STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235088	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Traverse Pavilions	1000 Pavilions Circle Traverse City, MI 49684

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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. On 6/11/25, the following observations were made of the dining rooms: Elm Dining Hall: At 12:25 p.m., 25 Residents were observed sitting in the dining room without drinks. Three staff members were observed at 12:30 p.m. when the meal cart was delivered attempting to pass out meals to residents. Dogwood Dining Hall: At 12:20 p.m., six residents were observed in the dining room without drinks. At 12:30 p.m., 10 residents were observed in the dining hall without drinks. The meal cart was delivered at 12:44 p.m. with one staff member assisting residents with their meals. Cherry Dining Hall: At 12:40 p.m., six residents were observed in the dining room without drinks. At 12:45 p. m. nine residents were observed in the dining room without drinks. At 12:50 p.m., 14 residents were observed in the dining room without drinks. At 12:58 p.m., the meal cart was delivered with one staff member assisting residents with their meals. Birch Dining Hall: At 12:32 p.m., one resident was observed in the dining room without a drink. At 12:45 p.m., six residents were observed in the dining room without drinks. At 1:00 p.m., eight residents were observed in the dining room without drinks. At 1:15 p.m. the meal cart was delivered with one staff member assisting residents with their meals. On 6/12/25 at 12:58 p.m., an interview was conducted with General Manager/Staff T regarding the expectation of meal service. Staff T stated, The expectation is that staff would provide drinks as they are bringing residents into the dining hall. I am unsure why nursing brings residents down so early and then leaves them. We have had issues in the past, and believe we need more universal workers. Based on observation, interview, and record review, the facility failed to provide a dignified dining experience for those residents choosing to eat their meals in the congregate facility dining rooms and 6 of 8 residents attending the confidential group meeting. This deficient practice resulted in frustration and helplessness regarding wait times for meal arrival. Findings include: On 6/11/25 at 11:05 AM, a confidential group meeting was held with eight interested residents. Resident C1 stated, We wait in the dining room for a long time when the cart with the meals is sitting right there. Residents C2, C3 and C4 agreed on the long wait times in the dining room. C1 and C5 said there usually was only one woman passing out the trays. It takes more than that. The food cart comes, and it can sit for a half an hour while we wait. We just sit. C6 said usually there are no beverages served and we just sit and wait. (continued on next page)

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	A review of the previous Resident Council minutes revealed late service of trays had been brought up without resolution: 1/16/25 RESIDENT COUNCIL MEETING 1. Discussion regarding food . The floor was opened for residents to make comments, suggestions, concerns, and or ask questions: One resident asked why are meal (SIC) getting later and later? . 3/20/25 RESIDENT COUNCIL MEETING 1. Discussion regarding food . The floor was opened for residents to make comments, suggestions, concerns, and or ask questions: .Timeliness of residents receiving trays was discussed - (Staff) to follow up with nursing to make sure trays are being passed efficiently on all floors . 4/17/25 RESIDENT COUNCIL MEETING 1. Discussion regarding food . The floor was opened for residents to make comments, suggestions, concerns, and or ask questions: Dinners are cold . (Staff) to follow up with (staff) to discuss timeliness of trays being passed. 5/22/25 RESIDENT COUNCIL MEETING 1. Discussion regarding food . The floor was opened for residents to make comments, suggestions, concerns, and or ask questions: . Food is slow getting to the Dogwood dining area. (Staff name) to follow up with kitchen.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. . Based on interview and record review the facility failed to make prompt efforts to resolve grievances for three Residents (C3, C7, & #66) of nine residents reviewed for the facility's grievance and resolution process. Findings include: On 6/11/25 at 11:05 AM, a confidential group meeting was held with eight interested residents. The residents in attendance stated they were not happy with the grievance process. One confidential resident (C3) said, You voice concerns, but it seems to take a while until they let you know an answer. Another confidential resident (C7) stated, Most of the time we don't hear any solutions or any report back on our concerns. Two residents in this meeting stated they had concerns with missing items. Both residents stated they had told staff and never had resolution. A review of the previous Resident Council minutes revealed many concerns had been brought up without resolution. Examples include: 1/16/25 RESIDENT COUNCIL MEETING The minutes included: The floor was opened for residents to make comments, suggestions, concerns, and or ask questions. The minutes reflected many concerns and comments voiced by the residents, however the meeting minutes of 2/20/25 included the following: Old business: There was not any old business from the previous meeting that needed to be brought up for discussion or to follow-up on. 2/20/25 RESIDENT COUNCIL MEETING The minutes included: The floor was opened for residents to make comments, suggestions, concerns, and or ask questions. The minutes reflected many concerns and comments voiced by the residents, however the meeting minutes of 3/20/25 included the following: Old business: There was not any old business from the previous meeting that needed to be brought up for discussion or to follow-up on. 3/20/25 RESIDENT COUNCIL MEETING The minutes included: The floor was opened for residents to make comments, suggestions, concerns, and or ask questions. The minutes reflected many concerns and comments voiced by the residents, however the meeting minutes of 4/17/25 included the following: Old business: There was not any old business from the previous meeting that needed to be brought up for discussion or to follow-up on. 4/17/25 RESIDENT COUNCIL MEETING The minutes included: The floor was opened for residents to make comments, suggestions, concerns, and or ask questions. The minutes reflected many concerns and comments voiced by the residents, however the meeting minutes of 5/22/25 included the following: Old business: There was not any old business from the previous meeting that needed to be brought up for discussion or to follow-up on. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/25 at 11:33 AM, Resident #66 (R66) stated she was missing a few personal items including a purple shirt with an iris that was bedazzled and a queen-sized blanket. During an interview on 6/11/25 at 2:51 PM, Registered Nurse (RN) EE reviewed a log of grievances but the three residents with missing items were not recorded. RN EE stated there were forms that were filled out to track grievances including missing items and a procedure to alert other staff to resolve these concerns. RN EE said, I did not find any reports for the residents you mentioned (who were missing items). During a second interview on 6/11/25 at 5:00 PM, R66 again stated, Yes, I told someone about my missing purple shirt and my blanket. During an interview on 6/11/25 at 5:03 PM, Certified Nurse Aide (CNA) FF was asked about the procedure for missing items. CNA FF said if a resident reported a piece of clothing missing, she would call laundry. CNA FF said, I do not know about a form to fill out. During an interview on 6/11/25 at 5:05 PM, CNA GG also stated she would look in the room and the neighbors room and even take the resident to the laundry to find it, but CNA GG did not know about a form to fill out or to report it to other staff. During an interview on 6/11/25 at approximately 5:15 PM, RN HH stated, I could not find documentation on reporting of either missing item. RN HH agreed there needed to be more education on reporting concerns. During an interview on 6/12/25 at 8:09 AM, CNA II said she was familiar with R66 but did not work with her regularly. When asked if CNA II was aware of R66 missing things, she replied, Do you mean clothes? and then continued by stating, I believe she was missing a purple shirt. During an interview on 6/12/25 at 8:13 AM, Social Worker D said she had visited R66 and there was nothing missing. Social Worker D and this Surveyor visited R66 together and R66 confirmed she was missing a purple shirt and a blanket which she had told staff about. Social Worker D stated the facility had known about the blanket from a while back and she indicated she would pursue the other missing items. The facility presented a policy dated 7/5/2019 titled Missing Items on 6/11/25. The procedure for this policy read in full, PROCEDURE 1. When an item is reported missing, immediately search the surrounding area and initiate process. 2. If the item is missing and theft is suspected, notify the Administrator/designee. The administrator/designee will begin the investigation. 3. If it is determined to be a potential misappropriation of property and/or if the resident/family member states they suspect theft, the guidelines for reporting abuse will be implemented. There was no mention of a tracking tool or a reporting mechanism to keep the resident informed and promptly resolve grievances. .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to provide supervision to prevent resident to resident physical abuse resulting in harm from the reasonable person perspective, for three Residents (R149, R155, and R158) of three residents reviewed for abuse prevention. Findings include: A review of R158's Electronic Medical Record (EMR) revealed admission to the facility on 3/11/25 and diagnoses including dementia with psychotic disturbance. R158's Minimum Data Set (MDS) assessment, dated 3/17/25, showed severe cognitive impairment, was rarely understood, showed signs of physical and verbal behaviors 1-3 days, ambulated independently and resided in the secure (locked) memory care unit. An observation on 6/10/25 at 12:32 p.m. revealed R158 in the main dining hall of the memory care unit. R158 was observed becoming confrontational with other residents while waiting for the lunch meal service to arrive. R158 was observed getting very close to residents sitting at the table, attempting to take various drinks from them and then becoming upset. One staff member was observed attempting to redirect R158 away from other residents. R158 would then pace up and down the hallway and come back to the main dining room to repeat the process. A request for R158's Incident and Accident Reports from May 15th, 2025, through June 10th, 2025, were reviewed with the following incidents noted: 5/19/25: Staff heard resident yell in the common area. This nurse looked up at the camera and another resident (R149) had ahold of this resident's arms and was pushing her backwards into a chair. Resident was visibly upset and telling the other resident to 'let me go or I'm gonna knock you out.' Staff intervened and led both residents in different directions .Resident does not remember what happened but continued to be agitated . 6/4/25: This nurse received witness statement on 6/6/25 in ADON (Assistant Director of Nursing) mailbox from CNA (Certified Nurse Aide) reading '(R158) wandered into (R155's) room and (R155) grabbed her arm and squeezed it and was yelling at her.' This nurse notified nursing administration and contacted nurse assigned to resident that day. Nurse's witness statement obtained and stated, 'CNA informed me that a resident, (R158) was wandering the halls and entered another resident's room (R155). CNA stated (R155) confronted (R158) when entering and squeezed (R158's) arms. (R155) was visibly agitated and yelled at (R158). (R158) was escorted out of the room to separate resident's . A review of R158's care plan on 6/12/25, revealed the following: The resident has the potential to be physically aggressive r/t (related to) dementia; date initiated: 3/12/25; Interventions: Date initiated: 3/12/25 The resident's triggers for physical aggression are multiple people around her/walking with her. The resident's behaviors are de-escalated by 1:1. Snack if able, likes to carry something that resembles a cigarette . The resident was involved in (2) resident-to-resident altercations and the resident was the (aggresse); date initiated: 6/4/25 revision on 6/6/25; Interventions: Date Initiated: 6/6/25 Immediately separate residents and secure their safety . