STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235058	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lapeer County Medical Care Fac	1455 Suncrest Dr Lapeer, MI 48446

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49944 Based on observation, interview and record review the facility failed to ensure call lights were within reach and responded to in a timely manner for 11 residents (R3, R16, R22, R36, R46, R52, R61, R63, R80, R116, R138) and a confidential group of residents, resulting in long call light wait times, delayed assistance and call lights not being accessible. Findings include: Resident #16 R16 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include hypertension, gastro-esophageal reflux disease and atherosclerotic heart disease. R16 has a brief interview for mental status (BIMS) score of 15, indicating they are cognitively intact. On 02/19/25 at 10:16AM, an interview was conducted with R16. R16 was asked if the facility staff answers her call light in a timely manner. R16 stated the staff can be slow to answer call lights, it's especially slow during meal pass times and when they are picking up trays. R16 stated that she has waited 3hrs one time. R16 was asked if they have ever had any issues with incontinence due to long wait times. R16 stated they have had several accidents (incontinence) due to long call light waits. R16 stated they had to self-transfer at one point to get to the bathroom because they couldn't wait, R16 stated they have observed the staff walking by her door and not answering her call light. Record review of call light times revealed that on 2/17/25 at 3:10PM the call light was on for 1 hour and 23 minutes, on 2/15/25 at 6:51PM the call light was on for 1 hours 50 minutes on 2/15/25 at 10:03AM the call light was on for 1 hour and 4 minutes and on 2/12/25 at 5:47PM the call light was on for 1 hour and 26 minutes. Resident #36 R36 is [AGE] years old and most recently admitted to the facility on [DATE], with diagnoses that include neurogenic bladder, hypertension and multiple sclerosis. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/18/25 at 11:37AM, an interview was conducted with R36. R36 was asked if the facility staff answers his call light in a timely manner to meet his needs. R36 stated no they don't and that the staff takes on average 15-20 minutes to answer the call light and sometimes it is longer. R36 was asked if that wait time is good for him. R36 stated that at times it can be too long, luckily for me I have a catheter and a colostomy otherwise it would be way too long of a time to wait if I had to go to the bathroom. Record review of recent call light times revealed that on 2/19/25 the call light was on for 35:27, on 2/18/25 the call light was on for 31:39, on 2/15/25 the call light was on for 1 hour and 10 minutes, on 2/12/25 the call light was on for 36:09 and on 2/8/25 the call light was on for 43:49. Resident #52 R52 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include hemiplegia and hemiparesis following cerebral infarction, panic disorder, overactive bladder and anxiety disorder. R52 has a BIMS score of 14 indicating they are cognitively intact. On 02/18/25 at 12:45PM, an interview was conducted with R52. R52 was asked if the staff answers her call light in a timely manner. R52 stated it takes the staff a long time to answer the call light because they have to check a screen at the nurses desk to see who has their light on. R52 stated staff said that is the only way they know which call lights are on. R52 was asked how long they have waited to receive help. R52 stated I have waited up to 45 minutes before to get help and when they do, they only 'half-help. Record review of recent call light times revealed that on 2/18/25 at 7:13PM the call light was on for 48:35, on 2/6/25 at 1:45PM the call light was on for 1 hour and 7 minutes and on 2/6/25 at 1:02PM the call light was on for 33:18. Resident #61 R61 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic respiratory failure, end stage renal disease with dependence on renal dialysis, hypertension and anemia. R61 has a BIMS score of 14 indicating that they are cognitively intact. On 02/19/25 at 09:11AM, an interview was conducted with R61. R61 was asked if the staff answers his call light in a timely manner. R61 said that it takes long time to get call light answered, I had at least a 90 minute wait just yesterday. R61 was asked if there are specific shifts or times of the day that the responses are slower. R61 stated that all shifts struggle to answer call lights timely, there is no specific time of the day. Record review of recent call light times revealed that on 2/18/25 at 7:15PM the call light was on for 1 hour and 17 minutes, on 2/17/25 at 7:35PM the call light was on for 1 hour and 21 minutes and on 2/12/25 at 11:20PM the call light was on for 44:58. 22348 Facility (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident Council: 02/19/25 02:45 PM, the surveyor reviewed the Resident Council Meeting Minutes submitted by the facility dated from July 2024 up to January 2025. The contents did not reflect the staffing shortage and delayed call light response discussed. The Activities Director was absent during the Resident Council meeting held on 2/20/25 at 3:00 PM. Six confidential residents attended the Resident Council Meeting. On 2/19/25 at 3:00 PM, during the Resident Council Meeting, six confidential groups of residents complained about delayed call light response time in an average wait time of an hour up to 2 to 3 hours sometimes. Confidential Resident #6 indicated that the call lights were not within reach, or they turned the call lights off when they came to your room and then left, and it took 4- 6 hours before staff returned. Confidential Resident #6 stated, Some staff turn the call light off and don't return. Showers are done but at the staff's convenience. There's not enough help with feeding. I have to wait a while for someone to come and feed me. After the meeting on 02/19/25 at 03:58 PM, the Administrator was made aware of the Resident Council's concerns. Resident #3 (R3) During the resident interview on 02/19/25 at 10:21 AM, R3 was found groaning in pain while in bed, positioned almost sitting upright in (high-fowlers) when the surveyor asked how he was. R3 indicated that he was uncomfortable and his head and neck were hurting. He further described that he sat up to eat breakfast and stated, No one came back since, and his neck really hurts. It was observed that dried blood stains were found on the pillowcase. CNA T, who responded from the call light, was queried and stated that she was unsure where the blood came from, but she thought it was coming from the lesion on his head. Further reply from CNA T explained that she was not assigned to the hall but happened to be walking by and thought help was needed. The surveyor confirmed with CNA T that there was no call light sounding, and no light was visual to alert staff even if the R3 had activated his call light. R3 was [AGE] years old and admitted on [DATE] with a diagnosis of Chronic Kidney Disease Stage 3, Squamous Cell Carcinoma of the scalp and neck, and Dementia, in addition to other diagnoses. His Brief Interview for Mental Status (BIMS) score, dated 12/4/2024, was 08/15, which indicated a moderate cognitive impairment. This means that the person may need extra help with daily activities. A review of R3's Minimum Data Set (MDS) GG section, dated 12/4/24, revealed that he depended on most ADLs, such as upper and lower body dressing, showers, and toilet use. He was assessed as frequently incontinent with a bladder elimination pattern and occasionally with a bowel elimination pattern. CNA T repositioned R3, and the pillow case was changed. Resident #116 (R116) (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/18/25 at 11:38 AM, R116 was observed resting in his room while lying in bed. R116's wife was sitting at the bedside (at R116's left side). R116 call light was found on the floor, which was inaccessible and away from R116 reach. R116's wife confirmed that the call button was found on the floor on the resident's right side. It was not anchored or did not dangle for the resident to access when needed. R116's wife explained that R116 had used his call light made his needs known when he was hungry or in pain. The wife stated that they must know I was here, that is probably why they did not place the call light where he could reach them. R116's wife said, It has happened before. A review of R116's Electronic Medical Record on 2/19/2025 at 1:30 PM revealed R116 was [AGE] years old and admitted to the facility on [DATE] with a diagnosis of Seizure Disorder, Dementia, and cerebrovascular accident (CVA) with 1-sided upper and lower extremity impairment in addition to other diagnoses. R116 BIMS Score was 07/15 assessment date of 1/22/2025. A BIMS Score of 0-7 means severe cognitive impairment. R116, on the assessment date of 1/22/2025, was dependent on all daily activities such as eating, toileting, and showers and was always incontinent with both bowel and bladder elimination patterns. Resident #80 (R80) On 02/19/25 at 11:16 AM, R80 discussed issues with staff call light response. Sometimes it takes a little while. Sometimes, 1 hour and could take more than 2 hours before they return. The request varies from a cold pack to food and nursing care-related needs. R80 explained, I am transferred using a Hoyer lift, so it is quite a wait to get the lift and have the staff put me in it. All I can do is wait. I get hot at times due to my medical condition, and I get the shakes if I don't have an ice pack resting on my chest. Sometimes, it takes over 2 hours just to get the ice pack. I live in my chair practically, so I need assistance most of the time, especially when going to the toilet. A review of Electronic Medical Records on 2/20/25 at 2:00 PM revealed that R80 was [AGE] years old and admitted to the facility on ,d+[DATE]/ 2023 with the following diagnosis: Multiple Sclerosis, Type 2 Diabetes, and Paraplegia in addition to other diagnoses. R80 has a BIMS Score of 15/15. The date of assessment was 12/23/24. A BIMS score of 15 indicates that R80 has intact cognitive functioning. The Minimum Data Set Section GG assessed on 1/2/2025 revealed that the resident had no impairment in the upper extremities but impaired both sides of the lower extremities. R80 depended on most activities of daily living, including upper and lower body dressing, toileting, and maximum assistance with his personal hygiene. R80 is transferred via the mechanical lift. R80 was always continent with a bladder elimination pattern, although he was always incontinent with bowel movements. On 2/21/25 at 3:00 PM, The Facility's Resident's Rights and Call Light Policies were reviewed. 37771 Resident #22 A review of Resident #22's medical record revealed an admission on 3/5/24 with diagnoses that included dementia, heart disease, anxiety, and fall. A review of the Minimum Data Set (MDS) assessment revealed a BIMS (brief interview of mental status) score of 10/15 that indicated moderately impaired cognition, and the Resident needed, and the Resident needed partial/moderate assistance with toileting hygiene and most mobility and transfers and substantial/maximal assistance with dressing. