed with the Director of Nursing (DON) on 7/8/26 at 4:04 PM. When queried if Dementia without behaviors was a reason for a resident to receive Seroquel, the DON responded it was not. When asked why Resident #48 was receiving Seroquel with Unspecified Dementia, Unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety listed as the reason, no documentation of behaviors and no non-pharmacological interventions, the DON stated that was not okay. Review of facility policy/procedure entitled, Use of Psychotherapeutic Medications (Revised: 2/1/25) revealed, A resident will not receive psychotherapeutic medications unless such a medication is needed to treat a (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	specific condition as diagnosed and documented in the clinical record with clearly defined target behaviors and non-pharmacological interventions are not effective. Monitor Alternative Interventions: Document non-pharmacological interventions attempted before prescribing psychotropic medications.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 3053493. Based on observation, interview and record review, the facility failed to ensure that one resident (Resident #45) of 19 residents reviewed for care plans had a comprehensive safety care plan (dated 02/24/26 and updated on 05/30/26) in place, resulting in the discontinued use of a non-skid chair mat. Findings Include: Resident #45: Review of the Face Sheet, Nursing and Physician notes dated 5/30/26 through 7/7/26, physician orders dated 2/24/26 through 6/16/26 and Hospital records dated 6/11/26, revealed Resident #45 was 85 years-old, confused, admitted to the facility on [DATE], required assist with all transfers and was a fall risk upon admission due to a recent fall outside of the facility resulting in a fracture of the right upper leg/femur. The residents diagnosis included, difficulty walking, heart disease, Dementia, Alzheimer's disease, end stage kidney disease, diabetes and anemia (low iron). The resident had a fall with a fracture and surgery of the right upper leg just prior to being admitted to the facility. Review of the resident's facility Falls/safety care plan dated 2/24/26, had the non-slip mat placed on the resident's chair discontinued by facility on 5/30/26, 3 days before the resident fell from his chair and fractured his left upper leg which required surgical intervention (05/30- discontinued mat and fell on 06/03). Nurse who discontinued was not working at facility and the surveyor was unable to contact her. During a phone interview done on 7/8/26 at 11:00 a.m., Family Member #1 C said He fell and fractured his leg at the other nursing home so we brought him here and thought they would keep him safe. Observation was made on 7/7/26 at 2:00 p.m., of Resident #45. The resident was in bed, confused and was unable to answer questions on how he fell; his chair was next to his bed with an incontinent pad on the seat, no gripper pad was on the chair. During an interview done on 7/8/26 at 9:45 a.m., Nurse Manager, RN A stated I think we need to re-look at the environment to prevent another fall. Manager A said she was not aware the residents non-slip chair pad had been removed from his safety care plan. During an interview done on 7/8/26 at 10:00 a.m., the Director of Nursing was not aware he did not have the any non-slip chair pad in his chair (he frequently sits in the chair and fell out of the chair on 6/3/26). During an interview done on 7/8/26 at 10:06 a.m., Cooperate Nurse, RN B stated Something else should of been put in the chair; the dycum (name of non-slip pad in chair) was wrinkling up and he did not like it so we took it off. Review of the facility Baseline Care Plans policy, dated 12/8/25, stated The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered and care of the resident that will meet professional standards of quality care.		

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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 maintain physician's orders and maintain the head of the bed safely for one resident (Resident 7) of one resident reviewed for enteral feeding, resulting in the likelihood of aspiration and/or illness. Findings include: Resident #7: On 7/07/2026, at 10:42 AM, Resident #7 was lying in their bed with their enteral feeding solution hooked up to their abdomen and infusing. The head of the bed angle appeared to be about 20 degrees elevated. On 7/07/2026, at 10:46 AM, an observation with Nurse N of Resident #7's angle of elevation for their head of the bed revealed she's at 25 degrees. Nurse N elevated the head of the bed to the appropriate elevation for safe enteral feeding infusion. On 7/08/2026, at 9:30 AM, a record review of Resident #7's electronic medical record revealed an admission on [DATE] with diagnoses that included Gastrostomy status, dysphagia and stroke. Resident #7 required extensive assistance with Activities of Daily Living and had moderately impaired cognition. A review of the physician orders revealed Elevate HOB to 30-45 degrees at all times during feeding and for at least 30-40 minutes after the feeding is stopped every shift for tube feeding . Active Start Date 10/31/2025 .		