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the [States] Facility Reported Incident portal revealed the facility had reported four incidents of Resident-to-Resident Abuse for R158. Three reported incidents involving R158 as the aggressor and R149 the victim. As stated in the above observation, R158 did not receive any of these interventions as directed per the care plan. On 6/12/25 at 12:36 p.m., an interview with the Director of Nursing (DON) revealed the facility had already identified behavioral issues with R158. We have too many issues going on with (R158) and (R149) and now with (R148). We continue to have issues with scheduling with [third party behavioral agency]. One to One's don't work because it just makes (R158) more upset. We've thought about doing a sleep study on (R158). We are also trying to get the facility an in-house psychologist to help residents who have mental health services, but that has not happened yet. Just short of sending (R158) out to the hospital, we are unsure what to do. Review of the facility's Abuse Prohibition and Prevention Program Policy) dated 7/12/23, revealed the following, in part: Our organization will not condone any form of resident abuse and will continually monitor our policies, procedures, training programs, systems, etc., to assist in preventing resident abuse . Resident-to-Resident Altercations 1) Facility staff will monitor residents for aggressive/inappropriate behavior towards other residents . occurrences of such incidents shall be promptly reported to the Director of Nursing/designee 2) If two (2) residents are involved in an altercation, staff will: . f) Make any necessary changes in the care plan approaches to any or all of the involved individuals; g) Document in the resident's clinical record all interventions and their effectiveness; h) Consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the Attending Physician or Interdisciplinary Care Planning Team; j) If, after carefully evaluating the situation, it is determined that care cannot be readily given within the facility, transfer the resident .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to provide applicable bed hold policy information and/or written transfer notifications to two Residents (#154 and #68) of four residents reviewed for transfer and discharge process. Findings include: Resident #154 (R154) The medical record for R154 revealed a census record on 2/24/25 stating R154 was sent out to the hospital. The medical record did not have a record that a written notification of discharge or explanation of the bed hold policy was sent to the resident or the responsible party. On 6/11/25 at approximately 12:00 PM, a request was made to the Director of Nursing (DON) for documentation of any written notification of hospital transfers and bed hold policy notifications for R154 for all hospitalizations over the past six months. At 2:36 PM that same day, an email follow up was sent to the DON for the transfer documents for R154. While a written notification of transfer was presented for a December transfer, the 2/24/25 documents were not presented. It was noted that R154 was on the Ombudsman hospital transfer list for February confirming this transfer, but no evidence of notices sent, or bed hold policy was provided. The facility undated document titled Discharge and Transfer Procedure Policy was presented on 6/12/25 at 10:37 AM. It read in part, Notify Campus Manager to facilitate bed hold policy and document in nurses notes . The signed or not signed Bed Hold Authorization or Decline Form will be maintained . This policy did not reference the Ombudsman log or the Written Notification of Transfer. Resident #68 (R68) During an interview on 6/10/25 at 2:00 PM, R68 indicated they had been sent out to the local hospital during their stay at the facility but were unsure of the exact date. The medical record for R68 revealed a transfer to the hospital on 2/4/25 with a readmission on [DATE]. Review of the facility ombudsman transfer notification log, dated February 2025, revealed that R68 was not listed on the log to notify the ombudsman of their transfer out of the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to revise care plan interventions for one Resident (R155) of five residents reviewed for behavior care planning. Findings include: Review of R155's Electronic Medical Record (EMR) revealed admission to the facility on 9/16/24 with diagnosis including Alzheimer's Disease. R155 was not responsible for her medical and financial decisions. R155 had a recent resident to resident altercation on 6/6/25. Review of R155's Care Plans read, in part, .Modify environment: (redirect others away from my room. If I allow it, place [Name Brand] stop/gate on my room door when I am not in it. I often remove this, but at times it can reassure me) date initiated: 4/2/25 . On 6/10/25 at approximately 11:50 a.m., R155's room was observed by this Surveyor. R155 was not located in her room, and a stop sign appeared to be placed on a fire exit door adjacent to R155's room. The Director of Nursing provided an incident report for R155 on 6/12/25. There was one incident which was provided which occurred on 6/4/24 at approximately 3:40 p.m. between R155 and R158 where R158 wandered into 155's room. R155 then subsequently grabbed and squeezed R158's arm. There was no documentation to show the facility had addressed this incident with any updated intervention as a result of this altercation. The current intervention of the stop sign on the door when R155 is not in their room was observed ineffective during the survey. An interview was conducted with Assistant Director of Nursing (ADON) W on 6/11/25 regarding R155's care plan interventions. ADON W stated, The intervention of a stop sign was added to (R155's) care plan to deter other residents from coming in her room. (R155) frequently removes the stop sign and places it around the unit. On 6/12/25 at 10:07 a.m., R155 was observed to be walking down the hallway returning her breakfast tray to the dining hall. R155 was noted to be anxious and stating she wanted to, Get out of here. After returning her tray, R155 sat in a recliner chair near the nurses' room and continued to show signs of restlessness in wanting to leave the facility. R155's room was observed at this time with no stop sign placed on her door. On 6/12/25 at approximately 2:40 p.m., R155's room was observed to not have a stop sign placed on the front of her door. R155 was not in her room at the time of this observation. Review of the facility's Care Plan policy dated 10/9/23 read, in part, .The care plan is periodically reviewed and revised by the interdisciplinary team after each assessment but at least once quarterly. Interventions no longer applicable should be removed .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer medication per physician order for one resident (Resident #2) of 35 residents reviewed for quality of care. Findings include: Resident #2 (R2) Review of R2's electronic medical record (EMR) revealed initial admission to the facility on 6/13/16 with diagnoses including anemia, depression, diabetes mellitus, nausea, and hypertension. Review of R2's progress note, dated 3/10/25 at 11:19 PM, read in part, Resident received wrong dose of medication .Resident aware of medication error. Review of facility incident and accident report, dated 3/10/25, read in part, .Incident description .Floor nurse gave resident wrong dose of medication. Resident is ordered 0.5mg (milligrams) of (name brand for lorazepam, a controlled substance commonly used to treat anxiety) and was given 3.0mg .Level of consciousness: Lethargic (drowsy) .Mental status: Resident drowsy due to (name brand for lorazepam) being administered 30 minutes prior . Review of R2's physician order, dated 3/5/25, revealed the following: Lorazepam 0.5 mg, give one tablet by mouth every 4 hours as needed for anxiety/EOL (end-of-life) care. On 6/12/25 at 10:00 AM, an interview was conducted with Assistant Director of Nursing (ADON) L who was asked about R2 receiving the wrong dose of lorazepam on 3/10/25 and replied, I would guess that the nurse gave R55's lorazepam dose and not R2's. The ADON was asked if they could investigate the incident and provide more information. Review of R2's Medication Administration Record (MAR), dated March 2025, revealed one administration of lorazepam date 3/8/25 at 9:01 PM. Review of R2's controlled substance administration record, dated March 2025, revealed two administrations for lorazepam on 3/8/25 at 8:58 PM and 3/9/25 at 11:56 PM. Resident #55 (R55) Review of R55's EMR revealed initial admission to the facility on [DATE] with diagnoses including anxiety, depression, bipolar disorder, and restless leg syndrome. Review of R55's physician order, dated 11/4/24, revealed the following: Lorazepam 1 mg, give three tablets by mouth one time a day (bedtime) for bipolar disorder. Review of R55's controlled substance administration record, dated March 2025, revealed two administrations for lorazepam on 3/10/25 at 10:00 PM with one being marked as a wasted dose. On 6/12/25 at 10:30 AM, an interview was conducted with the Director of Nursing (DON) who was asked if Registered Nurse (RN) M was disciplined for the medication error and educated and replied, I would have to check with human resources. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's physician order, dated 3/10/25 at 10:56 PM, read in part, Medication incident - Monitor vitals. Medication error monitor vitals one time a day for anxiety for three days BID (two times a day) VS (vital signs) r/t (related to) medication incident. PM (evening) nurse: review vitals and add to vitals board AND one time a day for anxiety for 3 days BID VS r/t medication incident. AM (morning) nurse: review vital signs . Review of R2's vital signs, dated 3/10/25 through 3/14/25, revealed the following: A,) No vital signs recorded for PM shift on 3/11/25. B.) No vital signs recorded for PM shift on 3/12/25. C.) No vital signs recorded for PM shift on 3/13/25. Review of R2's progress notes, dated 3/10/25 through 3/14/25, revealed: No nursing progress notes following up the medication administration error of R2 receiving 3 mg or lorazepam instead of 0.5 mg. On 6/12/25 at 1:00 PM, an interview was conducted with the DON who was asked if medication rights should be followed with each medication pass and replied, Yes, that is the expectation for all nursing staff. The DON was then asked if the MAR and the controlled substance log should reflect the same administration of medications and replied, Yes, absolutely. On 6/12/25 at 1:05 PM, an interview was conducted with RN L who explained that RN N wrote the incident and accident report for the medication error involving R2 and RN M. RN L confirmed that RN M was not disciplined but should have been and that RN L was on vacation that week. RN L stated that RN M should not have written wasted on the controlled substance sheet and should have instead recorded an error, and a second dose was pulled for R55.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent the development and progression of two stage 4 pressure ulcers for one resident (Resident #68) out of five residents reviewed for pressure ulcer development. This deficient practice resulted in Resident #68 experiencing severe pain during dressing changes and subsequently required wound debridement and antibiotics. Findings include: Resident #68 (R68) On 6/10/25 at 2:00 PM, an observation was made of R68 sitting up in his wheelchair eating lunch. R68 was asked if they had a pressure sore on their bottom and replied, Yes. Review of R68's progress note, dated 3/12/25 at 5:49 PM, read in part, A DTI (deep tissue injury) was observed to residents scrotum measuring 1.1 x 0.7 cm (centimeters) .Resident was observed to be sitting on the tubing from his wound vac. Review of R68's wound assessment, dated 3/12/25, revealed the following: Pressure - Medical Device Related Pressure Injury - Deep Tissue Injury, Body Location: Scrotum. New - Minutes old. Acquired: In-House Acquired. Measured: Length 1.13 cm x Width 0.72 cm. Progress: Notes 1.5 x 0.7 cm. CNA (certified nurse aide) staff reports wound vac cord was pressing against area. Review of R68's wound assessment, dated 3/19/25, revealed after seven days the wound on the scrotum worsened and measured length 1.09 cm x width 1.01 cm x depth 0.1 cm. Review of R68's wound assessment, dated 4/2/25, revealed after 14 days the wound on the scrotum measured length 1.34 cm x width 0.49 cm x depth 0.1 cm. Review of R68's wound assessment, dated 4/9/25, revealed after one month the wound on the scrotum worsened into a stage 4 pressure injury and measured length 0.85 cm x width 0.62 cm x depth 1.1 cm with tunneling 2.0 cm at 7 o'clock (location of the tunneling if a clock face were superimposed over the wound). Review of R68's electronic medical record (EMR) revealed initial admission to the facility on 5/28/19 with diagnoses including hypertension, diabetes mellitus, pressure ulcer stage 4, depression, and spastic hemiplegia (paralysis) affecting the left nondominant side. Review of R68's minimum data set (MDS), dated [DATE], revealed under Section M: Skin conditions. Current number of unhealed pressure ulcers at each stage. Number of Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcers: 1. Number of these Stage 4 pressure ulcers that were present upon admission/reentry: 0. Number of Unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar: 1. Number of these Unstageable pressure ulcers that were present upon admission/reentry: 0. Review of R68's wound assessment, dated 4/9/25, revealed the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Pressure - Stage 4: Full-thickness skin and tissue loss. Location: Left Ischium. Exact date: 11/14/23. Acquired In-House. Measured: Length 0.3 cm x Width 0.3 cm, and Depth 0.9 cm with undermining 1.0 cm. Goal of Care: Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration. Review of R68's Medical Professional Note, dated 6/6/25, read in part, .Per wound care notes it appears the scrotal wound has worsened and went from 0.1 cm in April to 0.7 cm in diameter this month . Review of R68's Medical Professional Note, dated 5/23/25, read in part, .Wound care following for two stage four PI's (pressure injuries) to L (left) ischium and scrotum .Debridement performed by wound care notes on 5/21/25 .Erythema improved around scrotal wound with antibiotic use . Review of R68's Medical Professional Note, dated 4/4/25, read in part, .Pressure injury of left hip, stage 4 . Wound vac over area. Debridement performed by wound care note 4/2/25 .Scrotal infection active acute wound to scrotum. Treated and packed by wound care .