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/18/25 at 1:15 PM, an observation was made of Resident #22's room. The Resident was not in the room at that time. The Resident's bed was positioned up against the wall and the call light cord hung down between the wall and the bed and the push mechanism was on the floor. The call light cord was towards the foot of the bed. The call light was not in reach for the Resident. On 2/19/25 at 8:56 AM, an observation was made of the Resident in the dining room eating, seated in her wheelchair. The Resident's room had the call light cord hanging between the wall and the bed and the push mechanism was on the floor. The Resident was observed in their room after breakfast seated in their wheelchair. The call light remained on the floor and not in reach for the resident. On 2/20/25 at 9:15 AM, an observation was made of Resident #22 in bed with her eyes closed. The Resident's call light was positioned on the floor and not within reach for the Resident. On 2/21/25 at 9:38 AM, an observation was made of Resident #22 laying in bed. There was a breakfast tray on the overbed table that was partially eaten. The call light was observed to be hanging from the wall and positioned between the wall and the bed with the push apparatus on the floor and not within reach for the Resident. On 2/21/25 at 11:08 AM, an observation was made with Unit Manager, Nurse Q of Resident #22 sleeping in her bed. An observation was made of the Resident's call light cord hanging down the wall past the mattress and laying on the floor. The call light was not in reach for the Resident. The Unit Manager retrieved the call light off the floor and positioned it within reach for the Resident. The Unit manager indicated that the call lights should be within reach for the Residents. Resident #46 A review of Resident #46's medical record revealed a readmission into the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, quadriplegia, heart disease, and contracture of unspecified joint. A review of the MDS assessment revealed the Resident had intact cognition and was dependent on staff for activities of daily living, mobility and transfers. On 2/19/25 at 12:18 PM, an interview was conducted with Resident #46 who answered questions and engaged in conversation. The Resident was asked if they had concerns regarding their care. The Resident reported that the call light could take 30 minutes to an hour to answer and stated, I have to yell out to get help. The Resident reported the staff do not have the pagers anymore, there is no light above the door and the staff had to look at a screen at the nurses' station or on tablets and the screen does not work. The Resident voiced frustration that the CNAs do not answer call lights timely. Resident #63 A review of Resident #63's medical record revealed an admission into the facility on [DATE] with diagnoses that included neurocognitive disorder with Lewy Bodies, Parkinson's disease, diabetes, obstructive sleep apnea, and anxiety disorder. A review of the MDS revealed the Resident had intact cognition and was dependent on helper for most activities of daily living, mobility and transfers. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/19/25 at 2:11 PM, an interview was conducted with Resident #63 who answered questions and engaged in conversation. The Resident was up in her wheelchair seated next to the bed. An observation was made of a call light that was upside down V shape. The Resident reported she could not use the push button call light. When asked about any concerns she had regarding her care, the Resident reported long call light wait times and that staff will shut it off, say they will be back and then they don't come back. The Resident expressed having to wait up to four hours to be changed due to having incontinence. When asked if they do a check and change every, two hours, the Resident expressed frustration and stated, They don't come every 2 hours to check on us, not enough people (staff). The Resident reported that staff have left the room without making sure the call light is in reach or hide it under the covers and I can't find it. The Resident reported not having her oxygen on during the night and went several hours without the oxygen and stated, It gives you a sick feeling to have that light on and no one comes to find out why it is on. Resident #138 A review of Resident #138's medical record revealed an admission into the facility on [DATE] with diagnoses that included arthritis, dementia and anxiety disorder. On 2/19/25 at 10:01 AM, an observation was made of Resident #138 sitting in her wheelchair in their room. The Resident was yelling out to staff that passed by her room. The Resident was interviewed, did not answer questions appropriately, but engaged in random conversation. The Resident was asked about her call light but did not know where it was and asked if it was on. The call light was not on. An observation was made of the call light at the top of the bed and positioned underneath the pillow. The Resident was seated next to the bed in front of the bedside table and was not in reach of the call light.

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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** 22348 Based on observation, interview, and record review, the facility failed to validate and update the care plan for DNR status for one resident (R#47) of 3 residents reviewed for advanced directives. Findings include: Resident #47 Advance Directives On 02/19/25 at 12:47 PM, R47's Advanced Directives in her clinical file was dated 11/1/2023. Resident #47 (R47) According to the review of Electronic Medical Records conducted on 2/20/25 at 2:45 PM, R47 was [AGE] years old and admitted to the facility on [DATE] with the diagnosis of Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side, vascular dementia with mood disturbances, and peripheral vascular disease in addition to other diagnoses. R47's son was the Durable Power of Attorney (DPOA) and emergency contact. R47's Brief Interview of Mental Status (BIMS), which was assessed on 12/25/24, revealed a score of 09/15. A score of 9 indicates moderate cognitive impairment. A score of 0-7 represents severe cognitive impairment, and 13-15 signifies intact cognitive function. R47 Care Plan on Advanced Directives was reviewed and revised on 11/07/2023. Upon interview with the Social Worker (SWS) on 02/21/25 at 10:11 AM, the SW indicated that they reviewed the resident's Advanced Directives with the staff every quarterly, during care conferences, and annually. The surveyor and SW reviewed the care conference notes and the social worker's progress notes. The SW S revealed she cannot find the notes for now and will ask the unit manager to help find any notes on R47 Advanced Directives. The SW S also confirmed that R47's care plan for Do-Not-Resuscitate was last updated in 2023. R47's BIMS Score was 9/15, and she has a Durable Power of Attorney (DPOA). The SW stated, Sometimes, the family may have difficulty coming in to sign. The SW S confirmed that she could not find any progress notes regarding discussing the Advanced Directive with the family/DPOA and updating the care plan. On 02/21/25 at 10:20 AM, The Unit Manager (UMK) confirmed that she could not find any progress notes or care conference notes indicating that the Advanced Directive has been reviewed since 2023. A facility policy entitled Advanced Directives, last updated on 2/14/2024 was reviewed on 2/21/25 at 10:30 AM. The Policy Statement: To provide the resident, guardian, medical durable power of attorney (DPOA), and /or resident advocate an opportunity to make their wishes known prior to a life-threatening incident occurring. It should be understood that any decision that is made is not binding and can be revoked at any time by the above listed parties . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.7. If at any time the resident/responsible parties decide on changing the current advance directives the nurse will follow the above policy. Quarterly with MDS/care plan reviews the Floor Coordinator will review current Advance Directives with appropriate parties (if in attendance) and answer any questions or make any necessary changes.

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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** 49944 Based on interview and record review the facility failed to complete a comprehensive care plan for one resident (R32) of four residents reviewed for unnecessary medications. Findings include: Resident #32 R32 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include, dementia, major depressive disorder, dysphagia and atrial fibrillation. R32 has a brief interview for mental status (BIMS) score of 3 indicating severe cognitive impairment. On 02/20/25 at 09:57AM, record review revealed that R32 admitted to the facility on [DATE] and there is a physician's order dated 09/10/24 for Venlafaxine (Effexor) HCl ER Tablet 150mg, give one tablet by mouth one time a day for depression. On 02/20/25 at 11:31AM, record review revealed that R32 has a care plan in place for Effexor for depression, however, Effexor was discontinued on 01/05/25. The psychotherapeutic medications care plan was initiated on 12/6/24, psychotherapeutic medication (Effexor) was initiated on 09/10/24. On 02/20/25 at 11:53AM, an interview was conducted with Unit Manager (UM) D. UM D was asked who is responsible for implementing and updating care plans for psychotherapeutic medications. UM D stated that, Usually it is social work that does that (implements and updates care plans) but the Minimum Data Set (MDS) nurse or me will do it if it needs to be done. This surveyor verified with UM D that the care plan for psychotherapeutic medication was initiated and updated on 12/6/24. UM D was asked if the care plan should have been initiated sooner when R32 started on psychotherapeutic medication. UM D stated, Yes, the care plan should have been implemented at that time and updated with changes in medication. It was just missed, I don't really know why it wasn't implemented or updated. Record review of the policy titled, Interdisciplinary Care Plan, reviewed 01/12/24, revealed: Policy Interpretation and Implementation: 1. Upon admission, resident status is assessed by the Interdisciplinary Team members (Dietary, AT, SW, Nursing, Restorative Nurse R.N., Skilled Therapies) using a combination of assessment tools including the MDS/CAA's. Care plans are developed on a timely basis, according to the RAI process. 2. Each discipline, based on their admission assessment, submits care plan information (i.e.: problems, goals, approaches) to the appropriate Unit manager. Unit managers will compile all assessment information to create an individualized computer care plan. Cardiovascular Respiratory (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Neuromuscular/ Skeletal Psychosocial/Orientation (includes Discharge Plan) Integumentary Nutrition Gastrointestinal Genitourinary Endocrine/ Metabolic Sensory ADL/ Safety Miscellaneous 3. The Unit manager will review the information found in each care plan section looking at the care that has been provided related to physician orders, labs, diagnostic testing, current medical status, etc. in order to assure continuity of care. Any issues found will be discussed with the appropriate interdisciplinary care plan team member and if necessary, taken to the physician and resident/family seeking direction for future plan of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 Based on observation, interview and record review the facility failed to update and reviews care plans for psychotropic meds, pain, skin care and respiratory care for 4 Residents (R#3, R#32, R#47, & R#90) of 5 sampled residents reviewed for care plans. Findings include: Resident #3 (R3) General According to the Electronic Medical Record reviewed on 2/19/2025 at 2:00 PM, R3 was [AGE] years old who was admitted to the facility on [DATE] with a diagnosis of Alzeihmers Disease (late onset), Carcinoma of the situ of skin and scalp, and neck, Squamous cell cardinoma of the skin of scalp and neck and Chronic Kidney Disease Stage 3 in addition to other diagnoses. R3 has a Brief Interview of Mental Status (BIMS) Score of 08/15 assessed on 12/4/2024. A Score of 08-12 on the BIMS indicates moderate cognition impairment. A score of 0-7 points suggests severe cognitive impairment and a scor of 13-15bpoints suggests that cognition is intact. R3, according to the Minimum Data Set (MDS) assessment dated [DATE] is dependent with staff in all Activities of Daily Living and Personal Hygiene except for Eating where he needed set up and clean up assistance. R3 is always incontinent with Bladder elimination pattern but occassionally incontinent with bowel elimination pattern. During the R3 interview conducted on 02/21/25 at 11:20 AM, after the scalp dressing was applied to R3, R3 was asked of his level of pain from 1-10, with 10 being the most pain). R3 responded, Pain is 100. R3 complained of pain and requested for pain relief. R3 further described the location by stating, my neck hurts from the position I was in. R3's gown had some blood stain on his right side of the shoulder that looks like a dried blood stain. Registered Nurse (RN H) was ask