STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235089	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tuscola County Medical Care Facility	1285 Cleaver Road Caro, MI 48723

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area, resulting in the potential to spread food borne illness to all residents who consume food from the kitchen. Findings Include:On 12/9/25 at 10:15 AM, an initial tour of the kitchen was conducted with Dietary Manager (DM) C. The following observations were made: -A drain from the walk-in freezer drained into a hole in the floor. The tube was lower than the floor. -A drain that the DM reported she thought it was for the ice machine, was observed going into a cut out from the floor drain area and did not have an air gap. The drainpipe was below the level of the floor. There was another plastic tubing in the cut-out floor drainage area that was wrapped around the inside of the drain box in the floor. The tubing was below the level of the floor and debris was noted where the piping lay. -Osmosis system had a black tube inside slotted box drain in the floor. The black tube was below the level of the floor. -Nosey cups were stored in a plastic container with the lid secured. Multiple nosey cups were stored wet inside. The DM took them out to be cleaned. When queried regarding storage, the DM reported that the items should be air dried prior to storage or stacked. On 12/11/2025 at approximately 8:30am-9:00am during the kitchen tour with the Director of Food and Nutrition Services C, observed the ice machine drain line sitting directly inside the drain located in the kitchen. On 12/11/2025 at approximately 8:30am-9:00am observed built up residue on the meat slicer located in the kitchen. When interviewed on how often the meat slicer is cleaned, the Director of Food and Nutrition Services C stated it's cleaned after every use. On 12/11/2025 at 11:00am-Noon during lunch service with the Director of Food and Nutrition Services C, this surveyor temped chicken nuggets on the steam table with a Thermapen and the temperature was 106 degrees Fahrenheit. On 12/11/2025 at 11:00am-Noon when interviewed on what temperature the chicken nuggets should be during hot holding, the Director of Food and Nutrition Services C answered 135 degrees Fahrenheit or above. On 12/12/2025 at 9:00-9:40am during the kitchen tour of the Cortland House with the Director of Food and Nutrition Services C, observed ice machine drain line sitting inside the drain. (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 Food Code, 5-202.13 Backflow Prevention, Air Gap, An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the 2022 Food Code, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, Except during preparation, cooking, or cooling, or when time is used as the public health control, time/temperature control for safety food shall be maintained: At 57 degrees C (135 degrees F) or above. According to the facility's policy on hot holding, Compliance with Hazardous Analysis Critical Control Points (HAACP) guidelines will ensure that food will be kept out of the danger zone (between 41-135) during preparation and service.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure appropriate backflow prevention was installed at plumbing fixtures, resulting in the potential for contamination of the water supply, affecting all residents. Findings include: On 12/11/2025 at approximately 12:41pm-1:24pm during the environmental tour with the Life Safety Officer B, observed a hose attached to a spigot without a backflow preventer at the cold water line located in the boiler room. On 12/11/2025 at approximately 12:41pm-1:24pm observed the water softener drain line sitting directly inside a drain. On 12/11/2025 at approximately 12:41pm-1:24pm observed a utility sink with a chemical feed downstream of an atmospheric vacuum breaker located in the housekeeping closets in Rooms 278, 206, 136, and 178. On 12/12/2025 at 9:00-9:40am observed a utility sink with an attached chemical dispenser downstream of an atmospheric vacuum breaker located in the janitor's closet in Cortland House. On 12/12/2025 at 9:00-9:40am observed a utility sink with an attached hose and a chemical dispenser downstream of an atmospheric vacuum breaker in the janitor's closet located in [NAME] House. According to 2018 Michigan Plumbing Code, 608.16.4.2 Hose Connections, Sillcocks, hose bibs, wall hydrants, and other openings with a hose connection shall be protected by an atmospheric-type or pressure vacuum breaker or a permanently attached hose connection vacuum breaker.According to the 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve).According to the 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure.According to the 2008 Cross Connections Manual on water softeners, Typical water softener installations may pose a public health threat mainly due to the waste discharge piping being terminated in a floor drain or sewage piping system thereby creating a submerged inlet cross connection.