(brand name antibiotic) sulfamethoxazole and trimethoprim and (brand name antifungal) metronidazole initiated for scrotal infection . Review of R68's care plan, dated, 3/12/25, read in part, .Focus (Braden Score less than or equal to 18) The resident is at a heightened risk for skin breakdown .Goal: The resident will not develop any new skin breakdown. The resident's skin will remain intact .Interventions: Keep bed linens clean, dry, and wrinkle free. Ensure resident is not laying on medical devices or tubing (dated 5/6/25) .Focus: The resident has a Stage 4 pressure injury to scrotum. Goal: The resident's (sic) will have no complications r/t (related to) pressure injury of the scrotum through the review date. Interventions .Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Keep skin clean and dry. Use lotion on dry skin. Do not apply on scrotum. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration . Review of R68's wound clinic progress notes, read in part: 11/22/24: .Left ischial is a stage 4 pressure injury pressure ulcer and has received a status of not healing. Subsequent wound encounter measurements are 0.3 cm length x 0.6 cm width x 1.2 cm depth .Muscle and bone are exposed .Undermining has been noted at 9:00 and ends at 3:00 with a maximum distance of 1 cm . The wound is deteriorating .When reading patient dressing orders from the (facility name) it appears that they are adding .cream .onto the foam. I am afraid this is clogging the pores of the foam and is resulting in his increased in maceration around the wound and periwound (skin area surrounding wound) . Procedures . left ischial. A selective debridement . 12/6/24: .He does have pain to the left ischial wound bed .Left ischial is a stage 4 pressure injury pressure ulcer and has received a status of not healing. Subsequent wound encounter measurements are 0.3 cm length x 0.5 cm width x 1.5 cm depth .Muscle and bone are exposed .Assessment .Upon assessment patients ROHO cushion is deflated .is unsure of when it was last inflated .Procedures .left ischial. A selective debridement .I did inflate ROHO cushion and demonstrated this . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	12/16/24: .Left ischial is a stage 4 pressure injury pressure ulcer and has received a status of not healing. Subsequent wound encounter measurements are 0.3 cm length x 0.5 cm width x 1.7 cm depth .Muscle and bone are exposed .Undermining has been noted at 10:00 and ends at 2:00 with a maximum distance of 2 cm .Procedures .left ischial. A selective debridement .Additional orders .the patients wound appears worse today .antibiotics for proper bacterial coverage . 1/2/25: .Left ischial is a stage 4 pressure injury pressure ulcer and has received a status of not healing. Subsequent wound encounter measurements are 0.3 cm length x 0.5 cm width x 1.5 cm depth .Muscle and bone are exposed .Undermining has been noted at 10:00 and ends at 2:00 with a maximum distance of 1.9 cm . Procedures .left ischial. A selective debridement . 1/29/25: .Left ischial is a stage 4 pressure injury pressure ulcer and has received a status of not healing. Subsequent wound encounter measurements are 0.4 cm length x 0.5 cm width x 1.7 cm depth .Muscle and bone are exposed .Undermining has been noted at 10:00 and ends at 2:00 with a maximum distance of 2 cm .Procedures .left ischial. A selective debridement .Wound orders .Wound like to initiate negative pressure wound vac . 2/19/25: .Patient states they did not initiate the wound vac .Left ischial is a stage 4 pressure injury pressure ulcer and has received a status of not healing. Subsequent wound encounter measurements are 0.4 cm length x 0.5 cm width x 1.6 cm depth .Muscle and bone are exposed .Undermining has been noted at 10:00 and ends at 2:00 with a maximum distance of 2 cm . Procedures .left ischial. A selective debridement . Wound orders .Wound like to initiate negative pressure wound vac . 3/12/25: .His wound vac externally is not correctly applied. Patient states he had a new staff member apply it on Monday .Wound Orders .Place black foam bridge over to patients' hip form the wound opening (to avoid any suction/tubing compromise .I will call (facility name) to ensure management knows there is a need for wound vac training. Vac taken down today included layer: white foam, Tegaderm, black foam, pieces of black foam, not connected, bridging over to patients' hip, final Tegaderm, and vac seal. These layers are incorrect, block the flow of exudate, and does not provide proper suctions to the wound base .there were 2 visiting nurses to their unit who do not have vac training that cared for (R68) recently and placed his vac Monday . 4/14/25: .Left ischial is a stage 4 pressure injury pressure ulcer and has received a status of not healing. Subsequent wound encounter measurements are 0.4 cm length x 0.4 cm width x 1.0 cm depth .posterior scrotum is a stage 4 pressure injury pressure ulcer acquired on 3/19/25 and has received a status of not healed. Subsequent wound encounter measurements are 1 cm length x 0.5 cm width x 2.2 cm depth . 4/30/25: .Left ischial is a stage 4 pressure injury pressure ulcer and has received a status of not healing. Subsequent wound encounter measurements are 0.4 cm length x 0.4 cm width x 1.2 cm depth .posterior scrotum is a stage 4 pressure injury pressure ulcer acquired on 3/19/25 and has received a status of not healed. Subsequent wound encounter measurements are 1 cm length x 0.5 cm width x 1.8 cm depth . Procedures .left ischial. A selective debridement .Procedures .posterior scrotum. A selective debridement . with a pain level of 2 throughout . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/14/25: .Patient seen for a follow up examination of ischial pressure injury and scrotal ulceration .Left ischial is a stage 4 pressure injury pressure ulcer and has received a status of not healing. Subsequent wound encounter measurements are 0.5 cm length x 0.5 cm width x 1.2 cm depth .posterior scrotum is a stage 4 pressure injury pressure ulcer acquired on 3/19/25 and has received a status of not healed. Subsequent wound encounter measurements are 1 cm length x 0.5 cm width x 1.5 cm depth .Procedures .left ischial. A selective debridement .posterior scrotum. Review of R68's order summary, dated 2/20/25, revealed an order for a pressure injury: Stage 4 Left Ischium as needed Left Ischial wound vac, dressing to be changed M/W/F (Monday/Wednesday/Friday). On 6/11/25 at 5:03 PM, an interview was conducted with Licensed Practical Nurse (LPN) C who was asked about R68's pressure injury to their scrotal area and replied, R68 got that from their wound vac tubing. Another nurse did not apply the wound vac correctly and bridge the tubing properly. On 6/12/25 at 10:00 AM, an interview was conducted with Assistant Director of Nursing (ADON) L who was asked if R68 should have developed the pressure injury to their scrotal area and replied, No. The wound vac tubing was not placed properly. ADON L was asked if therapy had assessed R68's wheelchair after they developed a pressure injury to their left ischial area and replied, I think so. Therapy usually evaluates equipment in cases like that. ADON was asked to provide therapy evaluation notes. ADON L was asked if the nurse who improperly applied the wound vac dressing was educated or disciplined and ADON replied, I believe so. ADON was asked to provide the education and disciplinary action. Review of employee file dated 4/28/25, for LPN U, revealed an ongoing unsatisfactory work performance for a wound vac dressing change completed on 4/25/25 indicating that the bridging on the wound vac was incorrectly done which led to the wound not receiving the appropriate suction that was ordered. Note that R68 developed their scrotal pressure injury on 3/19/25. Review of R68's occupational therapy (OT) progress note, dated 4/18/25 through 5/17/25, revealed diagnoses of spastic hemiplegia affecting left nondominant side and muscle weakness. Current referral (reason for referral) was, referred to OT services to address L (left) hand contracture and current interventions as client reports minimal carryover with L hand brace, overall difficulties with positioning of LUE (left upper extremity) impacting hygiene care and progressing of contractures. Recommendations: Splint / Orthotic recommendations: It is recommended the patient wear a resting hand splint on left hand. R68's wheelchair or cushion system was not re-assessed during this OT evaluation. Review of policy titled, Pressure Injury Prevention, dated 9/8/22, read in part, Purpose: To prevent pressure injuries . Review of policy titled, Pressure Injury Care, dated 9/8/22, read in part, Purpose: To properly care for pressure injuries .The licensed nurse is responsible for seeing that the treatments prescribed by the physician are carried out as ordered and recorded.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to properly supervise one Resident (#121) of two residents reviewed for Activities of Daily Living during (ADL) care. This deficient practice resulted in a fall with injury. Resident #121 (R121) On 6/10/25 at 12:24 p.m., R121 was observed sitting in the main dining hall waiting for her meal tray. R121 was noted to have a large purple bruise under her left eye and a dark red/purple bruise under her left nostril. An attempted interview was conducted with R121 who was not able to respond appropriately. Review of R121's Progress Notes read, in part, 6/6/25: (R121) is being seen today to follow up on a witnessed fall that occurred this morning at 6:06 a.m. in the member's room while CNA (Certified Nursing Aide) was dressing her for the day. She (CNA) had turned her back for a moment and the resident fell forward from a seated position on her bed and struck the left side of her head on the floor She is lying in her bed at this time and a large hematoma to the left forehead with ecchymosis to the left eye is noted. She also sustained a skin tear to her right elbow and an abrasion to the left knee .DPOA/husband (Designated Power of Attorney) was notified and informed about recommendations to send to [Hospital Name] for a CT [computed tomography scan] of the head. He refused and reports that he wishes to maintain comfort care at this time. He was also informed that she threw up all her breakfast and that it is a sign of brain injury .pupils are equal and sluggish to react to light. She awakens and looks at you before falling back asleep .staff reports some groaning earlier in shift . An interview was conducted with CNA X on 6/12/25 at 8:25 a.m. CNA X confirmed she was the staff member assisting R121 the morning of 6/6/25 and stated, I just remember trying to get her up and dressed. I had changed her shirt and brief and knelt while she (R121) was sitting at the edge of the bed. I was down by her feet trying to put her pants on when she bent over, and I couldn't stop her. Once she was on the floor, I moved her around and then went to get the nurse. A written statement from Registered Nurse (RN) Y read, in part, .CNA staff alerted this nurse that the resident had fallen in her room. Upon arrival to her room, she was observed in between her bed and her recliner chair laying on her right side with her right arm slightly underneath her with her legs extended outward. CNA staff stated that they rolled her onto her side from a prone position prior to this writer's arrival. Resident unable to give description. Resident assisted off of her side and onto her back. She was assisted up to a standing position via three staff assist and then she sat down in her wheelchair . On 6/12/25 at 9:16 a.m. an interview was conducted with the DPOA for R121 who stated that the facility did call him on the morning of 6/6/25 and informed him that R121 had fallen while trying to get dressed for the morning. He stated that he wanted to the facility to continue to monitor R121, and if she continued to get worse then he would consider sending her to the local hospital. The DPOA for R121 then stated, She easily forgets that she is doing something, and staff know that. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 6/12/25 at 10:03 a.m. The DON stated that R121 will become impulsive, and that staff should know and recognize that about her. The DON stated that CNA X should not have moved R121 before notifying RN Y.