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure timely management and implementation of updated interventions for pain management for one resident (Resident #5) of one resident reviewed. Findings include: Resident #5:An interview was completed with Resident #5 on 7/7/26 at 4:21 PM. When queried, Resident #5 verbalized they have pain in their back, legs, and arm. When queried regarding interventions to help relieve their pain, Resident #5 responded, They give me something (medication), it helps but don't take it away. When queried regarding their current pain level, Resident #5 indicated it was currently tolerable but would get very bad. When asked to rate their pain on a scale of zero to 10, Resident #5 shrugged their shoulders and indicated they were not sure. Resident #5 was asked if they spoke to staff regarding their pain and their current medications not controlling their pain and responded they did. Resident #5 then stated, The Doctor came in last week and said he was gone get me a brace for my (right) hand and change my meds but ain't got nothing. Review of Resident #5's Electronic Medical Record (EMR) revealed the Resident was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), chronic viral hepatitis C, spinal stenosis, and osteoarthritis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, used a wheelchair for ambulation, and was able to complete Activities of Daily Living (ADLs) independently. The MDS further detailed the Resident received daily medication for pain. Review of Resident #5's EMR revealed a care plan entitled, Pain Management r/t (related to) -chronic viral hepatitis C -spinal stenosis. -OA (Osteoarthritis) -opioid med (Initiated and Revised: 12/5/25). The care plan included the interventions:- Medications as ordered (Initiated: 12/5/25; Revised: 12/15/25)- Assess for verbal & non-verbal s/sx (signs/symptoms) of distress or pain unrelieved by ordered meds (Initiated: 12/5/25; Revised: 12/15/25)- Discuss concerns regarding pain management with the MD & consulting pharmacist PRN (as needed) (Initiated: 12/5/25; Revised: 12/15/25) Review of documentation in Resident #5's EMR revealed the Resident had been complaining of wrist/arm pain since 6/10/26 and was seen by the Physician on 6/28/26 related to pain. Detailed review revealed the following:- 6/10/26 at 2:45 PM: Nurse's Note. Resident c/o pain in right wrist able to move wrist without difficulty. - 6/12/26 at 1:53 PM: Nurse's Note. Resident reports mild pain to BIL (bilateral) wrist and forearm. - 6/19/26 at 12:00 PM: Nurse's Note. This writer spoke with resident (has) complains of right hand pain with swelling stated ice does not help the pain. This writer reached out DR. x-ray order. - 6/25/26 at 10:35 AM: Nurse's Note. Contacted Dr to inquire about getting a doppler ordered on Pt Right wrist/arm due to the mass and pain (Resident) has been continuously experiencing. Awaiting follow-up - 6/28/26 at 4:39 AM: Physician's Note. Follow-up on presenting issues as well as review of the chronic medical conditions' patient is currently taking active medical treatment for including medications and non-pharmacological interventions. This patient has evidence of osteoarthritis in multiple joints. focus on improving pain in quality of function. Has increased pain. Will increase Neurontin (medication used to treat nerve pain). Review of Resident #5's Health Care Provider (HCP) orders and Medication Administration Record (MAR) on 7/7/26 revealed the Resident was receiving the following medications for pain:- Gabapentin (Neurontin) 300 milligram (mg) twice a day for Degenerative Joint Disease related to spinal stenosis (Start Date: 12/5/25).- Tylenol 650 mg every six hours for pain (Start Date: 12/5/25).- Buprenorphine HCl-Naloxone HCl (Suboxone- medication used to treat opioid dependence) 2/0.5 mg tablet sublingually twice a day with the indication listed as being used for pain (Start Date: 4/1/26).Resident #5 was admitted to the facility on Buprenorphine (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HCl-Naloxone HCl 2/0.5 mg two tablets three times a day and changed to one tablet sublingually twice a day in April 2026. Resident #5 had no medication changes following Physician documentation on 6/28/26 specifying they were going to increase the Resident's Neurontin dose. An interview was completed with Licensed Practical Nurse (LPN) F on 7/9/26 at 10:11 AM. When queried if there had been any changes in Resident #5's pain medications recently, LPN F reviewed the Resident's EMR and stated there had not been. When asked if the HCP had ordered a splint or brace for the Resident's arm/wrist recently, LPN F reviewed the EMR and stated they had not. An interview was completed with the Director of Nursing (DON) on 7/9/26 at 11:57 AM. When queried regarding Resident #5 verbalizing complaints of pain and lack of implementation of planned pharmacologic and non-pharmacologic interventions per their discussion with the Physician, the DON revealed they were unaware Resident #5 had requested additional interventions related to pain. The DON was then asked why Resident #5's Neurontin dosage had not been increased after the Physician documented they were going to increase in on 6/28/26, the DON revealed they were unsure and would need to review Resident #5's EMR further and speak to the Physician. A follow up interview was conducted with the DON at 12:10 PM on 7/9/26. When asked about Resident #5, the DON stated, We are going to increase it (Neurontin) and get with Therapy (services) about a brace. When asked why the interventions had not been ordered when indicated by the Physician in their note dated 6/28/26, the DON stated, It should have been caught in our morning meeting and note review honestly. No further explanation was provided. The facility pain management policy/procedure was requested from the facility Administrator on 7/9/26 at 12:06 PM but not received by the conclusion of the survey.		