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents' rights were being met by 1) Ensuring that call lights were within reach or easily accessible to residents and/or 2) Ensuring that call lights were responded to in a timely manner for four residents (R11, R74, R78 and R121) of four residents sampled for accommodation of needs and also a Confidential Group of Residents. Findings include:Resident #11 (R11): On 12/11/25 at 12:32 PM, an observation was made of Resident 11 sitting up in his wheelchair, propelling himself in his room. An observation was made of the Resident's call light positioned on the floor underneath the bed. The call light hung from the wall and the bed was positioned up against the wall. The call light was lying on the floor between the wall and the bed. The call light was not within reach for R11. The Resident was asked for help. A staff member was alerted to the Resident needing assistance from staff found in the hallway and was informed of the call light not in reach for the Resident. A review of R11's medical record revealed an admission into the facility on [DATE] and readmission on [DATE] with diagnoses that included heart disease, schizophrenia, anxiety disorder, dementia, bilateral hip and knee contractures and cerebral palsy. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 6/15 that indicated severely impaired cognition, and the resident was dependent on a helper for toileting hygiene, bathing, lower body dressing, and transfers. Resident #78 (R78): On 12/9/25 at 11:51 PM, an interview was conducted with Resident #78 (R78) who was dressed, lying in bed with her feet elevated up. The Resident answered simple questions and engaged in limited conversation. The Resident had asked to get up out of bed. The Resident was asked if she had used the call light. The Resident indicated she had a metal bell to ring by pointing to a call bell on the overbed table. An observation was made of no cord connected to the wall where the call light would be. The Resident was asked why she had the bell and not a call light. The Resident was unsure and reported the metal bell on her overbed table was what she used to call for help. The Resident reported she had already pushed the bell, but no one had come. The Resident was asked about how long ago she had used the call bell, but the Resident was unsure and indicated it had been a while and stated, No one came yet. At 11:53 AM, the Resident rang the call bell again and stated, It can take a while, or not at all indicating staff response time to the call bell. The Resident was asked how long she had to wait, and the Resident reported a long time sometimes, did not give a length of time but indicated yes when asked if she had to wait more than a half an hour and yes to more than an hour. An observation was made of no staff response to the call bell. The Resident reached over to the call bell and gave a rapid fire of the call light at 12:08 PM. The Resident reported she could not get up on her own and could not use her right side. An observation was made of no staff in the hallway. An observation was made at 12:15 PM of staff assisting R78's roommate into the room. At 12:33 PM, R78 was assisted out of bed and into the wheelchair. A review of Resident #78's medical record revealed an admission into the facility on 2/22/2020 with diagnoses that included stroke, vascular dementia, anxiety disorder, and contracture of right wrist. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(BIMS) score of 5/15 that indicated severely impaired cognition, and the Resident was dependent on a helper for transfers. On 12/11/25 at 10:49 AM, an interview was conducted with Unit Manager (UM), Nurse A regarding R78's call bell. The observation of R78 using the call bell on 12/9/25 was reviewed with the UM. When asked if the Resident could use the call bell, the UM reported that the Resident was able to call for assistance with the call bell. When asked how the staff hear the call bell, the UM stated indicated staff would have to be in the area to hear it and stated, That's an issue with the bells. The UM manager reported she was unsure why the resident had a call bell instead of a call light. The Restorative Therapy Nurse (RTN) L reported she did not know why the Resident was changed either. The Resident's medical record was reviewed, and it was reported that the care plan was last updated in 2022 when the call bell was started. When asked if the call light versus call bell use was reassessed since 2022, the RTN stated, It depends on why it was taken away. The UM reported that if someone had a concern, then we would review it as a team and get everyone's opinion on it. When asked if a reassessment had been done since 2022, the UM stated, Not that I know of. The UM reviewed the medical record and reported that on 8/15/22 the Resident had threatened suicide and was having suicidal thoughts. The UM indicated the Resident no longer had concerns like that and no threats. It was reviewed with the UM and the RTN of the concern that it was approximately a half an hour or longer depending on when the Resident had first rung the call bell and no one was in the area to hear it with needs not met timely and lack of reassessment for call light use. Resident #121 (R121): On 12/9/25 at 3:07 PM, an interview was conducted with Resident 