where the blood was coming from. RN H indicated that she was unsure where it was coming from but she assumed that R3 scratches a lot and have skin lesions all over his body. RN Hrevealed that R3 receives a daily treatment applied to his skin. She stated, Some type of cream. On 2/21/25 at 11:00 am, RN H was observed during wound care and dressing change. There was a scant drainage noted on the dressing that was removed. The wound area measured 2 centimeter (cm) wide by 1.5 cm length with width open area at the scalp area. Although R3 was grimacing and complained of pain during dressing change, RN H stated that R3 did not have any complaints of pain earlier this morning upon administering his routine aspirin (ASA) 1 mg at around 9:30 AM. On 2/21/25 at 11:30 AM, R3 was queried about the blood stains on nis gown. R3 indicated that he was unaware where it came from or when his gown was last changed. Pain Management: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/19/25 at 10:21 AM, R3 complained he is uncomfortable. R3 was observed sitting upright in bed and complained of extreme head and neck pain, grimacing and moaning. Pain scale level of 10/10 revealed by R3 during an interview on 02/19/25 10:21 AM witnessed by staff. Staff CNA T stated that she was getting the nurse. CNA T Lowered the head of the bed and repositioned him in bed. CNA J stated, we got him comfortable and got his head down. R3's pillow case had dried blood stain noted. After confirming the observation with CNA T, she revealed that it was the nurses that did the wound dressing changes daily. CNA T stated that the blood must have been from his head lesion. CNA T further stated that sometimes the dressing come off from his scalp. It was observed by CNA T and the surveyor that R3 did not have a dressing on his scalp during this observation and was in extreme pain. A review of the Medication Administration Record (MAR) for R3 dated February 2025 revealed only 2 medications for pain relief: Pain orders in the February 2025 MAR were: Aspirin 81 mg 1 tab P. O. in AM and Acetamenophen 325 mg 2 tablets for PRN. The February 2025 MAR (from February 1 through February 20) showed R3 had zero pain daily assessed and recorded. There were no PRN Tylenol administered for relief of pain. R3's February 2025 MAR revealed no pain relief was given despite R3 was observed and verbally complained of extreme head and neck pain, grimacing and moaning, Pain scale level of 10 per R3 during an interview on 02/19/25 10:21 AM to staff. The next pain relief received was on 2/10/25, the following day of ASA 81 mg 1 tablet routinely administered daily. Upon review of the Electronic Record Review for R3's Care Plan on 2/21/25 at 12: 00 PM, It revealed: 1. Pain care plan was initiated on 8/28/23 and date of Revision was 09/07/2023. The most recent intervention update was dated 3/6/24, which indicated to: Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria. nausea, vomiting, dizzyness and falls. Report occurrences to the physician. Date initiated 03/06/2024. No other revisions of the care plan for pain was noted after 03/06/2024. 2. Wound/Skin Care Plan was initiated on 08/28/2023, Last revised on 08/01/2024 Skin lesions that were found and observed all over his body with blood stains on his linens were not updated in his wound/skin care plan. No new interventions and update were entered despite new treatment orders, new monitoring and assessment orders and update in R3 wound condition and specialist consultation and recommendations. Resident #47 (R47) Advanced Directive Care Plan (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/19/25 at 12:47 PM, R47's Advanced Directives in her clinical file was dated 11/1/2023. R47's care plan on Advanced Directives were last revised on 11/7/2023. According to the review of Electronic Medical Records conducted on 2/20/25 at 2:45 PM, R47 was [AGE] years old and admitted to the facility on [DATE] with the diagnosis of Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side, vascular dementia with mood disturbances, and peripheral vascular disease in addition to other diagnoses. R47's son was the Durable Power of Attorney (DPOA) and emergency contact. R47's Brief Interview of Mental Status (BIMS), which was assessed on 12/25/24, revealed a score of 09/15. A score of 9 indicates moderate cognitive impairment. A score of 0-7 represents severe cognitive impairment, and 13-15 signifies intact cognitive function. R47 Care Plan on Advanced Directives was reviewed and revised on 11/07/2023. Upon interview with the Social Worker (SW) on 02/21/25 at 10:11 AM, the SW indicated that they reviewed the resident's Advanced Directives with the staff every quarterly, during care conferences, and annually. The surveyor and SW reviewed the care conference notes and the SW progress notes. The SW revealed she cannot find the notes for now and will ask the unit manager to help find any notes on R47 Advanced Directives. The SW also confirmed that R47's care plan for Do-Not-Resuscitate was last updated in 2023. R47's BIMS Score was 9/15, and she has a Durable Power of Attorney (DPOA). The SW stated, Sometimes, the family may have difficulty coming in to sign. The SW confirmed that she could not find any progress notes regarding discussing the Advanced Directive with the family/DPOA and updating the care plan. On 02/21/25 at 10:20 AM, The Unit Manager confirmed that she could not find any progress notes or care conference notes indicating that the Advanced Directive has been reviewed since 2023. A facility policy entitled Advanced Directives, last updated on 2/14/2024 was reviewed on 2/21/25 at 10:30 AM. The Policy Statement: To provide the resident, guardian, medical durable power of attorney, and /or resident advocate an opportunity to make their wishes known prior to a life-threatening incident occurring. It should be understood that any decision that is made is not binding and can be revoked at any time by the above listed parties . .7. If at any time the resident/responsible parties decide on changing the current advance directives the nurse will follow the above policy. Quarterly with MDS/care plan reviews the Floor Coordinator will review current Advance Directives with appropriate parties (if in attendance) and answer any questions or make any necessary changes. The Facility's Interdisciplinary Care Planning Policy, updated on 1/12/2024, was reviewed on 2/21/25 at 3:00 PM, indicated: Policy Statement: To provide a system to ensure all resident's care plans are developed and updated. This facility utilizes an electronic charting system. The resident care plan is created and stored via orders and entries into the electronic charting system. Note: The electronic version of the care plan is considered the current care plan. .Policy Interpretation and Implementation: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Upon admission, resident status is assessed by the Interdisciplinary Team members (Dietary, AT, SW, Nursing, Restorative Nurse R.N., Skilled Therapies) using a combination of assessment tools including the MDS/CAA's. Care plans are developed on a timely basis, according to the RAI process. 2. Each discipline, based on their admission assessment, submits care plan information (i.e.: problems, goals, approaches) to the appropriate Unit manager. Unit managers will compile all assessment information to create an individualized computer care plan. Cardiovascular Respiratory Neuromuscular/ Skeletal Psychosocial/Orientation (includes Discharge Plan) Integumentary Nutrition Gastrointestinal Genitourinary Endocrine/ Metabolic Sensory ADL/ Safety Miscellaneous 3. The Unit manager will review the information found in each care plan section looking at the care that has been provided related to physician orders, labs, diagnostic testing, current medical status, etc. in order to assure continuity of care. Any issues found will be discussed with the appropriate interdisciplinary care plan team member and if necessary taken to the physician and resident/family seeking direction for future plan of care. 4. For quarterly/annual/CIS care plan updates, the Interdisciplinary care plan team will review their goals and approaches for appropriateness and request any necessary changes by notifying the Floor Coordinator. The Unit manager will discuss the goals/approaches with the physician and make any necessary changes in the electronic care plan. 5. After review of the care plan by the interdisciplinary care plan team member, a quarterly progress note is made to reflect the review. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Interdisciplinary Care Plan meetings (clinicals) are conducted by the RN Unit manager and attended by Dietary, AT, SW, Restorative Nurse R.N., if requested by family. Resident (if desires) and resident's representative also attend. Other disciplines, when applicable, also attend meeting. (Restorative Nurse R.N., OT, PT, ST, Charge Nurse, CMH, Hospice, etc.) Also note that a phone conference may be done if representative is unable to attend meeting. 7. During the meeting, the Unit manager reviews and discusses any adjustments, clarifications, etc. to the plan of care. A review of current Advance Directives will also be discussed. Any concerns requiring physician evaluation are compiled by the Charge Nurse or Unit manager and placed on physician board after meeting. 8. The Unit manager will document a brief summary of the Care Plan meeting in the EMAR. 9. Updating of the CNA Bedside Kardex is completed once the pertinent order is saved in the computer and the LPN copies off the new CNA Bedside Kardex as indicated in the Noting Orders Policy. This incorporates approaches that are the responsibility of the CNA. 10. The MAR's and TAR's and shift charting tasks are updated the moment the order is saved in the computer. This completes the requirement for licensed nurse to follow the physician orders/plan of care. 37666 Pressure Ulcer/Injury Resident #90 A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #90 indicated an admitted [DATE] with diagnoses: Alzheimer's dementia, depression, arthritis, hypertension, heart disease, and anxiety. An unstageable pressure ulcer on the right heel was identified on 1/13/2025. The MDS assessment dated [DATE] identified the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of 5/15 and the resident needed assistance with all care. An MDS significant change assessment dated [DATE] revealed the resident was dependent with care needs and her condition and declined. A review of the 11/13/2024 MDS assessment revealed the resident did not have any pressure ulcers or other type of skin ulcers. A 2/5/2025 MDS significant change assessment indicated the resident had 2 unstageable pressure ulcers. A review of the assessments for Resident #90 revealed the resident had an unstageable pressure ulcer to the right heel 1/13/2025 and also an unstageable pressure ulcer on the outer base/hallux of her right great toe dated 12/17/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/21/2025 at 8:45 AM, wound care for Resident #90 was observed with Nurse B. The resident was observed sitting in a Broda chair. Nurse B washed her hands and applied gloves, then opened the dressing to show 3 wounds on Resident #90's right foot: 1. right great toe outside edge about 0.25 cm x 0.25 cm blackened area, 2. outer right foot near base of great toe ~1.5 x 1.5 cm wound black around and pink in the middle and 3. a black scabbed area ~ 1 x 1 cm on the right heel. The Nurse did not know how long the resident had the wounds and said they were facility acquired. A review of the Care Plans for Resident #90 identified the following: Pressure Injury Focus: (Resident #90) has an unstageable pressure injury to her right hallux (base of right great toe). She has a history of cellulitis to this area. She has an unstageable pressure injury to her right heel, date initiated 12/202024 and revised 1/20/2025 with 3 interventions: Administer treatments as ordered and monitor for effectiveness, date initiated 12/20/2024; Assess/record/monitor wound healing weekly date initiated and revised 12/20/2024; Monitor/document/report (as needed) any changes in skin status . date initiated 12/20/2024. There were no preventive measures identified before or after the pressure ulcers were