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure the sanitary storage and cleaning of respiratory equipment for two Residents (#430 and #433) of two residents reviewed for respiratory services. Findings include: Resident #430 (R430) Review of R430's electronic medical record (EMR) revealed initial admission to the facility on 5/27/25 with diagnoses including chronic obstructive pulmonary disease (COPD), moderate persistent asthma, and chronic respiratory failure. Review of R430's Minimum Data Set (MDS) assessment, dated 6/2/25, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicative of intact cognition. On 6/10/25 at 11:42 AM, oxygen tubing was observed connected to a concentrator next to R430's bed and coiled up on the floor. No storage bag was noted. R430 verified she required supplemental oxygen at night and did not recall ever having a storage bag for the tubing. Review of R430's EMR revealed a physician's order, initiated 5/30/25, which read: Continuous Oxygen 2 L (liters)/min (minute) via NC [nasal cannula] at night and PRN [as needed], Maintain sats [saturations] >90%, two times a day for HX [history of] Asthma. On 6/11/25 at 11:53 AM, oxygen tubing was observed connected to a concentrator next to R430's bed and coiled up on the floor with no protective covering. The nasal prongs were observed in direct contact with the floor which was covered with various debris. On 6/11/25 at 4:04 PM, oxygen tubing was again observed connected to a concentrator next to R430's and coiled up on the floor with no protective covering. Resident #433 (R433) Review of R433's EMR revealed initial admission to the facility on 5/23/25 with diagnoses including acute respiratory failure with hypoxia, pneumonitis, asthma, and obstructive sleep apnea. On 6/10/25 at 12:29 PM, R433's undated nebulizer was observed lying on top of their bedside table in one piece with visible condensation in the medication cup. A CPAP [Continuous positive airway pressure] mask was observed in direct contact with bedside chair. Two sets of oxygen tubing were observed connected to a concentrator and portable oxygen tank at the end of R433's bed without protective covering. Review of R433's EMR revealed the following physician's orders: 1. Oxygen 2 lpm [liters per minute] via NC as needed for O2 (oxygen) sat <90% or SOB [shortness of breath], initiated 5/27/25. 2. CPAP/BiPAP (Bilevel Positive Airway Pressure) on at HS [nighttime], initiated 5/23/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Budesonide (inhaled steroidal medication) Suspension 0.5 MG (milligrams)/2 ML (milliliters) 2 ml inhale orally [via nebulizer] every 12 hours for COPD [chronic obstructive pulmonary disease], initiated 6/2/24. 4. Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3 ML 1 vial inhale orally four times a day [via nebulizer] for COPD, initiated 6/5/25. On 6/11/25 at 9:03 AM, R433's undated nebulizer was again observed lying on top of their bedside table in one piece with visible condensation in the medication cup. Two sets of oxygen tubing were observed connected to a concentrator and portable oxygen tank at the end of R433's bed without protective covering. On 6/11/25 at 4:39 PM, two sets of oxygen tubing were again observed connected to a concentrator and portable oxygen tank at the end of R433's bed without protective covering. On 6/12/25 at 11:55 AM, an interview with conducted with Assistant Director of Nursing (ADON) O regarding oxygen storage expectations. ADON O stated oxygen tubing and CPAP masks should be stored in bag when not in use. ADON O stated nebulizers should be cleaned and allowed to dry after every use. On 6/12/25 at 1:06 PM, an interview was conducted with the Director of Nursing (DON) regarding oxygen storage expectations. The DON verified oxygen tubing should be stored in a labeled and dated bag when not in use. The DON stated nebulizers were to be disassembled and cleaned after each use. Review of the facility policy titled, Oxygen Therapy, dated 2/2/23, read, in part: .PRN oxygen -temporarily discontinued: clean prongs with exterior tubing with alcohol swab and store in Ziploc bag . Review of the facility policy titled, Medication Administration: Nebulizer Treatment, dated 11/9/09, read, in part: .When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece, and medication cup . rinse and disinfect the nebulizer equipment according to facility protocol: a. Wash pieces with warm, soapy water, b. Rinse with hot water, c. Allow to air dry on a paper towel .

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to provide pain management as prescribed by the physician for one Resident (#431) of two residents reviewed for pain. This deficient practice resulted in unrelieved pain and required Resident #431 to be subsequently transfer to the emergency department (ED). Findings include: Resident #431 (R431) Review of R431's EMR revealed initial admission to the facility on 6/4/25 with diagnoses including fracture of the left acetabulum (a break in the socket portion of the hip joint), fracture of the left ulna (a break in one of the two bones of the forearm), fracture of the left tibia (a break in the large bone in the lower leg), displaced fracture of the left acromial process (a break in the bony projection of the shoulder blade), and fractures of facial bones.). Review of R431's Minimum Data Set (MDS) assessment, dated 6/10/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. On 6/10/25 at 12:20 PM, R431 was observed in his room standing at a platform walker with his left leg immobilized. An interview was conducted with R431 regarding his level of satisfaction with care at the facility. R431 stated he was admitted to the facility for rehabilitation following a motor vehicle accident (MVA) in which he sustained several injuries including fractures of his left arm, left leg, and face. R431 stated over the weekend, the facility ran out of his prescribed pain medication and he had to be transferred to the ED at a local acute care hospital for pain management. R431 recalled, My pain level was a 12 out of 10 . I suffered all weekend to get my pain back under control. R431 stated he waited in the ED for several hours in a wheelchair without appropriate positioning of his immobilized left leg due to the facility's inability to locate a proper footrest prior to the transfer. Review of R431's EMR revealed the following physician's orders initiated on 6/4/25: 1. Morphine Sulfate ER [Extended Release] Oral Tablet 30 MG [milligrams]. Give 1 tablet by mouth two times a day for PAIN. 2. Morphine Sulfate Oral Tablet 15 MG. Give 2 tablet by mouth every 4 hours as needed for Moderate-Severe Pain. Review of a Telehealth visit (a virtual appointment which allows patients to consult with healthcare providers remotely using digital communication) on 6/7/25 at 16:39 [4:39 PM] revealed the following: Patient admitted 6/4 with script for PRN [as needed] Morphine IR [immediate release] 1-2 tablets q4 [every 4 hours]. No more pills/fills left. New script needed to be able to fill. Patient is requesting PRN's [as needed medication] about every four hours . Pharmacy can't deliver until Monday morning . Willing to try Oxycodone 20 mg .facility doesn't have enough oxycodone also . Morphine can't be delivered until Monday .facility doesn't have enough oxycodone. Will send him [R431] to hospital as he can't go without pain medication . (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 6/12/25 at 11:26 AM, an interview was conducted with Licensed Practical Nurse (LPN) V who verified she was the nurse responsible for R431's care on 6/7/25. LPN V stated R431 was consistently requesting ordered morphine every four hours since admission for pain control. LPN V recalled on 6/7/25, when R431 requested his next dose of morphine around 4-5:00 PM, she discovered no more pills were left in the medication cart. LPN V indicated there was no additional morphine in the back-up medication room and another script had not been ordered from the pharmacy. LPN V stated his medication blister pack indicated there were 0 refills remaining and there were no providers in the facility on the weekend, so she contacted a telehealth doctor. LPN V stated the telehealth physician recommended a substitute pain medication, oxycodone 20 MG, but the facility only carried 5 MG tablets in back-up which were not sufficient to last the weekend. LPN V stated the telehealth physician recommended R431 be sent to the ED to obtain the proper pain medication. LPN V stated upon R431's return to the facility, he had a telehealth appointment with a different physician who wrote a script for morphine. However, because it was the weekend, the script had to be sent to a down-state pharmacy, approximately 2 hours away, and couriered to the facility via vehicle. LPN V stated her shift ended but received in report that the medication arrived at the facility around midnight. When asked the typical process, LPN V stated nurses on the night shift are supposed to ensure medications are ordered in advance but somehow R431's medication got missed. LPN V stated, Ultimately, it was [the facility's] fault . we should have had the med [medication] re-ordered. Review of R431's EMR revealed the following Health Status note on 6/7/25 at 20:20 [8:20 PM]: Resident has returned from [local hospital] ER [emergency room] . waiting to get VS [vital signs] and contact telehealth provider regarding need for Rx [prescription] for controlled med. Review of a Telehealth visit on 6/7/25 at 20:55 [8:55 PM] revealed the following: .patient has chronic pain. has been taking morphine. has run out of medication and needs refill . morphine 15 mg immediate release tablet . 2 tablet(s) every 4 hours as needed for 3 Day(s), oral route . Review of R431's EMR revealed the following notes: 1. Health Status Note on 6/7/25 at 21:02 [9:02 PM]: Spoke with [physician's name] via TELEHEALTH regarding need for new Rx for morphine 15 mg IR tab 1-2 tab q4h [every four hours] . Rx to be faxed to [pharmacy] within next 10 mins. Per [pharmacy] waiting fax w/ [with] Rx to send courier from [downstate city] with medication. 2. Behavior Note on 6/7/25 at 23:28 [11:28 PM]: What behavior(s) are observed? Accusing of others, Express Frustration/Anger at Others, Agitated, Restless, Insomnia, Not Sleeping, Panic. 3. Administration Note on 6/8/25 at 1:16 AM: Morphine Sulfate Oral Tablet 15 MG Give 2 tablet by mouth every 4 hours as needed for Moderate-Severe Pain. Resident c/o [complains of] 10/10 pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	4. Administration Note on 6/8/25 at 4:11 AM: Anxiousness, restlessness, and agitation assessed this shift. Resident reports behaviors are 2/2 [secondary to] uncertainty of PRN morphine tablet delivery from [pharmacy]. Resident was reassured throughout shift that courier was in route to facility w (with)/ medication. Resident continued to anxiously use call light and ask for ETA [estimated time of arrival]/any updates . Visibly upset - short periods of crying/tears in moments of increased agitation. The following pain levels (out of 10) were recorded following R431's return from the ED on 6/7/25: 1. 6/7/2025 at 21:05 [9:05 PM] - 10 2. 6/8/2025 at 1:16 AM - 10 3. 6/8/2025 at 5:34 AM - 10 4. 6/8/2025 at 8:17 AM - 9 5. 6/8/2025 at 11:30 AM - 8 6. 6/8/2025 at 13:38 [1:38 PM] - 8 7. 6/8/2025 at 17:35 [5:35 PM] - 8 8. 6/8/2025 at 21:38 [9:38 PM] - 10 9. 6/9/2025 at 00:44 [12:44 AM] - 7 10. 6/9/2025 at 1:40 AM - 10 11. 6/9/2025 at 5:59 AM - 10 12. 6/9/2025 at 10:04 AM - 10 13. 6/9/2025 at 14:20 [2:20 PM] - 10 14. 6/9/2025 at 15:41 [3:41 PM] - 7 15. 6/9/2025 at 18:21 [6:21 PM] - 9 16. 6/9/2025 at 20:22 [8:22 PM] - 8 17. 6/9/2025 at 22:57 [10:57 PM] - 9 Review of a facility physician note dated 6/10/25 at 3:59 PM read, in part: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	.Apparently there was some issues with his morphine prescriptions this past weekend. He ran out of both extended release and immediate release morphine. On- call provider had been contacted but prescribed oxycodone instead. Patient ended up in the emergency room where he was given a dose of morphine and sent back to this facility. Second on-call provider was contacted and per patient's report did send a new prescription for his morphine. He is quite upset about this, states he felt very worried for his safety at this facility . On 6/11/25 at 12:56 PM, an interview was conducted with Assistant Director of Nursing (ADON) O regarding the facility pharmacy protocol and pain control expectations. ADON O stated upon initial admission, a resident is typically sent with 3-5 days' worth of narcotic medications. After the resident is evaluated by the facility provider, longer scripts are written. ADON O stated R431 ran out of the prescription written by the acute care hospital and there was not an in-house provider over the weekend to write a new script. ADON O stated the prescription should have been re-ordered when it was getting low. In the event a medication did run out, ADON O stated the protocol would be to first call the pharmacy to check for any available refills and then contact a telehealth provider for a new script if no refills remained. ADON O said, [R431] should have never been sent to the ER. On 6/12/25 at 1:06 PM, an interview was conducted with the Director of Nursing (DON) regarding the facility pharmacy protocol and pain control expectations. The DON verified the prescription should have been ordered prior to running out. The DON confirmed the pharmacy should have been contacted first and in the event no refills remained, the telehealth provider should have been asked for a script. Review of the facility policy titled, Pain Management, dated 12/1/23, read, in part: It is the policy of [facility name] to promote the best quality of life for each resident by managing each resident's pain through person-centered care . Review of the facility policy titled, Medication and Treatment Administration, dated 3/17/22, read, in part: .Each shift is responsible to maintain the medication cart in a sanitary, well organized condition at all times, and to replace depleted supplies . Medication/treatment ordered on an as needed basis (prn) will be administered in accordance with the physician's order .