121 (R121) of the care received by the facility and any concerns they might have. The Resident reported that sometimes she must wait for call light response from staff and reported she has had her call light on for a long time. The Resident stated, I have to use a Hoyer lift to get me up. When I have to go to the bathroom, they just tell me to go in my diaper then they will clean it up. Sometimes it takes them a long time to get me cleaned up, so I am sitting in it for a long time. When asked if she used the call light to let them know, the Resident reported that she does use the call light and stated, sometimes fast to answer and sometimes not, and reported waits of thirty minutes or more as yes, many times. I have had messes in my pants waiting for them to get to me. The Resident was asked if they answer do they meet your needs at that time. The Resident reported at times they answer the call light, turn it off and they say they will be back, but they don't come back very soon. The Resident stated, It's hard to be in this position and then have to wait like that to get help, they don't know how it is on this side of things. A review of R121's medical record revealed an admission into the facility on [DATE] and readmission on [DATE] with diagnoses that included history of falling, anxiety disorder, depression, obesity, urinary incontinence, and knee, shoulder and bilateral hip joint replacement. A review of R121's MDS revealed a BIMS score of 15/15 that indicated intact cognition and needed substantial/maximal assistance with chair/bed-to-chair transfer and dependent on helper with toilet transfer. Confidential Group of Residents On 12/10/25 at 10:32 AM, a Confidential Group of Residents were interviewed. The group consisted of 18 Residents. The majority of Residents were able to answer questions and engaged in a group conversation. The Residents were asked about issues they had with the care received at the facility. The majority of Residents reported concerns with call lights not answered timely with wait times that would exceed 30 minutes or longer. The Residents reported that 30 minutes or more was too long to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wait for staff to answer the call light. Eight of the Residents reported that the 3rd shift had more issues with getting the light answered and reported call light response time that would exceed 30 minutes. The Residents reported that staff would come in, turn the call light off and tell the Resident that they will be back then don't show up. Six of the Residents reported concerns with this issue. One Resident reported they had complained in Resident council but It was still happening. Four Residents reported issues with call light response times during mealtimes and unable to get to the bathroom timely and incontinence due to call light not responded to timely. A review of the facility document titled, Resident Rights, date reviewed 1/22/2025, revealed, .The Resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility . 39. The resident has the right to be treated in a manner and in an environment that maintains of enhances each resident's dignity and respect in full recognition of his or her individuality . Resident #74: On 12/09/2025, at 10:30AM, Resident #74 complained that they often wait at least 30 minutes for staff to answer their call light. Resident #74 complained that staff use the excuse that they were busy with someone else or that they were short staffed. Resident #74 was asked how that made them feel and Resident #74 stated, makes me wonder if I'm going to get the help. On 12/10/2025, at 2:00 PM, a record review of Resident #74's electronic medical record revealed an admission on [DATE] with diagnoses that included Hypertension, Cerebral Palsy and Diabetes. and their most recent Brief Interview for Mental Status (BIMS) score revealed intact cognition.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that food was palatable and maintained at a palatable temperature for one resident (Resident #68) of three residents reviewed for food palatability and a group of confidential residents. Findings include: Cold food complaints with a Confidential Group of Residents On 12/10/25 at 10:32 AM, a Confidential Group of Residents were interviewed. The group consisted of 18 Residents. The majority of Residents were able to answer questions and engaged in a group conversation. The Residents were asked about issues they had with the care received at the facility. The Confidential Group of Residents reported concerns with food being too cold to eat. Six of the Residents reported that food was not warm enough sometimes when they received the food in their room and other residents reported that sometimes the food that should be warmer was cold in the dining room as well. One resident reported getting eggs that were not at a good temperature to eat them. Other Residents reported issues with the eggs as well and discussed other food items that arrived too cold to enjoy eating them. Many of the Residents talked about the serving of vegetables received cold. The group reported having a meeting with a food committee once a month and expressed