identified. Integumentary Focus: (Resident #90) is at risk for potential impairment to skin and feet integrity related to the aging process with potential for increased dryness, fragility, incontinence, need for assistance with care as her Alzheimer's Dementia progresses ., date initiated 2/14/2023 and revised 5/14/2023 with Interventions including: Roho: Check Proper inflation cushion Thursday, date initiated 12/27/2024 and revised 1/30/2025. There were no Care Plan interventions specific to the resident right foot pressure ulcers. The Care Plans did not include measures to prevent skin breakdown on the resident's feet. 49944 Resident #32 R32 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include, dementia, major depressive disorder, dysphagia and atrial fibrillation. R32 has a brief interview for mental status (BIMS) score of 3 indicating severe cognitive impairment. On 02/20/25 at 09:57AM, record review revealed R32 has physician's orders for Rexulti 1mg initiated 02/18/25 and Pristiq 100mg initiated 01/28/25, both medications are for depression On 02/20/25 at 11:31AM, record review revealed that R32 has a care plan in place for Effexor for depression, however, Effexor was discontinued on 01/05/25. The psychotherapeutic medications care plan was initiated and last updated on 12/6/24. The care plan does not reference that R32 is on Rexulti 1mg initiated 02/18/25 and Pristiq 100mg initiated 01/28/25, both medications are for depression (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/20/25 at 11:53AM, an interview was conducted with Unit Manager (UM) D. UM D was asked who is responsible for implementing and updating care plans for psychotherapeutic medications. UM D stated that, Usually it is social work that does that (implements and updates care plans) but the Minimum Data Set (MDS) nurse or me will do it if it needs to be done. This surveyor verified with UM D that the care plan for psychotherapeutic medication was initiated and updated on 12/6/24. UM D was asked if the care plan should have been initiated sooner when R32 started on psychotherapeutic medication. UM D stated, Yes, the care plan should have been implemented at that time and updated with changes in medication. It was just missed; I don't really know why it wasn't implemented or updated. Record review of the policy titled, Interdisciplinary Care Plan, reviewed 01/12/24, revealed: 4. For quarterly/annual/CIS care plan updates, the Interdisciplinary care plan team will review their goals and approaches for appropriateness and request any necessary changes by notifying the Floor Coordinator. The Unit manager will discuss the goals/approaches with the physician and make any necessary changes in the electronic care plan. 5. After review of the care plan by the interdisciplinary care plan team member, a quarterly progress note is made to reflect the review. 6. Interdisciplinary Care Plan meetings (clinicals) are conducted by the RN Unit manager and attended by Dietary, AT, SW, Restorative Nurse R.N., if requested by family. Resident (if desires) and resident's representative also attend. Other disciplines, when applicable, also attend meeting. (Restorative Nurse R.N., OT, PT, ST, Charge Nurse, CMH, Hospice, etc.) Also note that a phone conference may be done if representative is unable to attend meeting. 7. During the meeting, the Unit manager reviews and discusses any adjustments, clarifications, etc. to the plan of care. A review of current Advance Directives will also be discussed. Any concerns requiring physician evaluation are compiled by the Charge Nurse or Unit manager and placed on physician board after meeting.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to ensure nail care was provided for two residents (#46 and #78) of five residents reviewed for Activities of Daily Living (ADL). Findings include: Resident #46: A review of Resident #46's medical record revealed a readmission into the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, quadriplegia, heart disease, and contracture of unspecified joint. A review of the Minimum Data Set (MDS)assessment revealed the Resident had intact cognition and was dependent on staff for activities of daily living, mobility and transfers. On 2/18/25 at 12:27 PM, an interview was conducted with Resident #46 who answered questions and engaged in conversation. The Resident was observed to have limited mobility of her hands. The Resident's fingernails were long and there were a couple nails that had nail polish that was chipped or worn off from most of the nails. The Resident was asked about her fingernails, and she responded that activities would do them sometimes and stated, They are supposed to ask when I get my shower, but they don't, and expressed that the fingernails were longer than she liked. Resident #78: A review of Resident #78's medical record revealed an admission into the facility on [DATE] with diagnoses that included cerebral palsy, aphasia, severe intellectual disabilities and abnormal involuntary movements. A review of the MDS assessment revealed the Resident had severely impaired cognition and was dependent on a helper for activities of daily living, mobility and transfers. On 2/18/25 at 12:07 PM, an observation was made of Resident #78 sitting up in a chair in their room. The Resident was not able to be interviewed and did not engage in conversation. The Resident was observed to have jerking motions of his arms and hands had limited mobility and contractures. The Residents nails were observed to be long, and a couple of the nails were jagged. The Resident occasionally got his hands to his face and made contact with his eyes and nose with non-purposeful jerking movements. On 2/20/25 at 12:30 PM, an observation was made of Resident #78 sitting up in his wheelchair. The Resident's nails remained long, and a couple were jagged. A scratch mark was observed on the Resident's right cheek area. The Resident was observed to flail his arms around. On 2/20/25 at 1:40 PM, Resident #78's tube feeding was administered by Nurse AA. The Resident was observed to flail his arms around. The scratch on the Resident's right cheek was observed. The Nurse was asked about the Resident's bathing schedule and reported the Resident would get a bed bath twice a week. When asked about nail care, the Nurse indicated they don't look like they had recent attention. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #78's medical record revealed a progress note titled Incident Note, dated 5/9/24 at 1:00 AM, Nurse and aid were boosting resident when a scratch on the resident forehead and nose was observed. Red scratch on bridge of the nose measure approximately 0.6 cm. Dry open to air. Scratch to the forehead is red and dry measures approximately 1.2 cm. Superficial scratch on the forehead measures at 5 cm. Fingernails trimmed. A review of Resident #78's care plan revealed an integumentary focus (Resident name) is at risk for potential skin and feet integrity secondary to cerebral palsy, total assist with cares, involuntary movement ., and an intervention of Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short, with initiation on 1/24/23. On 2/21/25 at 11:08 AM, an interview was conducted with Unit Manager, Nurse Q regarding fingernail care. The Unit Manager was asked about facility policy regarding nail care. The Unit Manager indicated nail care was to be performed on shower or bathing days and as needed. When review of Resident #46, the Unit Manager indicated that her showers were weekly and more if requested or needed. When asked if Resident #46 refused nail care, the Unit Manager reported that if she refused, the nurse would be notified and put a note in the medical record. A review of the medical record did not reveal documentation of refusals for nail care. An observation was made with the Unit Manager of Resident #78's fingernails long and not trimmed. A review of Resident #78's medical record revealed the Resident had bathing activities the prior night but there was no documentation that the Resident had refused nail care. The Unit Manager indicated Resident #46 did not refuse nail care. The Unit Manager reported that when the CNA signs for the bathing activity it includes clipping and cleaning fingernails. A review of facility policy titled, Nail Care, updated 10/11/24, revealed, Policy Statement: To provide staff guidelines on how to care for residents fingernails/toenails on bath day and PRN (as needed) .

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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** 37666 Based on observation, interview and record review, the facility failed to 1). Ensure coordination of Hospice Services for one resident (#151) reviewed for Hospice service. Findings Include: Resident #151: Hospice and End of Life A review of the Face sheet and MDS/Minimum Data Set assessment indicated Resident #151 was admitted to the facility on [DATE] with diagnoses: Seizures, history of falls with fractures: fourth cervical vertebra, nasal bones, maxilla, Dementia, anxiety, depression and hypertension. The resident wore a neck brace for the cervical fracture. A review of the physician orders indicated the resident was admitted to Hospice services on 1/21/2025 on admission. On 2/18/2025 at 12:17 PM, Resident #151 was observed sitting in a chair in his room watching TV. He was talkative and tried to answer question. He said he did not think he was receiving Hospice services. A review of the Care Plans identified a Hospice Care Plan dated initiated 2/3/2025 and revised 2/4/2025 with an intervention: Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met, dated 2/20/25 and Work with nursing staff to provide maximum comfort for the resident, date initiated 2/3/2025. On 2/21/2025 at 1:00 PM, during an interview with Nurse I she was asked where the Hospice notes for Resident #151 were located, as they were not in the electronic medical record. Nurse I said she did not know where the hospice notes were. Nurse I asked the Charge nurse and said she was told they were in the electronic medical record. Reviewed the notes were not in the electronic medical record. On 2/21/25 at 1:14 PM, Nurse Manager K brought a Hospice binder from the 1st floor North hall. It was a Hospice book for Resident #151. There was one Hospice nurses note dated 1/21/2025, the day of Resident #151's admission. There was also a Social Worker's note was 1/24/2025. The Unit Manager K confirmed there were no additional Hospice notes for the resident. She said she would try to find them. A review of the Hospice Care Plan for Resident #151 was started on 2/3/2025; it was not initiated on admission. It was started almost 2 weeks after the resident was admitted with Hospice care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/21/2025 at 1:34 PM, Unit Manager K said the Hospice care notes for Resident #151 were not in the resident's chart or at the facility. She said she called Residential Hospice to request the documents. Nurse Manager K was asked who was to place the Hospice Notes in the resident's Hospice binder and she said another nurse manager had a code to view the Hospice documentation system and retrieve the documents, but that nurse was not working that day. Nurse K said she did not have a code to retrieve the Hospice documents. Resident #151 did not have evidence of coordination of Hospice Care. There was no documentation of Hospice clinical care provided to the resident in the medical record or at the facility. On 2/25/2025 at 12:30 PM, the Director of Nursing was asked if there was a policy for Hospice care. She said it would be included in the Hospice contract. A review of the facility policy titled, Hospice Program, dated November 2017, provided When a resident chooses to receive hospice care and service, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the residents' highest practicable physical, mental, and psychosocial well-being . The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the patient's care . The plan of care will identify the care and service that each entity will provide in order to meet the needs of the resident . Hospice staff will document progress notes and any new recommendations upon each visit. This documentation will be kept in a binder labeled for the appropriate hospice agency .