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a person-centered care plan for one resident (Resident #48) of one resident reviewed for dementia, resulting in the potential for lack of services and care. Findings include:Resident #48:On 7/7/26 at 11:24 AM, Resident #48 was observed sitting in their room in a chair. Family Member Y was sitting at their bedside. An interview was completed at this time. When asked questions, Resident #48 was pleasantly confused and did not always respond when asked questions. When queried, Family Member Y revealed the Resident has dementia is confused at times. Record review revealed Resident #48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Dementia without behavioral disturbance, subdural hemorrhage (collection of blood between the brain and outermost protective membrane layer), subarachnoid hemorrhage (stroke caused by bleeding into the layers surrounding the brain), and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to moderate assistance to complete all Activities of Daily Living (ADLs) with the exception of eating. Review of Resident #48's care plans in the Electronic Medical Record (EMR) revealed the Resident did not have a care plan in place related to dementia. Review of progress note documentation in Resident #48's EMR revealed the Resident was alert with some confusion. A Physician's Note dated 6/18/26 at 1:35 PM specified, In terms of dementia according to the nursing staff (Resident) has been doing about the same. is directable mostly by the staff. is not fighting with the staff about any care at present. Further review revealed the Resident had falls at the facility and did not consistently call for staff assistance. An interview with Social Services Designee (SSD) W and Social Services Director X was completed on 7/9/26 at 11:40 AM. When queried if Resident #48 had dementia, staff confirmed they did. When queried regarding a care plan and individualized interventions related to the Resident's known dementia, SSD W stated, Should have a care plan for dementia because (Resident #48) has had that a long time. When asked why the Resident did not have a care plan related to dementia and interventions to ensure they receive appropriate/personalized treatment and care, SSD W did not provide an explanation but confirmed the Resident should have a care plan. The staff were then queried regarding the facility procedure related to assessment of needs for residents with dementia to ensure they receive the necessary care to help them achieve their highest possible level of wellbeing and a response was not provided. An interview was completed with the Director of Nursing (DON) on 7/8/26 at 4:04 PM. When queried regarding Resident #48 not having a care plan for dementia, the DON revealed they were unaware of the Resident not having a care plan. When queried regarding individualized care and interventions related to the Resident's dementia, the DON was unable to provide an explanation. A facility policy/procedure related to assessment and management of residents with dementia was requested at this time but not received by the conclusion of the survey.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Hoyt Nursing & Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 Weiss St Saginaw, MI 48602	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to properly dispose of waste and maintain the dumpster area to mitigate the presence of pests, potentially affecting all residents in the facility. Findings include: On 07/07/2026 at 9:46AM dirty cups, a plate, napkins, wrappers, gloves, and a plastic lid were observed on the ground surrounding the dumpster area. On 07/08/2026 at 9:40AM during the environmental tour with Maintenance Director U was interviewed on maintaining the dumpster area, and stated that housekeeping checks the area and the dumpster area is checked daily. According to the FDA 2022 Food Code, 5-501.115 Maintaining Refuse Areas and Enclosures A storage area and enclosure for refuse, recyclables, or returnables shall be maintained free of unnecessary items.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 1) Ensure that the Infection Control data was fully analyzed for February 2026, 2) Ensure that clean linen was transported with a cover on it, and 3) Ensure that 1 of 2 urinary catheters reviewed for infection control standards was sanitarly maintained, resulting in the protentional for cross contamination, increased risk for urinary tract infection with antibiotic usage, incorrect infection rate and incorrect data analysis for the month of February 2026. Findings Include: On 7/07/2026, at 10:31 AM, CNA M was observed in the hallway near room [ROOM NUMBER] with multiple bed pads uncovered tucked under their arm. The linen was touching their uniform. CNA M entered an enhanced barrier precautions (EBP) room; 312 and set down half of the bed pads before leaving out of the room with the remaining bed pads under their arm. The bed pads were touching the front of their uniform. CNA M was asked if they normally carry clean linen uncovered and why they entered the EBP room, drop off half the linen and exit with the remaining linen and CNA M stated, I normally only have 1 but I knew she was looking for some. CNA M walked down the hall towards the nurses' station with the remaining two bed pads under their arm. On 7/07/2026, at 10:37 AM, CNA L was observed carrying clean linen/bed sheets tucked under their left