that issues with cold food had been brought up. One Resident stated, I can't understand why it can't be warmer. The consensus of the group reported that food does come warm but not consistently all the time. When asked about cold items being cold enough, Residents reported that the milk can be warm and three reported milk that smelled spoiled even when the date on the carton reflected that it should still be good. The Residents reported that the milk was an issue when served in the little carton containers. No residents had issues when the milk was served in a glass. One Resident reported issues with the ice cream and stated, If you are lucky, it's a little bit frozen, with three other Residents agreeing with the issue of the ice cream. Resident #68: On 12/09/2025, at 10:00 AM, Resident #68 was sitting in their room and complained their dinner of chicken nuggets the prior evening was colder than cold. Resident #68 further offered, they told me to go to the dining room for my meals because the food would be hotter. Resident #68 offered that even though they did go to the dining room the food temperatures were still cold. On 12/10/2025, at 12:30 PM, an observation of the second-floor dining meal service was conducted. The server was asked to prepare a sample tray and place it on the hall cart. There were four staff members sitting assisting residents with their meals. Certified Nursing Assistant (CNA) I was observed carrying trays from a cart in the kitchenette to the warming table across the dining room. Once the hot food was plated onto the tray, CNA I passed them. CNA I was walking in a fast motion. There was no other staff helping. CNA I was asked if they prepare the hall trays after the dining room trays were finished and CNA I offered, yes, and normally there is someone else helping but they were on break. A few moments later, another staff member entered the dining room and began assisting with trays and placed them on the medal hall cart. On 12/10/2025, at 12:45 PM, with the assistance of a staff member, a test tray was removed from the medal cart. The tray was taken down to the first-floor conference room from the second floor, which took approximately sixty-five seconds. The breaded chicken patty temperature revealed 121.8 degrees Fahrenheit. The egg roll temperature was 112.8 degrees Fahrenheit. The carton of milk (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature was 50 degrees Fahrenheit. On 12/10/2025, at 1:30 PM, a record review of Resident #68's electronic medical record revealed an admission [DATE] with diagnoses that included Hypertension, Heart failure and debility. A review of their most recent Brief Interview for Mental Status (BIMS) score revealed impaired cognition. A review of the facility provided policy Food and Nutrition Services Date Implemented: 11/23/2026 revealed . Residents have the right to make personal dietary choices regarding food and drink. Each resident receives and the facility provides: Food prepared by methods that conserve nutrient value, flavor, and appearance; food and drink that is palatable, attractive, and at a safe and appetizing temperature . An interview was conducted with Food and Nutrition Services Director C and Certified Dietary Manager (CDM) in training H on 12/12/25 at 10:40 AM. When queried regarding multiple resident complaints identified during the survey related to food temperatures, both Director C and CDM H verbalized they were not aware of any food temperature concerns. Director C and CDM H were informed of the temperature, both measured and palatability, of the food items on the test tray obtained. When queried what food temperatures are supposed to be for warm foods, Director C stated, Holding temp is 135 and the food should also be palatable to the resident. When queried regarding the milk on the obtained food tray not being cold and temperature being 50 degrees, an explanation was not provided.

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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 ensure ongoing collaboration with hospice care for one resident (R56) of two residents sampled for hospice care, resulting in the absence of documentation of care provided by hospice. Findings include:Resident #56 (R56): R56 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease, dementia, prediabetes and hypothyroidism. On 12/11/2025 at 3:00PM, record review of the Electronic Medical Record (EMR) revealed a physician's order for hospice care is present in the chart and dated 5/2/25. On 12/11/2025 at 3:05PM, record review of the EMR did not reveal any hospice documentation for R56. On 12/11/2025 at 3:13PM, Unit Manager (UM) A, provided the hospice binder for R56 that is stored at the nurse's station. On 12/11/2025 at 3:14PM, record review of the hospice binder was conducted. Record review revealed documents of Nurse and Certified Nursing Assistants (CNA) visits from 5/8/25 to 8/1/25. The documents contained the date, who provided the visit and what tasks were completed during the visit. There was no documentation of findings from assessments performed by the nurses during their visits. On 12/11/2025 at 3:16PM, UM A was asked if there