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Lapeer County Medical Care Fac	1455 Suncrest Dr Lapeer, MI 48446

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to provide a safe and monitored environment to prevent falls and injuries for 4 Residents (# 21, #103, #126, #127) of 13 residents reviewed for falls, resulting in residents having multiple falls and Resident's #'s 126 and #127 sustaining large bruises on their faces. Findings Include: Resident #21 Accidents A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #21 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Alzheimer's dementia, History of a stroke, heart disease, hypertension, , orthostatic hypotension, history of repeated falls, anxiety, kidney disease, and arthritis. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of 3/15 and the resident was dependent for most care. On 2/18/2025 at 11:18 AM, Resident #21 was observed sitting in the day room for an activity. A record review of the notes from the medical record revealed the resident had encountered multiple falls on the unit. A review of the Incident and Accident Reports indicated Resident #21 had 11 falls over the past year. Three of the fall incidents identified there was no nurse on the unit at the time of the fall; including the most recent fall on 2/14/2025. A record review of the Care Plans revealed the following: Falls/Safety Focus: (Resident #21) is at High risk for falls related to Confusion, Gait/balance problems, psychoactive drug use, Alzheimer's disease, and dementia with potential for decreased safety awareness as the dementia process progresses, date initiated 11/17/2022 and revision on 5/8/2024. The last updated intervention was 11/13/2024, Encourage gripper socks at all times. Resident #103 Accidents A record review of the Face sheet and MDS assessment indicated Resident #103 was admitted to the facility on [DATE] with diagnoses: Alzheimer's disease, history of seizures, history of a stroke, heart disease, peripheral vascular disease, arthritis, anxiety and cochlear implants. The MDS assessment dated [DATE] revealed the resident had a severe memory problem and was dependent with care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/18/2025 at 11:47 AM, Resident #103 was observed in the day room, sitting in a wheelchair with an activity blanket on her lap. The Activity aide P said the resident wanders in around the unit in her wheelchair; wherever she wants to go. The unit is a locked dementia unit. A review of the medical record for Resident #103 revealed she had several recent falls including 2/6/2025 and 2/8/2025 and on 2/13/2025 a new bruise on the resident's left chin was identified. Per a nurses note on 2/13/2025 Nurse noted a bruise to the left chin- while the bruise to the left eye was already charted and noted . Writer saw resident yesterday, and bruise to left lower chin was not there . A review of the Incident and Accident reports for Resident #103 identified 13 falls from 3/31/2024- 2/8/2025. Of the 13 falls for Resident #103, 6 Incident Reports said there was no nurse on the unit at the time of the fall. A record review of the Care Plans identified the following: Safety Focus: (Resident #103 is at high risk for falls related to diagnosis of dementia, seizures, . (Resident #103) is high fall risk due to inability to process surroundings due to sensory impairments and dementia. (Resident #103) has poor safety awareness and is unable to understand physical limitations . date initiated 4/17/2023 and revised 4/3/2024. The last updated intervention was 9/6/2024. The resident continued to fall. Resident #126 Accidents A record review of the Face sheet and MDS assessment indicated Resident #126 was admitted to the facility on [DATE] with diagnoses: Alzheimer's disease, history of a stroke, anxiety, hypothyroidism, history of urinary tract infection, and hearing loss. The MDS assessment dated [DATE] revealed the resident had a BIMS score of 2/15 with severe cognitive loss and needed some assistance with care. On 2/18/2025 at 11:31 AM, Resident #126 was observed lying in bed with a large purple bruise under her right eye. She said she had had it awhile and said she didn't know how she got it. A review of the incident and accident reports for Resident #126 indicated the resident was noted to have bruising on her left hand 1/30/2025. On 1/31/2025 a nurses note identified the resident had a bruise under her right eye, from a nurse aide bumping her head on the resident's eye during care and the resident had bruising under her left breast. A record review of the Care Plans for Resident #126 identified the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safety Focus: [NAME] is at high risk for falls related to diagnosis of dementia. Resident with potential for increased risk for falls related to inability to recognize physical limitations and poor safety awareness. History of fall with forehead laceration and hospital stay for brain hemorrhage, date initiated 3/28/2023 and revised 11/1/2024, with Interventions including: Follow facility fall protocol, date initiated and revised 3/28/2023 and Gripper straps at/to in front of toilet and sink in bathroom, dated initiated 3/17/2023 and revised 9/6/2024. The last time the Safety Care Plan was updated was 9/6/2024. A review of the Skin Care Plan for Resident #126 did not mention bruising on her right eye, left hand or left breast. Resident #127 Accidents A record review of the Face sheet and MDS assessment indicated Resident #127 was admitted to the facility on [DATE] with diagnoses: Alzheimer's dementia, anxiety, hypertension, hypothyroidism, back pain, depression and a history of kidney stones. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a BIMS score of 4/15 and the resident was independent with most care. On 2/18/2025 at 11:55 AM, Resident #127 was observed walking in the hall. She had a large dark purple bruise under her right eye. When asked about it the resident said she did not know how it happened. A record review of the progress notes revealed the following: A Fall Risk Evaluation dated 2/18/2025: The resident had 3 or more falls in the past 3 months. On 2/17/2025 at 5:00 PM, the resident was found on the floor in the hallway. On 2/14/2025 at 3:00 AM, the resident was found on the floor near her bathroom door. A review of an Incident and Accident report for Resident #127 revealed there was no nurse on the unit at the time of the fall. A review of the nurses notes indicated the resident had said she felt dizzy on several occasions prior to lowering herself to the floor or being assisted to the floor. A record review of the Care Plans for Resident #127 identified the following: Safety Focus: (Resident #127) is at high risk for falls due to history of falls prior to admission, decreased mobility, poor safety awareness, HTN (hypertension), and lumbar disc degeneration, date initiated 9/26/2024 and revised 10/1/2024 with Interventions including: Follow facility fall protocol, date initiated and revised 9/26/2024; Place Resident into the Fall prevention Program, date initiated 10/10/2024. The most recent intervention was dated 2/14/2025, Encourage gripper socks when not wearing shoes, date initiated and revised 2/14/2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no updated intervention after the resident fell on [DATE] and no mention of her facial injury/bruising. Residents #21, #103, #126 and #127 all resided on the locked Dementia Unit. The Dementia Unit consisted of 2 separate locked halls on the 1st floor, with a total census of approximately 29 residents. On 2/20/2025 at 9:40 AM, the call light notification pad, situated on a wheeling stand in the hallway of the Dementia unit, had a blank screen. Nurse I said the pad was like a tablet and was used for call light notifications. She said the pad screen would show which call lights were on so the staff could answer them. When asked why it was not on, she said it wasn't working. Nurse Aide GG was in the hall and said if you wanted to know which lights were on, you had to leave the locked unit and go outside the doors where another screen was located. The nurse and nurse aide were asked how they would know if someone needed help if they weren't aware of the call lights being on and they said they wouldn't know unless they left the locked hallway. On 2/20/2025 at 1:23 PM, Unit Manager Q and Quality Assurance/QA Nurse R were interviewed about the frequent falls of the residents on the Dementia unit. The QA Nurse R said the facility had a Fall prevention program that residents at risk for falls are placed in. The QA Nurse was asked what the program included and she said that residents who had more than 1 fall per quarter were considered a candidate for the program and an order would be written for the program. She said the residents' Kardex and Care Plan would say the resident was in the Fall prevention program. The program included adding an orange tag on the residents' wheelchairs and walker if they used one. The didn't receive an orange tag if they walked themselves without a walker. She said the residents were revaluated every quarter for continued need. If the resident went 2 quarters without a fall the program was discontinued. During the interview on 2/20/2025 at 1:23 PM, Nurses Q and R were asked if the Fall prevention program included any additional measures to aid in preventing falls and said the staff performed Purposeful rounding. Nurse R said Purposeful rounding was to encourage staff to be more aware of what was occurring on the unit and she also said the facility had added additional activities to the Dementia unit. A review of the facility's staff schedules for Nurse and Nurse Aides, indicated there wasn't always a Nurse specifically assigned for the Dementia unit on the night shift. During the survey the resident census was 29 on the Dementia unit. There were usually 2-3 nurse aides divided between the 2 locked hallways. On 2/21/2025 at 3:30 PM, the Director of Nursing/DON was interviewed related to staffing. The DON said on the night shift/11:00 PM-7:00 AM, one nurse was assigned to cover both the 2nd floor north area and 1st floor north area. A nurse was not assigned specifically to the 1st Floor locked Dementia unit. The DON was asked if that meant a nurse might not be on the Dementia unit but actually be upstairs on another unit and she said that was how they were staffed. Reviewed with the DON that the schedule indicated there were at times only 2 Nurse Aides assigned to the Dementia unit (one on each locked hall) and she said sometimes there were 3. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the interview with the Director of Nursing on 2/21/2025 at 3:30 PM, reviewed with the DON that some of the residents had repeatedly fallen and some with serious injuries. The DON said the residents were placed in the Fall prevention program: she said that included Purposeful rounding and the orange stickers if the resident was in a wheelchair or used a walker. There was no sticker if they walked on their own. The DON was asked if the program was effective because the residents continued to fall and she said she thought it might be. The DON was asked if the facility had looked at staffing on night shift on the Dementia unit to ensure there were enough staff to supervise the residents, as most of the falls were in the evening and at night. 11 of the falls did not have a nurse present on the unit when the resident fell . She said the facility had not planned to have a nurse specifically assigned to the Dementia unit on night shift: of 35 falls reviewed, 20 were on the night shift. On 2/21/2025 at 3:45 PM, during the interview with the DON, she was asked about the call light system as it was not working consistently on the halls of the Dementia unit and she said the staff could install an app on their personal phones that would notify them when a call light was on; the DON said not all staff had the app on their phones as it was an option for them to do this. A review of the Facility assessment dated [DATE] provided, . Nursing: Staffing Plan- The facility bases its nursing staffing patterns to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident centered assessments and individualized plans of care . On 2/25/2025 at 9:30 AM, the call light pads on the 2 halls of the Dementia unit were not working. A review of the facility policies identified the following: Fall Prevention and Identification Program: To provide all staff a means to identify and assist residents who have identified as frequent fallers The policy discussed the orange tags, obtaining an order for the Fall prevention program and adding the information to the resident's Kardex. The policy does not identify additional interventions. There was no intervention listed for a resident who did not use a wheelchair or walker.