arm, uncovered. The linen was touching their uniform. CNA L entered room [ROOM NUMBER] with the linen and then exited the room without the linen. CNA L was asked if they were making the bed in room [ROOM NUMBER] and CNA L stated, not right now, I will come back to do it. On 7/09/2026, at 10:52 AM, Infection Control Nurse (IC) D was alerted of the linen observations from Day 1 of the survey. Resident #75: On 7/7/26 at 9:53 AM, Resident #75 was observed in their room. The Resident was in bed with their eyes closed and they did not respond when spoke to. An indwelling urinary catheter drainage bag was observed directly on the floor on the right side of the bed, towards the hallway door. On 7/7/26 at 1:33 PM, Resident #75 was observed in their room in bed with their eyes closed. An uneaten food tray was observed on the overbed table. A wheelchair was directly next to the right side of the Resident's bed and their indwelling urinary catheter drainage bag was hooked to the bottom of the wheelchair. The catheter drainage tubing was visibly taunt and stretched. Record review revealed Resident #75 was admitted to the facility on [DATE] with diagnoses which included bone and prostate cancer, Chronic Obstructive Pulmonary Disease (COPD), schizophrenia, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required moderate to substantial assistance to complete Activities of Daily Living (ADLs) with the exception of supervision and set up for oral care (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and eating. The MDS further detailed the Resident had an indwelling urinary catheter. Review of Resident #75's Electronic Medical Record (EMR) revealed a care plan entitled Use of indwelling catheter. (Initiated: 4/17/26; Revised: 7/8/26). The care plan included the interventions, - Ensure the foley catheter is anchored q (every) shift (Initiated: 4/17/26) - Assure catheter and drainage bag are below the level of the bladder (Initiated: 4/17/26) - Check catheter system every shift for patency and integrity (Initiated: 4/17/26) - Foley cath care q shift (Initiated: 6/20/26) An interview was completed with the Director of Nursing (DON) on 7/8/26 at 4:18 PM. When queried regarding indwelling urinary catheter drainage bags, the DON verbalized drainage bags should not touch the floor. When queried regarding observations of Resident #75's urinary catheter drainage bag, the DON responded that the Resident does that sometimes and should have a care plan. Resident #75's care plans were reviewed with the DON at this time. After review, the DON confirmed the Resident did not have a care plan in place related to placing the urinary catheter drainage bag on the floor. Review of facility provided policy/procedure entitled Catheter Care. (Revised: 8/17/17) did not include information pertaining to urinary catheter drainage bag placement. On 7/7/26 at 3:28 p.m., this surveyor requested the analyzing data for the month of February 2026; Infection Control Nurse, RN D pulled the file of monthly analyzing sheets from her Infection Control book for this surveyor. Infection Control Nurse D said the questions were not all filled in for February 26, and she was not at the facility at the time. On 7/8/26 at approximately 8:30 a.m. Cooperate Infection Control Nurse, RN E said Infection Control Nurse D was not supposed to give you (this surveyor) that information (analyzing data from 2/26,) without letting me see it first. Review of the facility Monthly Infection Control Analysis dated 2/26, signed by the previous Director of Nursing, revealed the following: -Page 1: Blank answer for question regarding antibiotics prescribed (yes or no question). -Page 2: Blank answer for questions #1, #2 and #4 (yes or no questions) -Page 5: Blank answer for questions #6 (community risk factors previous month data), #7, #8, and #1, #2 and #3 under question #9 (Influenza Vaccination Rate of 80%, resident and employee data). -Page 6: Blank answers under Pneumonia vaccination rate of 75%, under Interpretation of respiratory Data, all the questions were left blank (yes or no questions). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Page 7: On top under Monthly Infection Control Analysis all the questions were left blank including (yes or no questions). -Page 8: On the bottom, under Interpretation of Skin Infections (data showed x1 skin infection) all the questions were left blank (yes or no questions). -Page 9: On top (continuing from page 8), all the questions were left blank (yes or no questions). -Page's 11 & 12: Under Outcome Surveillance-Other Infection Data, there was data of 1 confirmed other infection; on page 12, the top questions (under Other Infections) and under Interpretation of Other Infection Data all the questions were blank (yes or no questions). -Page 13: At the bottom of the page, under Interpretation of Process Surveillance, all questions were blank (yes or no questions). -Page 14: The question, Were there any trends in knowledge deficit it was blank (yes or no question), under Summary of Trends and Correction Action Plan, no documentation was found, and under QA committee questions, it also was blank. Review of the facility Infection Control Long-Term Care program, dated 2014, stated The duties of an Infection Preventionist include: Collecting and analyzing data. Review of the facility Infection Prevention and Control Program, dated 11/22/19, stated the program must provide ongoing analysis of surveillance data and review of data and documentation of follow-up activity in response.		