is any additional hospice documentation available? UM A stated, The CNA documents when he/she comes to the facility for showers. Confirmed there was no documentation of CNA visits after 8/1/25. UM A was asked if the hospice nurses make notes from their visits? UM A stated, I have never seen them make notes, they come in to sign the care plans and that is it. On 12/11/2025 at 3:26PM, an interview was conducted with the Director of Nursing (DON). The DON was asked if the hospice nurses provide notes from their visits? The DON stated, yes, they do, they write them up and fax them over and we put them in the binder. The DON was informed that there is no nursing documentation in the hospice binder for R56. Review of the policy titled Hospice Care and Coordination of Care, revealed:2. Coordination of CareA. Hospice and TCMCC nursing staff will communicate changes in resident condition and needs.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures for pressure ulcer management for one resident (Resident #33) of five residents reviewed resulting in lack of comprehensive identification and assessment of wound etiology and lack of correct application of pressure reduction devices. Findings include:Resident #33:On 12/11/25 at 10:07 AM, Resident #33 was observed in their room lying in bed. The Resident was positioned flat on their back with bilateral Prevalon heel boots (soft, cushioned boot which floats the heels off of a mattress or surface for pressure reduction) in place. The boots were positioned incorrectly and Resident #33's heels were not in the open area designed for the heel in the boot. Resident #33's heels were positioned directly on the side of the boot. An interview was completed at this time. When queried if they were having any pain, Resident #33 replied in my feet. When asked to rate their pain on a scale of zero to 10, with 10 being the worst pain imaginable, Resident #33 stated, Three. When asked if they had any wounds, Resident #33 revealed they have a wound on their heel. Resident #33 was asked what the wound was caused from and indicated they did not know. An interview was conducted with Licensed Practical Nurse (LPN) J on 12/11/25 at 10:19 AM. When queried, LPN J verbalized they were Resident #33's assigned nurse. LPN J was asked if Resident #33 had a wound care treatment for their heel and indicated they did. When asked to observe the wound care treatment, LPN J stated, Wound Care (LPN K) changed the dressing today. LPN J was then asked if they had ever changed the dressing and/or seen the wound and replied, Yes. When queried regarding the wound, LPN J stated, Right over heel and like a dark bruise. When queried what they meant when they said the wound was right over Resident #33's heel, LPN J proceeded to show the location individual's foot. The wound location specified by LPN J was directly over the bony prominence of the heel. LPN J was asked when they last saw the wound and replied, Last week I think. Record review revealed Resident #33 was originally admitted to the facility on [DATE] with diagnoses which included heart failure, pacemaker, diabetes mellitus, and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required substantial to total assistance for toileting, bathing, hygiene, dressing, and transferring. The MDS further detailed the Resident was at risk for pressure ulcer development and had no pressure ulcers, venous ulcers (wound caused by poor blood flow), arterial ulcers (wounds caused by poor oxygenated blood flow), and/or any other wounds. Review of Resident #33's care plans in the Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #33) has potential for pressure injury development R/T (related to) decreased mobility, DM. (Initiated: 7/31/24; Revised: 11/18/24). The care plan included the following active and resolved interventions: - Resolved: Float heels in bed and r/c (chair) (Initiated: 2/24/25; Revised and Resolved: 12/2/25)- Blanket Cradle (Device to keep blankets off feet in bed) (Initiated: 11/18/25)- Side to side repositioning in bed (Initiated: 2/24/25; Revised: 4/24/25)- Prevalon boots while in bed & r/c (Initiated and Revised: 12/2/25) A second care plan entitled, The resident has diabetic/arterial ulcer of the right heel r/t Diabetes, Lack of sensation to affected area, Renal Disease, Vascular insufficiency (Initiated and Revised: 12/10/25). The care plan included the interventions:- Determine and treat cause: poor fitting shoes, poor blood sugar control, pressure area, infection (Initiated: 12/10/25)- Ensure appropriate protective devices are applied to affected areas (Initiated: 12/10/25)- Monitor pressure areas for color, sensation, temperature (Initiated: 12/10/25)- Avoid mechanical trauma: Constrictive shoes, Cutting and trimming corns and calluses, Adhesive tapes. (Initiated: 12/10/25) Review of Resident #33's paper medical record revealed two paper forms related to identification of the etiology of the right heel wound. The first form was titled, Arterial Ulcer and the second form was titled, Diabetic Wound. Both forms were signed by Physician G on 11/25/25 and indicated the etiology of Resident #33's right heel wound was mixed but did not detail