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify Post Traumatic Stress Disorder (PTSD) triggers and develop individualized care plan interventions to mitigate trauma triggers for one Resident (#79) of one resident reviewed for trauma-informed care. Findings include: Resident #79 (R79) R79 was admitted to the facility 1/9/24 with diagnoses including PTSD. The Electronic Medical Record (EMR) contained a psychiatric follow up report dated 5/15/25 that read, in part: .significant history of psychiatric trauma from an abusive relationship . The report did not include trauma triggers. A nursing admission assessment dated [DATE] contained an initial trauma screening. The portion of the admission assessment; Section AS_15. Screening Trauma Informed Care documented the following questions and responses: 1. Have you faced a traumatic event or experience in the past? The answer was yes. 2. Recently, have you thought about the event(s) or experience when you did not want to? The answer was documented as yes. 3. Have you had poor sleep, poor concentration, jumpiness, irritability, or feeling watchful because of the event or experience? The documented response was yes. 4. Have you felt guilty or unable to stop blaming yourself or others? The answer was yes.' The admission assessment did not address potential triggers that could prompt R79's recall of a previous traumatic event. Further review of the EMR revealed R79 was re-admitted on [DATE] after a hospitalization. The portion of the re-admission assessment; Section AS_15. Screening Trauma Informed Care was completely blank with no answers to the screening questions regarding past traumas. The care plans for R79 did not include a trauma care plan that included potential triggers of trauma to provide staff with instructions for identifying potential triggers and interventions to avoid traumatic situations or how to handle traumatic situations should they occur. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse manager Registered Nurse (RN) AA and the social worker (SW) BB were interviewed on 6/12/25 at 12:48 PM. SW BB said social workers complete a separate trauma assessment form to identify trauma triggers when the nursing assessment screening confirms a history of trauma. SW BB said she was not in the social worker position when the admission trauma screen was completed for R79 on 1/9/24 and did not know why a subsequent screening for trauma triggers was not completed by the previous social worker. SW BB said she did not know why a care plan was not developed for PTSD. RN AA confirmed the re-admission nursing assessment of 4/18/25 for R79 was blank for trauma screening in Section AS_15. Screening Trauma Informed Care. RN AA admitted the re-admission nursing assessment screening for trauma should have been completed by nursing, and SW BB should have been made aware of the positive screening to complete an assessment and care plan for trauma triggers. When asked how staff would know the trauma triggers for R79 and interventions for R79, RN AA said, Ideally it would be in the care plan but it's not. When asked about the trauma triggers for R79, RN AA and SW BB said they did not know potential triggers. Both agreed an assessment for triggers should have been completed, and a care plan with appropriate interventions should have been developed. An undated policy Trauma Informed Care read, in part: . It is the policy of this facility to ensure residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice . resident will be screened for a history of trauma within 30 days of admission .The facility will account for residents' experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This will be reflected in the residents care plan/plan of care. This care plan will be reviewed at least quarterly and updated as needed. Potential causes of re-traumatization by staff may include, but are not limited to: a. Being unaware of the resident's traumatic history b. Failing to screen resident for trauma history prior to treatment planning .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review, the facility failed to provide sufficient staff to meet the needs of three sampled Residents (R9, R169 and R430), and eight Residents in a confidential group interview within the facility population of 181 Residents. This deficient practice resulted in actual and potential avoidable episodes of incontinence, frustration and helplessness with call lights going unanswered and needs not being addressed. Findings include: A review of the Resident Council minutes included: - 2/20/25 Discussion regarding call lights being answered in a timely manner . The time seems to be worse at night and early morning . - 3/20/25 Discussion regarding call lights being answered in a timely manner . There were a few concerns about call light times . - 4/17/25 Discussion regarding call lights being answered in a timely manner . When I push mine I have to wait and wait, a good 5 or more minutes during the day . - 5/22/25 Discussion regarding call lights being answered in a timely manner . o I had to wait for 15 minutes the other night for the bathroom and it made me upset. o To (SIC) slow getting to rooms to help you o At lunch a resident had to go to the bathroom but was told by the CNA (Certified Nurse Aide) that she was feeding and cant (SIC) help right now and they'll have to wait for another staff member (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility was asked to offer alert and cognitively intact residents the opportunity to meet and share meaningful discussion regarding their home in the facility. A confidential group meeting took place on 6/11/25 at 11:00 AM, and it was noted the residents stressed their desire to remain anonymous. The group for the most part had Brief Interview for Mental Status (BIMS) scores of 13-15 indicating intact cognition. The group voiced a main concern that the facility was understaffed. Resident C5 stated, The staff try really hard but there are not enough. C3 said the facility was often short staffed and they don't always listen. R9 stated, Sometimes I have to wait so long after asking for help I wet my pants. C2 said, I have to wait over a half hour to get help. C1 had an experience in the dining room when a resident said they needed to use the bathroom. There was an aide there feeding a resident and the aide said, I can't help I am feeding. C1 added, I felt they should help the person go to the bathroom, but no one did. C1 and C5 said there usually was only one woman passing out the trays. It takes more than that. The food cart comes, and it can sit for a half an hour while we wait. We just sit. C8 gave an example when they needed the oxygen tubing put on their face and the aide came in and said, I will be right back, and she never came back. C8 continued, I had to call out to the maintenance man who was walking by, and he helped me. C5 stated, I pooped my pants, and I tried to clean myself, but it went down my leg. An aide came in and said, 'I guess we got a mess here.' She washed up my butt and left. I put the call light on, but she did not come back. C2 stated, When I go to bed, I press my call light, and no one shows up. Resident #169 (R169) Review of R169's electronic medical record (EMR) revealed initial admission to the facility on 5/2/25 with diagnoses including left-sided hemiplegia (loss of movement) following a cerebral infarction (stroke). Review of R169's MDS assessment, dated 5/8/25, revealed a BIMS score of 15, indicative of intact cognition. MDS Section GG (Functional Abilities and Goals) revealed R169 required moderate assistance for functional transfers to the toilet and maximum assistance for toileting hygiene. On 6/10/25 at 1:41 PM, an interview was conducted with R169 who stated she admitted to the facility for rehabilitation following a stroke which affected her left side. R169 stated staffing at the facility was problematic, revealing one night she called 911 from her room because her call light went unanswered for approximately two hours after activating it for toileting assistance. R169 stated following the event she was given a facility number to call from her cell phone in the event of a delayed response time in the future. Review of R169's EMR revealed a Behavior Note dated 5/4/25 at 23:33 [11:33 PM] which read: Resident [#169] called 911 stating she had an emergency and was unable to reach someone. This nurse went to check on resident and she stated her call light was on for over an hour and half, and she needed to use the bathroom. Resident stated she called the building, but it was a recording, so she hung up and called 911. Rehab office number given to resident along with a bell to ding if unable to get ahold of staff. Resident #430 (R430) Review of R430's EMR revealed initial admission to the facility on 5/27/25 with diagnoses including a displaced fracture of the right olecranon process (the bony prominence of the elbow) and repeated falls. Review of R430's MDS assessment, dated 6/2/25, revealed a BIMS score of 13, indicative of intact cognition. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/10/25 at 11:40 AM, an interview was conducted with R430 regarding her satisfaction with the level of care at the facility. R430 voiced her concern over extended call light wait times indicating it typically takes, well over 20 minutes for a response to an activated light. R430 stated, That's a long time when you have to use the bathroom. R430 admitted she often negotiated to the bathroom independently instead of waiting for help due to urgency despite requiring help due to fall risk. Review of R430's Plan of Care revealed a Focus reading, The resident is at high risk for falls r/t [related to] poor safety awareness, weakness with the following intervention: Ensure the resident's call light is within reach and encourage resident to use it for assistance as needed. Further review of R430's Plan of Care read, AMBULATION: The resident requires (partial/moderate) assistance of 1 to transfer and ambulate in room . Review of the facility document titled Past Calls from 5/27/25 to 6/12/25 revealed the following call light date, time, and to room elapsed time that were greater than 25 minutes: -5/30/25 at 10:01 AM - 00:27:17 -6/7/25 at 7:35 AM - 00:27:57 -6/7/25 at 9:07 AM - 00:30:30 -6/8/25 at 12:27 PM - 00:27:52 -6/8/25 at 2:26 PM - 00:29:29 -6/10/25 at 6:23 AM - 00:31:38 -6/10/25 at 7:32 AM - 00:54:27 On 6/12/25 at 1:06 PM, an interview was conducted with the DON regarding call light response time expectations. The DON indicated the facility goal was to respond to call lights in 15 minutes or less. The DON stated extended wait times were something the facility was working on and were, unacceptable. Resident #9 (R9) Review of the (Minimal Date Set) MDS assessment dated [DATE], revealed R9 was admitted to the facility on [DATE], with active diagnoses that included gastroenteritis and colitis, type 2 diabetes mellitus with diabetic neuropathy, Gastrointestinal Esophageal Reflux Disease (GERD), and non-pressure chronic ulcer of skin. Section H revealed R9 was always incontinent, and Section GG revealed R9 was dependent (needs assistance) with toileting. R9 scored a 15 of 15 on the BIMS reflective of intact cognition. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/10/25 at 11:51 a.m., R9 reported, I have to wait for at least 45 minutes for the Certified Nurse Aide (CNA) to help me. I lay in my diarrhea for a long time because they are short staffed, and I don't want to get sore down there. Sometimes food feels like it gets stuck in my throat because of my GERD, what would happen to me if they don't come and help me in time. Review of the facility document titled Past Calls from 5/21/25 to 6/11/25 revealed the following call light date, time, and to room elapsed time that were greater than 25 minutes: - 5/21/25 at 6:16 p.m. - 00:33:55 - 5/22/25 at 5:04 p.m. - 00:47:11 - 5/22/25 at 7:58 p.m. - 00:32:07 - 5/23/25 at 2:19 p.m. - 00:27:45 - 5/25/25 at 6:28 a.m. - 00:26:41 - 5/25/25 at 9:28 a.m. - 00:56:28 - 5/25/25 at 12:47 p.m. - 00:50:25 - 5/26/25 at 11:23 a.m. - 00:57:00 - 5/26/25 at 4:44 p.m. - 00:26:24 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 5/26/25 at 6:31 p.m. - 00:34:17 - 5/26/25 at 9:37 p.m. - 00:59:27 - 5/28/25 at 7:06 a.m. - 00:37:34 - 5/28/25 at 10:28 a.m. - 00:26:50 - 5/31/25 at 7:14 a.m. - 00:34:25 - 6/1/25 at 8:29 a.m. - 00:30:39 - 6/1/25 at 2:27 p.m. - 00:58:22 - 6/2/25 at 10:55 a.m. - 00:50:27 - 6/2/25 at 9:28 a.m. - 00:33:05 - 6/3/25 at 2:22 p.m. - 00:32:06 - 6/3/25 at 7:40 p.m. - 00:34:05 - 6/4/25 at 11:59 a.m. - 00:37:31 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 6/4/25 at 3:18 p.m. - 01:00:00 - 6/4/25 at 6:26 p.m. - 00:32:55 - 6/4/25 at 8:17 p.m. - 00:33:15 - 6/6/25 at 2:13 p.m. - 00:28:33 - 6/6/25 at 4:06 p.m. - 00:42:17 - 6/7/25 at 9:19 a.m. - 01:02:49 - 6/7/25 at 1:48 p.m. - 00:53:28 - 6/7/25 at 6:13 p.m. - 00:29:50 - 6/7/25 at 10:07 p.m. - 00:29:29 - 6/8/25 at 11:22 a.m. - 00:43:57 - 6/8/25 at 9:08 p.m. - 00:32:18 - 6/10/25 at 9:28 p.m. - 00:25:43 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/12/25 at 9:23 a.m., CNA I reported, We are short today and people get pulled to help in other areas . we are doing the best we can . During an interview on 6/12/25 at 9:40 a.m., CNA J reported, There is not enough help on the weekends. During an interview on 6/12/25 at 11:10 a.m., CNA K reported, Staffing here is not good, there is a problem . last week there was an aide on light duty and she was not supposed to work but had to help us get people out of bed anyway.