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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** 22348 Based on observation interview and record review, the facility failed to assess and monitor pain levels and update a care plan for pain for one resident (Resident #3) with a diagnosis of Squamous Cell Carcinoma of the skin of scalp and neck requiring comfort in positing and wound care treatment of 3 residents reviewed for pain management. Findings include: Resident #3: Pain Management According to the Electronic Medical Record reviewed on 2/19/2025 at 2:00 PM, R3 was [AGE] years old who was admitted to the facility on [DATE] with a diagnosis of Alzheimer Disease (late onset), Carcinoma of the situ of skin and scalp, and neck, Squamous cell carcinoma of the skin of scalp and neck and Chronic Kidney Disease Stage 3 in addition to other diagnoses. R3 has a Brief Interview of Mental Status (BIMS) Score of 08/15 assessed on 12/4/2024. A Score of 08-12 on the BIMS indicates moderate cognition impairment. A score of 0-7 points suggests severe cognitive impairment and a score of 13-15 points suggests that cognition is intact. R3, according to the Minimum Data Set (MDS) assessment dated [DATE] is dependent with staff in all Activities of Daily Living and Personal Hygiene except for Eating where he needed set up and clean up assistance. R3 is always incontinent with Bladder elimination pattern but occasionally incontinent with bowel elimination pattern. On 02/19/25 at 10:21 AM, R3 complained he is uncomfortable. R3 was observed sitting upright in bed and complained of extreme head and neck pain, grimacing and moaning. Pain scale level of 10/10 revealed by R3 during an interview on 02/19/25 10:21 AM witnessed by staff. Certified Nursing Assistant (CNA T) stated that she was getting the nurse. CNA T Lowered the head of the bed and repositioned him in bed. CNA T stated, we got him comfortable and got his head down. R3's pillow case had dried blood stain noted. After confirming the observation with CNA T, she revealed that it was the nurses that did the wound dressing changes daily. CNA T stated that the blood must have been from his head lesion. CNA T further stated that sometimes the dressing come off from his scalp. It was observed by CNA T and the surveyor that R3 did not have a dressing on his scalp during this observation and was in extreme pain. On 2/21/25 at 11:00 am, RN H was observed during wound care and dressing change. There was a scant drainage noted The wound area measured 2 centimeter (cm) wide by 1.5 cm length with width open area at the scalp area. Although R3 was grimacing and complained of pain during dressing change, RN H stated that R3 did not have any complaints of pain in AM when she administered his routine aspirin (ASA) 1 mg at around 9:30 AM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the R3 interview conducted on 02/21/25 at 11:20 AM, after the scalp dressing was applied to R3, R3 was asked of his level of pain from 1-10, with 10 being the most pain). R3 responded, Pain is 100. R3 complained of pain and requested for pain relief. R3 further described the location by stating, my neck hurts from the position I was in. R3's gown had some blood stain on his right side of the shoulder that looks like a dried blood stain. RN H was ask where the blood was coming from. RN H was unsure of where it was coming from but explained that R3 scratches a lot and have skin lesions all over his body. RN H indicated that R3 receives a daily treatment applied to his skin. She stated, Some type of cream. A review of the Medication Administration Record (MAR) for R3 dated February 2025 revealed only 2 medications for pain relief: Pain orders in the February 2025 MAR are: Aspirin 81 mg 1 tab P. O. in AM and Acetaminophen 325 mg 2 tablets for PRN. The February 2025 MAR (from February 1 through February 20) indicated: R3 had zero pain assessed and recorded daily. There were no PRN Tylenol administered for relief of pain. R3 MAR showed that pain relief was not provided despite an observation and verbal complaint from R3 of extreme head and neck pain, grimacing and moaning, R3's pain scale was at level 10 per R3 during an interview on 02/19/25 10:21 AM to staff. CNA 'T' was present during the interview and that she indicated that although she was not the CNA assigned to R3, she was going to let his nurse know. Upon Review of the Electronic Record Review for R3's Care Plan on 2/21/25 at 12: 00 PM, It revealed: 1. Pain care plan was initiated on 8/28/23 and date of Revision was 09/07/2023. The most recent intervention update was dated 3/6/24, which indicated to: Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria. nausea, vomiting, dizziness and falls. Report occurrences to the physician. Date initiated 03/06/2024. No other revisions of the care plan for pain was noted after 03/06/2024. 2. Wound/Skin Care Plan was initiated on 08/28/2023, Last revised on 08/01/2024 Skin lesions that were found and observed all over his body with blood stains on his linens were not updated in his wound/skin care plan. No new interventions and update were entered despite new treatment orders, new monitoring and assessment orders and update in R3 wound condition and specialist consultation and recommendations. No pain control/ management intervention was in place prior to wound care to provide a more comfortable skin /wound care experience during wound care listed as part of the wound care intervention. The Facility's Interdisciplinary Care Planning Policy, updated on 1/12/2024, was reviewed on 2/21/25 at 3:00 PM, indicated: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement To provide a system to ensure all resident's care plans are developed and updated. This facility utilizes an electronic charting system. The resident care plan is created and stored via orders and entries into the electronic charting system. Note: The electronic version of the care plan is considered the current care plan. .Policy Interpretation and Implementation: 1. Upon admission, resident status is assessed by the Interdisciplinary Team members (Dietary, AT, SW, Nursing, Restorative Nurse R.N., Skilled Therapies) using a combination of assessment tools including the MDS/CAA's. Care plans are developed on a timely basis, according to the RAI process. 2. Each discipline, based on their admission assessment, submits care plan information (i.e.: problems, goals, approaches) to the appropriate Unit manager. Unit managers will compile all assessment information to create an individualized computer care plan. Cardiovascular Respiratory Neuromuscular/ Skeletal Psychosocial/Orientation (includes Discharge Plan) Integumentary Nutrition Gastrointestinal Genitourinary Endocrine/ Metabolic Sensory ADL/ Safety Miscellaneous 3. The Unit manager will review the information found in each care plan section looking at the care that has been provided related to physician orders, labs, diagnostic testing, current medical status, etc. in order to assure continuity of care. Any issues found will be discussed with the appropriate interdisciplinary care plan team member and if necessary taken to the physician and resident/family seeking direction for future plan of care. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. For quarterly/annual/CIS care plan updates, the Interdisciplinary care plan team will review their goals and approaches for appropriateness and request any necessary changes by notifying the Floor Coordinator. The Unit manager will discuss the goals/approaches with the physician and make any necessary changes in the electronic care plan. 5. After review of the care plan by the interdisciplinary care plan team member, a quarterly progress note is made to reflect the review. 6. Interdisciplinary Care Plan meetings (clinicals) are conducted by the RN Unit manager and attended by Dietary, AT, SW, Restorative Nurse R.N., if requested by family. Resident (if desires) and resident's representative also attend. Other disciplines, when applicable, also attend meeting. (Restorative Nurse R.N., OT, PT, ST, Charge Nurse, CMH, Hospice, etc.) Also note that a phone conference may be done if representative is unable to attend meeting. 7. During the meeting, the Unit manager reviews and discusses any adjustments, clarifications, etc. to the plan of care. A review of current Advance Directives will also be discussed. Any concerns requiring physician evaluation are compiled by the Charge Nurse or Unit manager and placed on physician board after meeting. 8. The Unit manager will document a brief summary of the Care Plan meeting in the EMAR. 9. Updating of the CNA Bedside Kardex is completed once the pertinent order is saved in the computer and the LPN copies off the new CNA Bedside Kardex as indicated in the Noting Orders Policy. This incorporates approaches that are the responsibility of the CNA. 10. The MAR's and TAR's and shift charting tasks are updated the moment the order is saved in the computer. This completes the requirement for licensed nurse to follow the physician orders/plan of care. On 2/21/25 at 3:00 PM, The Facility's Resident's Rights reviewed. It indicated, . e. A patient is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility information about his or her own medical condition, proposed course of treatments and prospects for recovery, in terms that patient can understand, unless medically contraindicated as documented in the medical record by the attending physician or a physician assistant to whom the physician has delegated the performance of the medical care services .