what the mixed etiology was. Review of Diagnostic Imaging and Laboratory (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	results in Resident #33's paper medical record revealed the Resident had an arterial doppler on 11/18/25 which specified, Bilat Dup (duplex) lower extremity Arterial (ultrasound) . Conclusion: Mild Peripheral Vascular Disease.Review of documentation in Resident #33's EMR revealed the following: - 11/13/25 at 6:57 PM: Health Status Note. LATE ENTRY. Writer noted a purple hued area noted to right heel while applying ace wraps in AM as ordered. - 11/13/25 at 1:29 PM: Skin/Wound Note. referred from nursing. has 2.5 x 2.5cm grey/purple discoloration noted to right heel, area firm to touch, no redness noted surrounding site, no open areas, right foot +3 edema, ace wraps present, foot warm to touch, cap refill wnl (Within Normal Limits) res denies pain to site, diabetic shoes in place, callus (thickened, hardened patch of skin that forms as a protective response to repeated friction, pressure, or irritation) noted during weekly assessment to right heel on 9/18/25, resident to float heels in bed. chronic cellulitis. has diabetes with current A1C (Hemoglobin[hbg] A1c- laboratory blood test which measures average blood glucose level for previous two to three months) of 6.6 (8/18/25). being referred to podiatry for further eval at this time. Note: Hbg A1c level of greater than 7% to greater than 8% indicates uncontrolled hyperglycemia in individuals with diabetes and a hbg A1c level of less than 7% is important for the prevention of diabetic ulcers ([NAME], et al., 2020 and [NAME], et al., 2019) - 11/17/25 at 2:50 PM: Skin/Wound Note. continues with 2.5 x 2.5cm purple/grey discoloration to right heel. also has 3 yellow/translucent circular firm areas on heel at this time next to purple discoloration. has pink blanchable area to tip of right 2nd toe with 2 yellow translucent spots noted. dressing changed as ordered, blanket cradle added. - 11/18/25 at 8:01 AM: Physician Acute Care Note. Chief complaints. heel skin changes. The patient has developed concerning lesions on right lower extremity, including a 2.5 x 2.5 centimeter grayish-purple discoloration of the right heel with slight purplish discoloration. Additionally. has a pink blanchable area at the tip of the right second toe with yellow translucent spots. Skin: 2.5 x 2.5 cm grayish-purple discoloration of the right heel with slight purplish discoloration. Pink blanchable area at the tip of the right 2nd toe with yellow translucent spots . Blood glucose was elevated at 191 - 11/20/25 at 1:28 PM: Plan of Care Note. Quarterly care plan summary. Nursing also stated that noted a purple hue on right heel, right and left callous (thickened, hardened skin from repeated pressure or friction) . Care plans reviewed. Problems, goals, and approaches reviewed, and updated in care plan. Current skin/pressure interventions for pressure ulcer prevention reviewed - 11/25/25 at 7:07 AM: Physician Acute Care Note. Chief complaints: Clinical assessment, medications review, heel ulcer and arterial doppler review. Present Illness. Recently found heel ulcer. Skin: 2.5 x 2.5 cm grayish-purple discoloration of the right heel with slight purplish discoloration. Pink blanchable area at the tip of the right 2nd toe with yellow translucent spots. - 12/4/25 at 11:27 AM: Wound Care Weekly Assessment. Right heel. Acquired. Type. diabetic/arterial. Wound Bed. skin intact, yellow discoloration with brown discoloration around edges. Length (cm- centimeters): 2.6. Width (cm): 4. Surrounding skin tissue appearance: a. Normal. b. Edematous. No redness surrounding site. Wound Progress: colored has changed from grey/purple discoloration to light yellow/tan color, no open areas noted, skin remains intact. - 12/8/25 at 2:09 PM: Wound Care Weekly Assessment. Right heel. admitted . Type. diabetic/arterial. Wound Bed. Cream colored discoloration to skin with dark brown edges. Length (cm): 2.3. Width (cm): 3.9. Surrounding Skin: Normal. Review of blood glucose monitoring documentation in Resident #33's EMR revealed no blood glucose levels were recorded on the Resident's Medication Administration Record (MAR) for November and December 2025 revealed no documentation of blood glucose level monitoring. A review of blood glucose levels documented in the vital sign documentation section of the EMR, revealed the last time Resident #33's glucose level was checked on 11/8/25. Prior to that, Resident #33's blood glucose levels were checked three to four times a day from 12/27/24 until 9/4/25.Further review of Resident #33's EMR revealed a care plan entitled, (Resident #33) has Diabetes Mellitus (Initiated: 8/14/24; Revised: 11/18/24). The care plan included the intervention, Monitor blood glucose as ordered, document and report abnormals to the physician (Initiated: 8/14/24). A review of Resident #33's Health Care Provider (HCP) orders in the EMR revealed the Resident did not have an order for (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood glucose monitoring. On 12/11/25 at 2:26 PM, Resident #33 was observed in their room in bed. The Resident was positioned flat on the back with