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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. Based on interview and record review, the facility failed to ensure availability of prescribed medications for one Resident (#431) of six residents reviewed for pharmacy services. Findings include: Resident #431 (R431) Review of R431's EMR revealed initial admission to the facility on 6/4/25 with diagnoses including fracture of the left acetabulum (a break in the socket portion of the hip joint), fracture of the left ulna (a break in one of the two bones of the forearm), fracture of the left tibia (a break in the large bone in the lower leg), displaced fracture of the left acromial process (a break in the bony projection of the shoulder blade), and fractures of facial bones.). Review of R431's Minimum Data Set (MDS) assessment, dated 6/10/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. On 6/10/25 at 12:20 PM, R431 was observed in his room standing at a platform walker with his left leg immobilized. An interview was conducted with R431 regarding his level of satisfaction with care at the facility. R431 stated he was admitted to the facility for rehabilitation following a motor vehicle accident (MVA) in which he sustained several injuries including fractures of his left arm, left leg, and face. R431 stated over the weekend, the facility ran out of his prescribed pain medication and had to be transferred to the ED at a local acute care hospital for pain management. R431 recalled, My pain level was a 12 out of 10 . I suffered all weekend to get my pain back under control. R431 stated he waited in the ED for several hours in a wheelchair without appropriate positioning of his immobilized left leg due to the facility's inability to locate a proper footrest prior to the transfer. Review of R431's EMR revealed the following physician's orders initiated on 6/4/25: 1. Morphine Sulfate ER [Extended Release] Oral Tablet 30 MG [milligrams]. Give 1 tablet by mouth two times a day for PAIN. 2. Morphine Sulfate Oral Tablet 15 MG. Give 2 tablet by mouth every 4 hours as needed for Moderate-Severe Pain. Review of a Telehealth visit (a virtual appointment which allows patients to consult with healthcare providers remotely using digital communication) on 6/7/25 at 16:39 [4:39 PM] revealed the following: Patient admitted 6/4 with script for PRN [as needed] Morphine IR [immediate release] 1-2 tablets q4 [every 4 hours]. No more pills/fills left. New script needed to be able to fill. Patient is requesting PRN's [as needed medication] about every four hours . Pharmacy can't deliver until Monday morning . Willing to try Oxycodone 20 mg .facility doesn't have enough oxycodone also . Morphine can't be delivered until Monday .facility doesn't have enough oxycodone. Will send him [R431] to hospital as he can't go without pain medication . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 11:26 AM, an interview was conducted with Licensed Practical Nurse (LPN) V who verified she was the nurse responsible for R431's care on 6/7/25. LPN V stated R431 was consistently requesting ordered morphine every four hours since admission for pain control. LPN V recalled on 6/7/25, when R431 requested his next dose of morphine around 4-5:00 PM, she discovered no more pills were left in the medication cart. LPN V indicated there was no additional morphine in the back-up medication room and another script had not been ordered from the pharmacy. LPN V stated his medication blister pack indicated there were 0 refills remaining and there are no providers in the facility on the weekend, so she contacted a telehealth doctor. LPN V stated the telehealth physician recommended a substitute pain medication, oxycodone 20 MG, but the facility only carried 5 MG tablets in back-up which were not sufficient to last the weekend. LPN V stated the telehealth physician recommended R431 be sent to the ED to obtain the proper pain medication. LPN V stated upon R431's return to the facility, he had a telehealth appointment with a different physician who wrote a script for morphine. However, because it was the weekend, the script had to be sent to a down-state pharmacy, approximately 2 hours away, and couriered to the facility via vehicle. LPN V stated her shift ended but received in report that the medication arrived at the facility around midnight. When asked the typical process, LPN V stated nurses on the night shift are supposed to ensure medications are ordered in advance but somehow R431's medication got missed. LPN V stated, Ultimately, it was [the facility's] fault . we should have had the med [medication] re-ordered. Review of R431's EMR revealed the following Health Status note on 6/7/25 at 20:20 [8:20 PM]: Resident has returned from [local hospital] ER [emergency room] . waiting to get VS [vital signs] and contact telehealth provider regarding need for Rx [prescription] for controlled med. Review of a Telehealth visit on 6/7/25 at 20:55 [8:55 PM] revealed the following: .patient has chronic pain. has been taking morphine. has run out of medication and needs refill . morphine 15 mg immediate release tablet . 2 tablet(s) every 4 hours as needed for 3 Day(s), oral route . Review of R431's EMR revealed the following notes: 1. Health Status Note on 6/7/25 at 21:02 [9:02 PM]: Spoke with [physician's name] via TELEHEALTH regarding need for new Rx for morphine 15 mg IR tab 1-2 tab q4h [every four hours] . Rx to be faxed to [pharmacy] within next 10 mins. Per [pharmacy] waiting fax w/ [with] Rx to send courier from [downstate city] with medication. 2. Behavior Note on 6/7/25 at 23:28 [11:28 PM]: What behavior(s) are observed? Accusing of others, Express Frustration/Anger at Others, Agitated, Restless, Insomnia, Not Sleeping, Panic. On 6/11/25 at 12:56 PM, an interview was conducted with Assistant Director of Nursing (ADON) O regarding the facility pharmacy protocol and pain control expectations. ADON O stated upon initial admission, a resident is typically sent with 3-5 days' worth of narcotic medications. After the resident is evaluated by the facility provider, longer scripts are written. ADON O stated R431 ran out of the prescription written by the acute care hospital and there was not an in-house provider over the weekend to write a new script. ADON O stated the prescription should have been re-ordered when it was getting low. In the event a medication did run out, ADON O stated the protocol would be to first call the pharmacy to check for any available refills and then contact a telehealth provider for a new script if no refills remained. ADON O said, [R431] should have never been sent to the ER. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 1:06 PM, an interview was conducted with the Director of Nursing (DON) regarding the facility pharmacy protocol and pain control expectations. The DON verified the prescription should have been ordered prior to running out. The DON confirmed the pharmacy should have been contacted first and in the event no refills remained, the telehealth provider should have been asked for a script. Review of the facility policy titled, Pharmacy Manual, undated, read, in part: .Orders/Delivery of Medications: .The reorder procedure of routinely administered unit dose or punch card drugs is determined by the dispensing system used by the facility . the nurse must request a refill of the drug ideally 2-3 days before the drug is completely used . If a new medication is needed prior to the next scheduled delivery, the nurse must contact the pharmacy by telephone to arrange the delivery. Such medications are ideally delivered and administered within four (4) hours, is possible. If a medication is needed after regular business hours, please contact the pharmacist call . Emergency pharmaceutical service is available on a 24-hour basis. Emergency needs for medication will be met by using the facility's approved emergency drug kit (EDK) or by special order from the pharmacy supplier . Only emergency orders should be called to the pharmacy after regular business hours . The pharmacy may deliver the medication or request a local back-up pharmacy to supply the medication; whichever best provides the quickest delivery as determined by the pharmacist on call .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure Medication Regimen Reviews (MRR's) were addressed by the attending physician and maintained in the clinical record for two Residents (#45 & #79) of five residents reviewed for MRR. Findings include: Resident #45 (R45) R45 was admitted to the facility 9/8/23. A review of physician's orders in the Electronic Medical Record (EMR) revealed R45 had an order for diclofenac (a pain medication) and quetiapine (an antipsychotic medication for mental health conditions). The EMR of R45 was reviewed for MRR on 6/11/25. No MRR's were found in the EMR, and a request was made to the Director of Nursing (DON) on 6/11/2025 at 5:37 PM to provide the MRR's for R45. MRR's were provided by the DON on 6/12/25 at 8:47 AM. Review of the MRR's revealed the pharmacist made requests and recommendations to R45's physician for dosage clarification of diclofenac on 1/24/25 and 3/19/25. The pharmacist documented in the MRR's for diclofenac on 1/24/25 and 3/19/25 both of which, read in part: . Resident has an order for diclofenac gel twice daily. Could a specific quantity to be administered be added to this order? The portion of the MRR's for the physician/prescriber response was blank. Review of R45's physician's orders on 6/12/25 revealed the order for diclofenac had not been amended as prescribed on 12/16/24 and the ordered did not contain a dose to be administered as requested by the pharmacist. The EMR did not reveal documentation by the physician regarding the reason the dose clarification request was declined. Further review of the MRR's revealed the pharmacist made a request and recommendation to R45's physician on 5/15/25 for a Gradual Dose Reduction (GDR) of quetiapine. The MRR read, in part: .Resident is currently due for a GDR evaluation on her quetiapine .If you feel that no GDR should be attempted, please document your reasoning for clinical contraindication at the bottom of this form or in your next progress note . The portion of the MRR for the physician/prescriber response was blank. The EMR, including the physician's subsequent progress notes, did not contain documentation by the physician for clinical reasoning or rationale for declining the GDR as requested by the pharmacist. Resident #79 (R79) R79 was admitted to the facility 1/9/24. A review of physician's orders in the EMR revealed R79 had orders for rosuvastatin (a medication used to treat high cholesterol and prevent strokes) and quetiapine. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EMR of R79 was reviewed for MRR on 6/11/25. The MRR's were not in the EMR, and a request was made to the DON on 6/11/2025 at 5:37 PM to provide the MRR's for R79. MRR's were provided by the DON on 6/12/25 at 8:47 AM. Review of the MRR's revealed the pharmacist made a request/recommendation to R79's physician on 1/25/25 to obtain a lipid panel (blood test) due to daily use of rosuvastatin and quetiapine. The MRR's read, in part: . Resident is taking rosuvastatin and quetiapine daily. Could a lipid panel and A1c (blood sugar average over 3 months) be done to respectively assess? The laboratory results of R79 did not reveal a lipid panel had been obtained as requested and recommended by the pharmacist. The EMR, including the physician's progress notes, did not contain documentation by the physician for clinical reasoning or rationale for declining the laboratory draw as requested by the pharmacist. The DON was interviewed on 6/12/25 at 2:03 PM. The DON said the facility did not have documented physician responses to MRR's recommendations for R45 and R79. The DON said a system for monitoring was not in place to ensure physicians were addressing the pharmacist's MRR recommendations. The policy titled Pharmacy Consultant Reports dated 7/3/19 read, in part: .Every month, the pharmacist will share the consulting recommendation .The provider is responsible for reviewing the recommendations and either agreeing, disagreeing, or writing an alternate response .will review to ensure all the recommendations have been addressed .