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on interview and record review the facility failed to ensure that clinical staff received completed yearly Performance Evaluations and competencies for 2 of 2 nurses (N and O) and Performance Reviews for 2 of 2 Nurse Aides (L and M), Findings Include: FACILITY Sufficient and Competent Nurse Staffing: On 2/24/2025 at 9:11 AM, during a review of the Nurse and Nurse Aide competency reviews for Nurses N (Charge Nurse) and O and Certified Nursing Assistants L and M, it was identified there were no yearly Performance reviews. The nurses' yearly competencies had not been completed. Nurse N's competencies were last completed 1/26/2024: greater than 1 year prior. Nurse O's competencies were last completed 1/22/2024: greater than 1 year prior. On 2/25/2025 at 10:30 AM, Staff Education Nurse C was interviewed about the yearly clinical staff Performance reviews. He said the facility did not complete performance reviews to aid in determining staff training/competency needs for the nurses or nurse aides. Staff Educator Nurse C said the facility talked about completing yearly Performance reviews but had not completed them. Nurse C was asked what the process was for determining which competencies to have the clinical staff complete and he said the online training program assisted in choosing them. He was asked if the clinical staff were able to provide input on specific training needs and he said there wasn't a process for that. The Staff Education Nurse was asked about the nurses not having competency training in greater than 1 year and he said he was preparing for that. A review of the Facility assessment dated [DATE] identified the following: . Staff Training/Education and Competencies: All staff in each department receive competencies that reflect the work, policy and procedures in their areas . On 2/25/2025 at 12:50 PM, the Director of Nursing was asked if there was a policy for Staff Education; she said the employees job description indicated what education was required. A review of the nursing and nurse aide job description identified the following: Team Charge/Charge Nurse, dated 2022 revealed, . Maintain compliance with state rules, federal regulations . Evaluate the LPN and CNA staff on an annual, and as needed basis, based on standards of care and job descriptions: collaborate with other Charge Nurses and Director and/or Assistant director of Nursing to complete this process . Attend and participate in scheduled training and education classes . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse (LPN), Team Leader, dated 2022 provided, . Staff Development: Participate in staff development program . attend and participate in scheduled training and education classes . Certified Nursing Assistant (CNA), dated 2022 revealed, . attend and participate in scheduled training and educational classes, as required .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37771 Based on observation, interview and record review, the facility failed to ensure that medication had arrived timely to the facility and that medication was administered following physicians' orders and professional standards of care for one resident (Resident #358) of six residents reviewed for medication administration, resulting in Resident #358 not receiving the medication Renvela and Cholestyramine as ordered and the medication Cholestyramine given with other medications. Findings include: Renvela, sevelamer carbonate, a medication used to control phosphorus levels used in diagnosis of patients with chronic kidney disease that are on dialysis. Cholestyramine, a bile acid sequestrant medication that absorbs/combines with bile acids, excreted in the feces which leads to a decrease in low density lipoprotein plasma levels and decrease in serum cholesterol levels and is recommended to take other medication at least 1 hour before or 4 to 5 hours after taking cholestyramine. On 2/20/25 at 10:29 AM, an observation was made during medication administration of Resident #358 receiving medication prepared by Nurse I . The medications given included: -Levothyroxine -Aspirin -Cholecalciferol -Ferrous Sulfate -Lasix -Loratadine -Carvedilol -Cholestyramine -PreserVision AREDS -Hydralazine (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #358's order for Cholestyramine Light Packet 4 GM (grams). Directions: Give 1 packet by mouth three times a day for Pure Hypercholesterolemia with a start date on 2/10/25 and further directions to DIS (dissolve) 1 packet in 8 oz of liquid and give three times a day for Pure Hypercholesterolemia (For optimal efficacy give other oral drugs 1 hour before or 4 hours after Cholestyramine). The medication Cholestyramine was scheduled to be given with other medication. A review of Resident #358's medication administration record (MAR) revealed the medication Cholestyramine was not given on 2/15 for the 1300 and 2100 doses, not given on 2/16 for 1300 and 2100 doses and not given on 2/17 for the 0900, 1300 and 2100 doses. The medication Renvela 800 mg, give 1 tablet by mouth three times a day with a start date on 2/3/25 at 2100 and a hold date on 2/6/25 at1606 to 2/7/25 1537 and hold date 2/17/25 at 1537 to 2/24/25 at 1536 was reviewed. The medication was documented as not given on 2/3, 2/4, 2/5, 2/6, 2/7, 2/8 for two doses, 2/9 for two doses, 2/10, 2/11, 2/12, 2/13, 2/14 for two doses, 2/15, 2/16 and 2/17 for two doses then on hold. A review of Resident #358's progress notes regarding Renvela included the following: -2/3/25, Writer received a phone call from pharmacy informing that resident's Renvela cannot be supply from pharmacy and per CMS (Centers for Medicare and Medicaid Services) guidelines dialysis need to supply medication. Unit manager notified. -2/3/25 at 11:18 PM, Renvela . Medication unavailable. CN (Charge Nurse) notified Pharmacy. -2/4/25 at 10:05 AM, Renvela . Medication unavailable. Will notify pharmacy. -2/4/25 at 1:25 PM, Renvela . Medication unavailable. -2/5/25 at 10:00 AM, Renvela . Medication unavailable. -2/5/25 at 1:00 PM, Renvela . Medication unavailable. -2/6/25 at 1:25 PM, Renvela . Medication not available. -2/6/25 at 4:02 PM, Writer called (dialysis unit) kidney care and spoke with attendant regarding Renvela and notice that was sent with (name) to dialysis yesterday regarding insurance coverage and that they are supposed to send medication to facility. Attendant stated that she did believe they were to send it, but that she was going to speak with dietician regarding this tomorrow. Writer left contact information. -2/6/25 at 4:07 PM, Communication with physician, Situation: Writer spoke with (Doctor's name) about dialysis getting back with writer about Renvela, and that they are supposed to be providing it for Resident per insurance. Background: Writer informed him that she has not received education since she admitted . Recommendations: Writer received order to hold medication until this issue is resolved. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/7/25 at 12:58 PM, Writer called over to dialysis center to speak with Dietitian. Writer spoke with dietitian regarding Renvela. Writer was informed that they would be covering it, but that she was awaiting their doctor to sign it. Dietitian stated that they send it from their pharmacy and that it would be coming via Fed Ex. Writer asked about her not having any right now, and dietitian stated that her phosphorus was okay on 2/4 and that at this time she is not going to recommend other supplementation as this could increase her calcium. Writer was instructed to hold medication until it is received from them. -2/11/25 at 12:28 PM, Renvela . Medication unavailable, dialysis contacted. -2/13/25 at 11:14 AM, Renvela . Medication not available. -2/17/25 at 12:06 PM, Writer called over to (dialysis center) regarding Renvela medication. Writer spoke with (Name) regarding not receiving medication at this time. (Name) stated that she would speak with nutritionist and call writer back. Writer received return call from nutritionist, and she confirmed that Revnela was delivered on Thursday. Writer and nutritionist discussed current address, and dialysis center had medication sent over to the (Name of place). Nutritionist stated that she had phosphorus level of 2.9 on 2/11/25 and that she would want medication held at this time. A review of Resident #358's progress notes regarding Cholestyramine included the following: -2/15/25 at 3:08 PM, Cholestyramine . Drug not available. On order from pharmacy. -2/16/25 at 1:07 PM, Cholestyramine . Medication unavailable, reordered from pharmacy. -2/17/25 at 11:10 AM, Cholestyramine . Medication unavailable. Writer contacted pharmacy, will be cycling tonight. On 2/20/25 at 3:08 PM, an interview was conducted with Unit Manager, Nurse Q regarding resident #358's medications Renvela unavailable for an extended period. The Unit Manager indicated that dialysis needed to supply the medication and then it was held due to labs. It was reviewed that the labs were back on 2/11 but the medication not to be given was addressed on 2/17. An observation with the Unit Manager of the medication cart revealed the medication was now available to be given after being held. A review of the medication Cholestyramine given with other medications was reviewed with the Unit Manager and the recommendations for optimal efficacy give other oral drugs 1 hour before or 4 hours after Cholestyramine. The Unit Manager indicated that yes, per the pharmacy directions, the med should not be given with other meds, and further stated, I will look into that. When asked how soon medication should arrive from pharmacy, the Unit Manager reported that the medication if reordered by 5 pm, it should have been to the facility by the 16th (2/16/25). The medication had not been administered until 2/18/25. On 2/21/25 at 1:18 PM, an interview was conducted with the Director of Nursing regarding Resident #358's medications not being available. The Cholestyramine, the DON reported that unless the pharmacy could not get it, it should have been here no later then the 16th (2/16/25). The Renvela not obtained timely for Resident #358 was reviewed. The DON stated, It should not have taken that long to get the medication.