their eyes closed. Prevalon heel boots were in place on both of the Resident's feet. The boots were positioned incorrectly, and the Resident's heels were not floated in the open area of the boots. An interview was completed with Wound Care LPN K on 12/11/25 at 3:04 PM. LPN K was queried regarding the etiology of Resident #33's left heel wound and stated, Diabetic. When asked why the wound is classified as diabetic, LPN K stated, That was determined by the doctor. Resident #33's paper forms related to wound etiology were reviewed with LPN K at this time. When asked why both form specified the right heel wound was Mixed, LPN K replied, Because (Resident #33) had interventions in place for pressure prevention and could move their legs. LPN K was asked what mixed etiology meant and stated, More than one etiology to the wound. When queried what the etiologies were to Resident #33's wound, LPN K responded, Diabetes and arterial insufficiency. When queried why Resident #33's blood glucose levels were not being monitored, if part of the etiology of the wound was diabetes, LPN K did not provide an explanation. When queried if pressure was a potential etiology of the wound, LPN K indicated it was not as there were interventions in place for pressure prevention. LPN K was then asked if Resident #33 had seen a wound care physician/provider related to their wound and responded their Primary Care Provider (PCP), Physician G, oversaw the evaluation and treatment of the wound. When asked when the Prevalon heel boots were implemented, LPN K reviewed Resident #33's medical record and stated, 12/2/25. LPN K was then asked when the wound was first identified and stated, 11/13/25. When asked why the Prevalon boots were not implemented until 12/2/25 when the wound was identified on 11/13/25, LPN K stated, (Resident #33) had float heels in place. LPN K was asked if facility staff were educated regarding appropriate application of Prevalon boots and answered, Yes. When queried if the heel has to be positioned properly to provide pressure prevention and relief, LPN K responded they did. LPN K was informed of observations of the position of Resident #33's heels in the boots and was asked if they had a Prevalon boot to demonstrate the position of the Resident's feet in the boots. Restorative Manager Registered Nurse (RN) L obtained a Prevalon boot and joined the interview. Both LPN K and RN L were shown the position of Resident #33's heels/feet in the Prevalon boots and verbalized understanding. When queried if the Prevalon boots were providing pressure reduction when positioned incorrectly as demonstrated, both LPN K and RN L verbalized the boots do not provide pressure reduction when positioned incorrectly. When queried if they understood the concern related to pressure, both LPN K and RN L responded they did. When queried how they knew pressure was not the etiology and/or a contributing etiology to the Resident's right heel wound, LPN K did not provide an explanation. LPN K was then asked about the wound care treatment and dressing for the right heel wound and responded that the dressing is just foam. When queried what the wound bed felt like when palpated, LPN K revealed the wound bed was more firm than boggy. With further inquiry, LPN K stated, It started off more purple/gray and is now cream in the center with a purple/gray ring around the outside. An interview was completed with Physician G on 12/12/25 at 9:01 AM. When queried regarding the etiology of Resident #33's heel wound, Physician G responded that the wound etiology was arterial and diabetic and revealed they had ordered an arterial doppler study. Physician G was then asked why they classified the wound as arterial when the results of the doppler only showed mild PVD and stated, Does not appear to be arterial because of the arterial doppler. When queried regarding the wound etiology being documented as mixed when they just said it did not appear to be arterial, Physician G stated, Diabetic ulcer because (Resident #33 has) mild PVD, uncontrolled diabetes, and arterial flow worse in the left than the right. When asked if they were saying the doppler showed the blood blow in the left leg was worse than in the right leg when the wound was on the right heel, Physician G confirmed. When queried regarding if they had visualized and assessed Resident #33's right heel wound, Physician G replied, Once. I go off of what the wound nurse (LPN K) tells me. Physician G was then asked why they determined the wound was not caused by pressure considering the Resident was at risk for pressure ulcer development and stated, (Resident #33) has uncontrolled (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diabetes. When asked why Resident #33's blood glucose levels were not be monitored if they were concerned that the etiology of the heel wound was diabetic and their blood glucose levels were uncontrolled, Physician G replied, We are (monitoring blood glucose levels). Physician G was informed the most recent blood glucose level in Resident #33's EMR was on 11/8/25 and prior to that was on 9/4/25. When asked about the lack of blood glucose monitoring, Physician G revealed they thought