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were safely secured and stored in three of six medication carts reviewed for medication storage and properly dispose of medications in one of six medication carts reviewed for medication storage. Findings include: During an environmental tour on the Maple Unit with the Nursing Home Administrator (NHA) on [DATE] at 3:36 PM, five loose medications were found between the seat cushions on the left side of a chair in the hallway. The medications consisted of a semicircular, orange-colored tablet, a pink and turquoise capsule, an elongated oval tablet, and two circular orange tablets. The NHA did not provide an explanation for the medications found in an unsecured and public location accessible to residents in the facility. The NHA said he would follow up with the nurse manager on the unit. Five medication carts were reviewed on [DATE] at 1:02 PM which included three medication carts (Green, Violet, and Orange) on the Maple Unit, and two medication carts on the Cherry unit (300-319 and 320-339). Observations revealed the following: The Maple unit [NAME] Cart had one loose white, round tablet with imprint EP/117 in the medication cart. The Orange Cart contained five loose medications at the bottom of the drawers: a round white tablet with imprint EP/117, a yellow oblong tablet with imprint 152, a white round tablet with imprint 428SG, an oblong blue tablet with imprint 461G, and a tan round tablet with imprint 1154. The Cherry unit cart 300-319 contained an expired insulin pen. The pen was dated as opened [DATE] with a written date to be discarded on [DATE]. Licensed Practical Nurse (LPN) C said she did not know why the pen was in the medication cart because the medication had been discontinued and should have been removed from the medication cart. The physician's order for the insulin pen was confirmed to be discontinued on [DATE]. LPN C said the medication should have been discarded when it was discontinued. Registered Nurse (RN) G was observed administering medications on the Cherry Hall on [DATE] at 7:17 AM. When RN G opened the medication cart, an undated plastic medication cup containing several medications was identified in the cart. RN G immediately picked up the cup and dumped the medications into the standard refuse receptacle on the side of the medication cart. When asked what the medications were or who they were for, RN G said, I don't know what those pills are, and I didn't put them in that cup. When asked about disposing of medications in the standard waste container, RN G said, Is that not right? That's how I always waste medications. The Nurse Manager on the Cherry Hall (RN L) was interviewed on [DATE] at 8:13 AM. RN L said it was not permissible for nurses to pre-set medications. The expectation was for nurses to prepare medications at the time of medication administration. The Assistant Director of Nursing (ADON) said nurses were expected to dispose of unwanted medication using Drug Buster® (a medication disposal system that breaks down medications and renders them inactive). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing (DON) was interviewed on [DATE] at 12:09 PM. The DON reiterated the facility utilized Drug Buster® and said medications should not be thrown into the garbage can. The DON said nurses were to prepare medications when medications were passed, and nurses were to refrain from preparing medications prior to medication pass. The policy titled Medication and Treatment Administration, dated [DATE] read, in part: . Medication and/or treatments will be prepared, administered, and documented by the same licensed individual only . The undated policy titled Storing Medications, read, in part: . Medications and biologicals will be stored in a safe, secure and orderly manner .and accessible only to licensed nursing and pharmacy personnel or others authorized by law to administer medications .

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. . Based on observation, interview, and record review, the facility failed to provide adaptive dining equipment for two Residents (#80 and #111) of three residents reviewed for adaptive dining equipment needs. This deficient practice resulted in increased difficulty with food consumption and independent eating. Findings include: Resident #80 (R80)/Resident #111 (R111) On 6/11/25 at approximately 9:00 AM, the breakfast meal was observed. R80 did not receive dycem (a non-slip material placed under the plate) to help secure his plate while eating. R80 did have special built up utensils for ease of gripping and feeding self. The breakfast tray card indicated R80 needed 1 each Nonslip Dycem. On 6/12/25 at 9:34 AM, the breakfast meal was observed. R80 did not receive dycem to help secure his plate while eating but did have special built up utensils to assist in feeding himself. During this same meal, R111 also did not receive non-slip dycem as indicated on his tray card. During an interview on 6/12/25 at approximately 9:35 AM, Certified Nurse Aide (CNA) CC stated R80 has not been using dycem since they now required total assistance for feeding. CNA CC agreed it was difficult to feed R80 with the adaptive utensils on the tray. During an interview on 6/12/25 at approximately 9:40 AM, Registered Dietitian (RD) DD stated she was aware there were changes in the need for adaptive equipment but had not been updated by the Occupational Therapy (OT) department so had not updated the tray card to reflect the residents' current feeding needs. A review of the medical record for R80 revealed a care plan that included a focus of: Increased Nutrition and Hydration risk r/t (related to) dx (diagnoses) of Cerebral Palsy, visual impairment, osteoarthritis, Gastritis, dysphagia (difficulty swallowing) . AEB (as evidenced by): -need for adaptive dining ware and meal assistance/supervision . The interventions for this care plan included: -Adaptive: Sip tip cup (spouted) with handles, divided plate, lids on hot liquids, and thinner built up utensils, and dycem under place setting; OT Recommending adjustable ht (height) table for meals . -Assistance: Setup, cueing, and supervision for meals . This care plan included an additional focus for R80: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t Disease Process (cerebral palsy), Impaired balance with further interventions which included: (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EATING: The resident requires (set up assistance) by (1) staff to eat. EATING: The resident requires (spout cup, divided plate, dicem (sic) under place setting, thinner handled built up silverware, and an adjustable height table for place setting . A review of the medical record for R111 revealed a care plan that included a focus of: Increased Nutrition and Hydration risk r/t dementia, falls . recent pneumonia AEB: -weight stabilization s/p (after) recent significant loss, -cognitive decline, -self feeding difficulty with need for adaptive dining ware, and -risk for further weight/fluid/skin changes r/t chronic disease, impaired cognition, and advanced age with transition to Hospice for end of life care. The interventions for this care plan included: Adaptive: Blue thermocup (protective cup from burns) with/ lid, Built up black and soup spoon, R(right) curved fork, divided plate, dycem, and scoop bowl with suction base . Assistance: Tray setup assistance. The undated facility policy titled Adaptive Equipment Policy was presented and read in part: Policy Residents requiring assistance in feeding are potential candidates for a restorative dining program or adaptive utensil use, as determined by the occupational therapist. Purpose . 5. The dietary department should be notified of residents needing adaptive feeding equipment; the equipment is stored and maintained in the dietary department. Appropriate utensils should be placed on the resident's food tray, at each meal, and returned to the dietary department, on the food tray, for sanitization. .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: During the initial tour of the kitchen, at 11:47 AM on 6/10/25, and interview with Dietary Manager (DM) R found that the plastic bag covering the mixer means it is clean. When asked how often the mixer gets used, DM R stated it gets used four to five times a week. Observation of the large mixer found an accumulation of white debris stuck on the under arm of the unit. During the initial tour of the kitchen, at 11:49 AM on 6/10/25, observation of the inside of the blue ice scoop holder found black debris in the bottom corner of the holder. During the initial tour of the kitchen, at 11:50 AM on 6/10/25, observation of two clean utensil bins, in the back prep area, found mechanical scoops and spoons stored in an accumulation of crumb debris. Further observation of two pull out utensil drawers found increased accumulation of debris in the back of the drawers. During the initial tour of the kitchen, at 11:54 AM on 6/10/25, an interview with DM R found that the bag on the slicer means its clean. When asked how often it gets used Chef S stated that its rarely used. Observation of the slicer found dried meat debris on the backside bottom of the blade and an accumulation of meat debris on the top back portion of the blade. Chef S acknowledge the accumulation upon inspection. During a revisit to the kitchen, at 7:37 AM 6/11/25, observation of the sheet pan under the large mixer found attachments and utensils for the large mixer. At this time, it was observed that the sheet pan was found with an accumulation of crumb debris According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. During the initial tour of the kitchen, at 11:50 AM on 6/10/25, observation of the clean utensil bin used for storing metal spoons found some spoons stored upright with water accumulation in the basin of the spoons. During the initial tour of the kitchen, at 12:09 PM on 6/10/25, it was observed that three half pans were found stacked and stored wet with noticeable water accumulation between the clean pans. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 FDA Food Code section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD . During the initial tour of the kitchen, at 11:57 AM on 6/10/25, observation of a shelf under and off to the side of the three-compartment sink, found two spray bottles roughly a quarter full, with no common name designation for what solution was in the spray bottles. According to the 2022 FDA Food Code section 7-102.11 Common Name. Working containers used for storing POISONOUS OR TOXIC MATERIALS such as cleaners and SANITIZERS taken from bulk supplies shall be clearly and individually identified with the common name of the material. During the initial tour of the kitchen, at 12:01 PM on 6/10/25, observation of the back corner main kitchen hand sink, between the three-compartment sink and the short cook line, found a wheeled cart stored in front of the hand sink full of dirty pots and pans waiting to be washed in the three-compartment sink. At this time, the hand sink was not accessible for use. According to the 2022 FDA Food Code section 5-205.11 Using a Handwashing Sink. (A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use . During a revisit to the kitchen, at 7:25 AM on 6/11/25, observation of the walk-in cooler found excess food and crumb debris under the storage racks and in the crevices and perimeter of the room. Further observation found that there was no base coving around the perimeter of the room that would act as a barrier to protect accumulation on the juncture of the wall and the floor. According to the 2022 FDA Food Code section 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair. According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean .