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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** 37666 Based on observation, interview and record review the facility failed to ensure Infection Prevention and Control standards of practice were followed for 1) Personal Protection Equipment/PPE use during wound care for one resident (Resident #90) in Enhanced Barrier Precaution. Findings Include: Resident #90: A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #90 indicated an admitted [DATE] with diagnoses: Alzheimer's dementia, depression, arthritis, hypertension, heart disease, and anxiety. An unstageable pressure ulcer on the right heel was identified on 1/13/2025. The MDS assessment dated [DATE] identified the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of 5/15 and the resident needed assistance with all care. A review of the assessments for Resident #90 revealed she also had a wound on the outer base/hallux of her right great toe and on the top of the toe. On 2/21/2025 at 8:45 AM, wound care for Resident #90 was observed with Nurse B. The resident was observed sitting in a Broda chair. Nurse B washed her hands and applied gloves, then opened the dressing to show 3 wounds on Resident #90's right foot: 1. right great toe outside edge about 0.25 cm x 0.25 cm blackened area, 2. outer right foot near base of great toe ~1.5 x 1.5 cm wound black around and pink in the middle and 3. a black scabbed area ~ 1 x 1 cm on the right heel. The Nurse does not know how long the resident has had the wound. A review of the physician orders for Resident #90 indicated Enhanced Barrier Precautions: due to wound was ordered on 10/23/2024. A review of the February 2025 Medication Administration Record/Treatment Administration (MAR/TAR) Record for Resident #90 identified the following: Enhanced Barrier Precautions (due to wound) every shift, dated 10/23/2024. The nurses had initialed they followed this order for each shift (day, evening, night) three times a day, including the day of wound observation on day shift with Nurse B. A review of the Care Plans for Resident #90 identified an Infection Care Plan, but there was no mention of Enhanced Barrier Precautions. On 2/21/2025 at 10:24 AM, The Infection Prevention and Control/IPC Nurse A was interviewed related to the wound care observation for Resident #90. The IPC Nurse was asked if Resident #90 was in Enhance Barrier Precautions; she said the resident was in precautions and the staff were to wear Personal Protective Equipment/PPE including a gown and gloves when they performed wound care. Reviewed with the IPC Nurse that neither Nurse B or a nurse aide who entered the room to assist was wearing a gown. Neither had the appropriate PPE on during wound care for Resident #90. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview with IPC A on 2/21/2025 at 10:24 AM, she said the facility did not use signs to indicate the resident was in Enhanced Barrier Precautions/EBP. Reviewed there were physician orders for EBP, and it was on the MAR, as well as nurses were signing, they were following the precautions, but not everyone was. The IPC Nurse A' said the EBP were to be followed. A review of the facility policy titled, Infection Prevention and Control Program Outline, dated updated 1/11/2022 and reviewed 10/11/2024 provided, It is the policy of this facility to establish and maintain an IPCP designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . To ensure that all staff prevent the spread of infection within the facility through the use of isolation precautions from the recommendations from the CDC . Staff to follow facility policies and procedures for all resident care activities not inclusive to but including urinary catheters, wound care .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review, the facility failed to maintain a consistently operational call light system affecting three residents (Resident #46, Resident #63 and Resident #74) and a resident census of 158, resulting in extended call light times, unmet needs, and inconsistent tablet operability. Finding include: FACILITY On 02/19/25 at 02:18PM, an interview was conducted with Certified Nursing Assistant (CNA) E. CNA E was asked how they know if there is a resident call light on. CNA E stated they have tablets in the halls that will show call lights that are on. CNA E was asked how reliable the tablets are. CNA E stated, sometimes the tablets will crash and I will reboot it. Sometimes it works and sometimes it doesn't. We have an app for our phones as well, but it drains my battery so I don't use it. There is a computer in the nurses station that has every call light that is on in the building. On 02/19/25 at 2:24PM, an interview was conducted with CNA F. CNA F was asked if there was any other way besides the tablets and the main computer at the nurses station to know if a call light is on. CNA F responded, No, there are no lights above the doors and no sounds. So if the tablets aren't functioning we have to go the main computer at the desk.: On 02/20/25 at 09:03AM, observation revealed the call light tablet screen outside of room [ROOM NUMBER] reads Vision Link II Mobile voice isn't responding. The device is not currently functioning. On 02/20/25 at 09:26AM, observation revealed the call light tablet at the 2nd Floor East Nurses station is not functioning. On 02/20/25 at 09:29AM, observation revealed the call light tablet by the Grand View Blvd. Sign is not on. On 02/20/25 at 09:30AM, on 2 North: observation revealed a call light tablet with the message on the screen reading, Not responding. This was verified with Registered Nurse RN H. On 02/21/25 at 09:42AM, an interview was conducted with CNA G. CNA G was asked if they ever have any issues with the tablets used for call lights. CNA G stated, Sometimes they don't connect and we have to reconnect them and get them going. We still have the monitor at the nurses station and some people have the app on their phone. CNA G was asked how often do the tablets disconnect daily? CNA G stated, I believe a lot, I mostly bypass them and go straight to the nurses station because I know it will be working. CNA G was asked if they have ever had any complaints of long call light times from the residents and have any residents been incontinent due to a long wait time. CNA G stated, Yes, I have had complaints and had to clean residents up after a long wait. On 02/21/25 at 09:47AM, observation revealed a tablet used for call lights by the Grand View Blvd. sign on the 2nd floor is not turned on and is plugged in to the wall. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/21/25 at 12:44PM, observation revealed a tablet used for call lights outside of room [ROOM NUMBER], it was not functioning. This surveyor turned on the call light in room [ROOM NUMBER], went back to the tablet and the tablet would not display that the call light was on. Review of the Policy titled, Vision Link II Call System with Mobile Application, revised 7/23/24 revealed: 2. All direct care staff (CNA's, RN's, LPN's, Hospitality Aides, and Housekeepers) will be required to utilize the nursing call system via the mobile app throughout the duration of their assigned shift. It is encouraged that all non-direct care facility employees log into the Mobile app as a means of communication with fell ow employees and for general call light oversight 37666 On 2/20/2025 at 9:40 AM, the call light notification pad, situated on a wheeling stand in the hallway of the Dementia unit, had a blank screen. Nurse I said the pad was like a tablet and was used for call light notifications. She said the pad screen would show which call lights were on so the staff could answer them. When asked why it was not on, she said it wasn't working. Nurse Aide GG was in the hall and said if you wanted to know which lights were on, you had to leave the locked unit and go outside the doors where another screen was located. The nurse and nurse aide were asked how they would know if someone needed help if they weren't aware of the call lights being on and they said they wouldn't know unless they left the locked hallway. On 2/21/2025 at 3:45 PM, during the interview with the DON, she was asked about the call light system as it was not working consistently on the halls of the Dementia unit and she said the staff could install an app on their personal phones that would notify them when a call light was on; the DON said not all staff had the app on their phones as it was an option for them to do this. On 2/25/2025 at 9:30 AM, the call light pads on the 2 halls of the Dementia unit were not working. 37771 Resident #46: A review of Resident #46's medical record revealed a readmission into the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, quadriplegia, heart disease, and contracture of unspecified joint. A review of the MDS assessment revealed the Resident had intact cognition and was dependent on staff for activities of daily living, mobility and transfers. On 2/19/25 at 12:18 PM, an interview was conducted with Resident #46 who answered questions and engaged in conversation. The Resident was asked if they had concerns regarding their care. The Resident reported that the call light could take 30 minutes to an hour to answer and stated, I have to yell out to get help. The Resident reported the staff do not have the pagers anymore, there is no light above the door and the staff had to look at a screen at the nurses' station or on tablets and the screen does not work. The Resident voiced frustration that the CNA's do not answer call lights timely. Resident #63: (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #63's medical record revealed an admission into the facility on [DATE] with diagnoses that included neurocognitive disorder with Lewy Bodies, Parkinson's disease, diabetes, obstructive sleep apnea, and anxiety disorder. A review of the MDS revealed the Resident had intact cognition and was dependent on helper for most activities of daily living, mobility and transfers. On 2/19/25 at 2:11 PM, an interview was conducted with Resident #63 who answered questions and engaged in conversation. The Resident was up in her wheelchair seated next to the bed. An observation was made of a call light that was upside down V shape. The Resident reported she could not use the push button call light. When asked about any concerns she had regarding her care, the Resident reported long call light wait times and that staff will shut it off, say they will be back and then they don't come back. The Resident expressed having to wait up to four hours to be changed due to having incontinence. When asked if they do a check and change every, two hours, the Resident expressed frustration and stated, They don't come every 2 hours to check on us, not enough people (staff). The Resident reported that staff have left the room without making sure the call light is in reach or hide it under the covers and I can't find it. The Resident reported not having her oxygen on during the night and went several hours without the oxygen and stated, It gives you a sick feeling to have that light on and no one comes to find out why it is on. Resident #74: A review of Resident #74's medical record revealed an admission into the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, emphysema, dementia, heart failure and anxiety disorder. A review of the MDS revealed the Resident had intact cognition, was independent with ambulation, mobility and needed partial/moderate assistance with shower/bathing. On 2/19/25 at 9:16 AM, an interview was conducted with Resident #74. When asked about any issues or concerns they had about their care at the facility, the Resident reported extended call light wait times. The Resident was asked how long they have had to wait for staff response when using the call light. The Resident stated, Can take 30 minutes, sometimes an hour. The Resident responded that she has called for her breathing treatment, needing her inhaler and stated, then have to wait for someone to answer the light. On 2/21/25 at 10:21 AM, an observation was made at the nurses' station 2nd floor south with a call light tablet that indicated on the screen Communication Error. Failed to communicate with server: unauthorized. There was no staff in the area at that time. On 2/21/25 at 10:24 AM, CNA FF was asked about the call light tablet at the nurse's station. The CNA tried to reset the tablet, but it would not resent. When asked how the staff was notified of call lights, the CNA reported the computer screen inside the nurses' station and stated, We can have it on our phone as well. When asked if they had it on their phone, the CNA stated, No not right now it's not up, and reported the app was not available on their phone at this time. The CNA was asked how they would get the tablet to work again, and they reported they would have to put a work order in to let them know it was not working.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 37771 Based on observation, interview and record review, the facility failed to ensure warm water availability in residents' rooms and that sink drainage was adequate for three residents (#23, #25 and #70), of a sample of 17 reviewed for environmental concerns. Findings include: On 2/19/25 at 10:12 AM, an observation was made in Resident #25's room of the Resident getting ready for a bed bath. CNA BB had left the room with a wash basin and returned a couple minutes later. When asked why the CNA had left the room to get water, the CNA reported that the sink in the room did not produce hot enough water to wash a resident up. The CNA state, It will get a little warm then go cooler, but not enough warm water when they are getting washed up. The hot water faucet was turned on and was lukewarm and the sink filled too much to keep it running. When asked about the poor drainage of the sink, the CNA stated, Most of the sinks down here, they don't drain fast enough. On 2/21/25 at 9:43 AM, an interview was conducted with Resident #70 who answered questions and engaged in conversation. The Resident was asked about any concerns she had about her care. The Resident reported that she could not get hot water from the bathroom sink. The Resident reported she does use the bathroom and the sink and stated, The water is not warm, you can't wash up with water like that. The water from the sink was turned on with the hot faucet. The water was cool to cold and was left to run to attempt to get hot water. The sink was observed to fill up and not drain properly. The water had to be shut off before warm water was obtained due to the sink filling to almost overflowing. During the interview, CNA CC came in to take the Resident's breakfast tray out of the room, the CNA returned and was questioned about the lack of hot water. The CNA reported that to get hot water for the Resident to wash up with, I have to go to get hot water from the spa room. The CNA was asked if the Resident used the bathroom and reported she does use the toilet, uses the sink to wash her hands. The CNA reported running the water for a long time in the morning and stated, It does not get warm enough to wash the Resident. The hot water was turned on with the CNA, but the water did not get hot enough before the sink filled too high with the water. On 2/21/25 at 10:05 AM, an interview was conducted with CNA DD regarding the lack of warm water in Resident #23 and 70's room. The CNA stated, We have to get warm water from elsewhere, you can't wash a resident with cold water, indicating the water in the rooms came out cold. When asked about poor drainage of the sinks, the CNA reported that yes, the sinks will fill up when running the water. On 2/21/25 at 10:33 AM, Resident #23 hot water was tested again, the hot water faucet was turned on and the water remained cool, and the sink drained poorly. Resident #70's hot water was tested at the sink and the water was cold coming out of the faucet with the sink draining poorly. The water filled the sink prior to the water getting warm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235058	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lapeer County Medical Care Fac	1455 Suncrest Dr Lapeer, MI 48446

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/21/25 at 10:43, an interview and observations with made with Maintenance Staff EE regarding Resident #23 and #70's lack of hot water and poor draining sinks. The Maintenance Staff reported they had issues with the hot water down this end, referring to the rooms in the halls that included Resident #23 and #70's room. The two Resident room sinks did not drain adequately when the hot water was turned on that filled the sink prior to getting hot/warm water. The Maintenance Staff indicated they would be calling a plumber.