facility staff were monitoring the Resident's blood glucose level and would check with the facility. When queried regarding Resident #33's Hbg A1c levels, Physician G stated, That can be deceptive. Physician G was then queried regarding Resident #33 being assessed as at risk for pressure ulcer development and Prevalon boots not being implemented until after the right heel wound developed but did not provide an explanation. Physican G was then informed of observations of Prevalon heel boots being positioned incorrectly and therefore not providing pressure relief and replied, I don't know about that. When asked if the right heel wound may have been caused by pressure, Physician G stated, That might be a possibility. On 12/12/25 at 11:37 AM, Resident #33 was observed laying in bed on their back with their eyes closed and mouth open. The Resident's brief was exposed and visible upon entering the room. An interview was completed with RN M on 12/12/25 at 11:55 AM. When queried if Resident #33's blood glucose levels were being routinely monitored, RN M reviewed the Resident's EMR and confirmed the Resident's blood glucose was not being monitored routinely and was last checked on 11/8/25. RN M was asked if Resident #33 moved their legs on their own and replied, Minimal. When queried if Resident #33 is able to reposition themselves in the bed, RN M stated, Not really. It is mainly us (staff) doing it. An interview was completed with the facility Administrator on 12/12/2025 1:43 PM. When queried regarding Resident #33's right heel wound including etiology and observations of Prevalon heel boots being positioned incorrectly, the Administrator did not provide further explanation. Review of facility provided policy/procedure entitled, Skin Care (Revised: 1/27/25) revealed, Pressure Injury or incidents involving skin. 1. Nursing staff will document their initial findings in EMR. Documenting using the clock method: In this method, the face of a clock is used as a measurement guide. The 12:00 reference position is towards the head of the body and 6:00 towards the feet, and measurements are thus obtained from 12:00 to 6:00 (length) and from 9:00 to 3:00 (width). Nursing or Wound Care Nurse will document on wound weekly in EMR. 2. Relieve pressure and/or causative measures to area when able 3. Evaluate pressure relief devices and interventions and initiate/change PRN (as needed). Citations:[NAME], M., Onar, L. C., [NAME], B., & Gumustas, S. A. (2019). Is high level of hemoglobin A1C an indicator for extended period of antibiotherapy in diabetic foot ulcers?. Northern clinics of Istanbul, 6(1), 21-27. https://doi.org/10.14744/nci.2018.25582Liu, L., [NAME], F., [NAME], E. J., [NAME], K., [NAME], S., [NAME], F., [NAME], P. Y., & [NAME], H. J. (2020). Burden of Uncontrolled Hyperglycemia and Its Association with Patients Characteristics and Socioeconomic Status in Philadelphia, USA. Health equity, 4(1), 525-532. https://doi.org/10.1089/heq.2020.0076

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility failed to ensure that daily posted nurse staffing data included delineation of licensed nursing staff and accurate documentation of actual hours worked, resulting in incomplete and inaccurate nurse staffing information. Findings include:On 12/10/25 at 2:49 PM, the facility posted nurse staffing hours were observed posted in the main hallway of the facility. The posted hours included a section for Licensed Nursing Staff but did not distinguish between the number and/or hours of Registered Nurses (RN) versus Licensed Practical Nurses (LPNs) who were working. An observation of the posted nurse staff information on 12/11/25 at 10:00 AM revealed the same form was used to post facility nurse staffing data and the number/hours of RNs and LPNs were not separate on the form. An interview was completed with the facility Administrator on 12/11/25 at 12:03 PM. When queried how an individual reviewing the posted nurse staff information knew if there was an RN in the building, the Administrator reviewed the facility posted staffing form and verbalized they could not because the posting does not distinguish between RN and LPN hours. When queried if they were familiar with the posted nurse staffing requirements, the Administrator responded they were not. F732 in the State Operations Manual (SOM) was reviewed with the Administrator at this time. After reviewing the SOM, the Administrator verbalized it was non-refutable that RN and LPN hours had to be separated on the form. The Administrator stated they were not aware it had to be like that and revealed they would change the form. When queried regarding the procedure for completion of the posted nurse staffing form, the Administrator responded that the form is completed at the beginning of each shift by the shift supervisor. When asked how the facility ensures the data accurately reflects nursing staff absences on the shift due to call-ins and/or leaving without working an entire shift, the Administrator verbalized the form did not provide accurate staffing information if a staff member left early and indicated they would ensure accurate information was posted and available to the public.