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	235088	A. Building B. Wing	06/12/2025

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Grand Traverse Pavilions	1000 Pavilions Circle Traverse City, MI 49684

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has two deficient practice statements. DPS A Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility. Findings include: During the initial tour of the kitchen pantry's, starting at 12:31 PM on 6/10/25, found the following areas with unused water lines protruding from the wall: Birch Pantry, Cherry Pantry, Dogwood Pantry, and Maple Pantry. During a tour of the Birch Hall soiled utility room, at 9:33 AM on 6/11/25, an interview with Environmental Services Assistant Director (ESAD) Q, found that staff should be using the hopper to clean linen before sending it to laundry. Observation of the hopper found discolored water dispensed from the over hopper faucet hot and cold water fixtures. ESAD Q stated that we would like staff to use them more. During a tour of the Cherry Hall soiled utility room, at 9:48 AM on 6/11/25, it was found that the foot pedals for the hopper spray were not in use and turned off at the source, indicating a stagnant line. During an interview with Environmental Services Director (ESD) P, at 9:53 AM on 6/11/25, it was found that the facility does annual Legionella samples but does not test for free chlorine or other disinfection levels in their water supply which could reduce the risk of Legionella or other OPPP. During a tour of the Dogwood soiled utility room, at 10:05 AM on 6/11/25, observation of the hopper spray found discolored water when sprayed into the basin of the hopper. During a tour of the Elm activity pantry, at 10:10 AM on 6/11/25, with the Nursing Home Administrator (NHA), two unused water lines were found protruding from the wall on the counter. The NHA stated the room used to be a pantry years ago and those water lines were probably hook ups for juice or coffee. During an interview with ESD P and ESAD Q, at 11:40 AM on 6/11/25, it was found that they are the only two on the water management team. When asked if any testing is done at the facility, ESD P stated that they send out annual Legionella samples and are due to take them soon. When asked about the flushing of minimal use or unused fixtures, ESD Q stated that they currently flush fixtures in the hall that's down, but the census is pretty high, so other fixtures are getting used regularly. When asked if the hot water boilers were set at 140 F or higher to achieve a kill step in the domestic hot water supply, ESD Q stated no, we keep the boilers set around 115 F. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facilities Water Management Program policy, not dated, found A water management team has been established to develop and implement the facility's water management program, the Infection Preventionist, maintenance employees, and administrative representatives. Further review of the facility provided document entitled Water Management Program Facility Assessment, not dated, found that Regular flushing of hot and cold water at outlets (e.g., sink taps, showers), particularly not in routine use or which experience low water flow, is necessary to ensure that engineering controls are maintained at sufficient levels for Legionella growth inhibition throughout the water distribution systems and at fixtures. Irregular use or low flow fixtures must be flushed at least twice per week to prevent water stagnation for extended period of time. DPS B Based on observation, interview, and record review, the facility failed to implement infection prevention practices and the appropriate use of personal protective equipment (PPE) for two Residents (#56 and #101) of six residents reviewed for infection prevention and control. Findings include: Resident #56 (R56) R56 was admitted to the facility 4/14/21 with a primary diagnosis of hereditary spastic paraplegia. A Minimum Data Set (MDS) assessment dated [DATE] documented R56 was non-ambulatory and dependent on staff for activities of daily living (ADL) including but not limited to toileting, hygiene, bed mobility, and transfers. R56 received hospice care for end-of-life services related to a terminal prognosis. On 6/10/25 at 1:48 PM, a meal tray with open food was observed on the overbed table in R56's room next to the bed. A stained, yellowed urinal was on the overbed table next to the food tray. On 6/10/25 at 4:09 PM, R56 was observed sleeping in bed. The stained urinal remained atop the overbed table with no barrier beneath it next to a white, Styrofoam cup of water and a plastic mug with lid and straw. The overbed table containing the urinal was at the foot of R56's bed. The Director of Nursing (DON) was interviewed on 6/11/25 at 2:19 PM. The DON said urinals, bedpans, and wash basins were to be kept in a cabinet in resident rooms or bathrooms. The DON said urinals should not be placed next to meal trays of food because it was an infection control concern. The DON said if a resident wanted a urinal on an overbed table the resident would be educated, and it would be care planned to indicate the resident elected to keep the urinal on the overbed table. The DON said the facility had been reviewing products intended to keep urinals within reach of residents without having the urinal on the overbed tables from which the residents were eating. The care plans for R56 were reviewed on 6/11/25. The care plans did not indicate the urinal was maintained on the overbed table at the request of R56. The care plans did not include maintaining the urinal on the overbed table or next to open food. On 6/12/25 at 8:36 AM, R56 was sleeping in bed. The overbed table was at the foot of the bed out of R56's reach. The urinal remained directly on the overbed table without a barrier. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/12/25 at 9:26 AM, a certified nurse aide (CNA) entered R56's room and obtained the urinal from the overbed table near the foot of the bed to assist R56 with toileting. When the CNA exited the room, the urinal was observed to have been placed back on the overbed table without a barrier beneath it. The overbed table remained near the foot of the bed out of R56's reach. The nurse manager, Registered Nurse (RN) AA was interviewed on 6/12/25 at 12:57 PM. RN AA said R56 wanted the urinal on his overbed table next to his meal trays. RN AA reviewed the EMR of R56 and acknowledged there was no care plan or documentation indicating the urinal was on the overbed table by R56's choice. RN AA said a privacy holder that attached to the side of the bed was ordered to keep the urinal off the bedside table but within the reach of R56. On 6/12/25, an untitled, undated document was supplied by the DON that read, in part: . our policy states 'return bedpan or urinal to resident's drawer' . Resident #101 (R101) On 6/11/25 at 12:13 PM, Licensed Practical Nurse (LPN) E was observed administering medications on the Dogwood unit. LPN E put on gloves and administered insulin to R101. LPN E exited the room of R101 wearing the gloves worn during the administration of the insulin. LPN E went to the medication cart wearing the gloves and began moving items atop the cart including the plastic medication cups and the water pitcher before removing the gloves and performing hand hygiene. During medication administration observation on the Cherry unit on 6/12/25 at 7:17 AM, RN G picked up a stack of plastic medication cups and began separating the cups by placing her bare, uncleansed fingers on the rim of each cup to pull them apart. The Assistant Director of Nursing (ADON), RN L, was interviewed on 6/12/25 at 8:13 AM. RN L said nurses were expected to refrain from touching the rims of med cups where residents place their mouths. The DON was interviewed on 6/12/25 at 12:09 PM. The DON said it was not permissible for staff to wear gloves from a resident's room into the hallway. The DON said LPN E should have removed her gloves and performed hand hygiene before leaving the room of R101. The policy MEDICATION AND TREATMENT ADMINISTRATION dated 3/17/22 read, in part: . Infection control standards will be maintained at all times during medication/treatment preparation and administration which includes first and foremost, good handwashing techniques . Appropriate gloving procedures will be maintained .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an eligible resident was provided a pneumococcal vaccine as recommended by the Centers for Disease Control and Prevention (CDC) for 1 Resident (#54) of 5 residents reviewed for immunizations. Findings include: Resident #54 (R54) Review of R54's electronic medical record (EMR) revealed initial admission to the facility on 5/23/25 with diagnoses including fractured left ribs, anemia, coronary artery disease, diabetes mellitus, and hypertension. R54 was admitted to the facility for rehabilitation. Review of R54's vaccination on the Michigan Care Improvement Registry (MICR), revealed the last dose of the pneumococcal was administered on 8/2/21. The status for eligible PCV20/PCV21/PPSV23 vaccination read, Overdue. Review of facility document for R54 titled, admission Consent Checklist, dated 5/16/25, read in part, .#9. Can we provide influenza vaccine, pneumococcal vaccine, tetanus and COVID-19 if due? Yes (marked) . Review of R54's EMR revealed a pneumococcal vaccine had not been administered since their initial admission on [DATE]. On 6/12/25 at 1:00 PM, an interview was conducted with the Director of Nursing (DON) who stated the facility keeps vaccinations on hand in a designated refrigerator for residents who want to be vaccinated. The DON further stated that their expectation is that all new admissions who want to be vaccinated are vaccinated within the first week and no later than 14 days after their admission. A review of policy titled, Pneumococcal Vaccine, dated 12/20/18, read in part, Purpose: All residents will be offered the Pneumovax (pneumococcal vaccine) to aid in preventing pneumococcal infections (e.g., pneumonia). Procedure .3. Pneumococcal vaccinations will be administered to residents .per our vaccination protocol .7. A series of vaccinations will be offered to immunocompetent* adults > 65, depending on current vaccination status and practitioner recommendation: a. No previous vaccination (or vaccination status is unknown): PCV13 first, then PPSV23 one year later. b. Previously received PPSV23 at age > 65: PCV13 at least 1 year after receipt of PPSV23. c. Previously received PPSV23 before age [AGE] years who are now aged > 65: PCV13 at least 1 year after receipt of PPSV23, then PPSV23 after 5 years of previous vaccination (no earlier than one year of PCV13). (* Residents who are immunocompromised may receive the series of vaccinations within a shortened interval in accordance with current CDC guidelines and practitioner recommendation, but no sooner than 8 weeks. These residents may receive up to 3 doses of PPSV23.).

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure eligible residents were provided a COVID-19 vaccine as recommended by the Centers for Disease Control and Prevention (CDC) for 2 Residents (#54 & #433) of 5 residents reviewed for immunizations. Findings include: Resident #54 (R54) Review of R54's electronic medical record (EMR) revealed initial admission to the facility on 5/16/25 with diagnoses including fractured left ribs, anemia, coronary artery disease, diabetes mellitus, and hypertension. R54 admitted to the facility for rehabilitation. Review of R54's vaccination on the Michigan Care Improvement Registry (MICR), revealed the last dose of the COVID-19 was administered on 12/13/21. The status for eligible COVID-19 vaccination read, Overdue. Review of facility document for R54 titled, admission Consent Checklist, dated 5/16/25, read in part, .#9. Can we provide influenza vaccine, pneumococcal vaccine, tetanus and COVID-19 if due? Yes (marked) . Review of R54's EMR revealed a COVID-19 vaccine had not been administered since their initial admission on [DATE]. Resident #433 (R433) Review of R433's EMR revealed initial admission to the facility on 5/23/25 with diagnoses including acute respiratory failure, atrial fibrillation, heart failure, pneumonia, and hypertension. R433 admitted to the facility for rehabilitation. Review of R433's vaccination on the MICR, revealed the last dose of the COVID-19 was administered on 1/14/22. The status for eligible COVID-19 vaccination read, Overdue. Review of facility document for R433 titled, admission Consent Checklist, dated 5/23/25, read in part, .#9. Can we provide influenza vaccine, pneumococcal vaccine, tetanus and COVID-19 if due? Yes (marked) . Review of R433's EMR revealed a COVID-19 vaccine had not been administered since their initial admission on [DATE]. On 6/12/25 at 1:00 PM, an interview was conducted with the Director of Nursing (DON) who stated the facility keeps vaccinations on hand in a designated refrigerator for residents who want to be vaccinated. The DON further stated that their expectation is that all new admissions who want to be vaccinated are vaccinated within the first week and no later than 14 days after their admission. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of policy titled, COVID-19 Vaccine, dated 11/12/21, read in part, Purpose: All residents offered the COVID-19 vaccine to aid in preventing COVID-19 .Procedure .3. COVID-19 vaccination(s) administered to residents .per our vaccination protocol .